IUOE Local 399 Health and Welfare Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 06/01/2016 - 05/31/2017

Coverage for: Family Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.iuoe399.org or by calling 1-312-372-9870.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$300** individual/ **$1200** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**$5,000** for in network. None for out of network.	The **out-of-pocket limit** (in network) is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. (Out of network) there's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	Prescription drug coinsurance, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on Page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see www.bcbsil.com or call 1-800-810-2583.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page **5**. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-312-372-9870 or visit us at www.iuoe399.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.iuoe399.org or call 1-312-372-9870 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **BlueCross BlueShield providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	----------none----------
	Specialist visit	10% coinsurance	30% coinsurance	----------none----------
	Other practitioner office visit	10% coinsurance for chiropractor	30% coinsurance for chiropractor	Coverage is limited to $1,000 per year for chiropractic.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Preventive care/screening/immunization	10% coinsurance	Not covered except as described (30% for covered services)	Covered when in-network (only): • Well-child visits and immunizations through age 18 • Annual adult physicals • Adult immunizations recommended by the Center for Disease Control • Adult diagnostic services recommended by the U.S. Preventive Services Task Force • Facility fee for screening colonoscopy Covered in- or out-of-network: • Mammograms over age 40, gynecological exams/tests, and PSA test over age 45 • Screening colonoscopies over age 50
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	No coverage for genetic testing.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	----------none----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	30% coinsurance	100%	No coverage for prescriptions filled at Sam's Club or WalMart. Covers up to a 30-day supply (retail prescription); up to 90 day supply (mail order). Coinsurance does not apply to the out-of-pocket limit.
	Brand drugs	40% coinsurance (retail), 30% (mail order)	100%	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	Pre-certification is required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	10% coinsurance after $100 co-pay	30% coinsurance after $100 co-pay	----------none----------
	Emergency medical transportation	10% coinsurance	10% coinsurance	----------none----------
	Urgent care	10% coinsurance	30% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Pre-certification is required.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	30% coinsurance	----------none----------
	Mental/Behavioral health inpatient services	10% coinsurance	30% coinsurance	Pre-certification is required.
	Substance use disorder outpatient services	10% coinsurance	30% coinsurance	----------none----------
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance	Pre-certification is required.
If you are pregnant	Prenatal and postnatal care	10% coinsurance	30% coinsurance	----------none----------
	Delivery and all inpatient services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Pre-certification is required.
	Rehabilitation services	10% coinsurance	30% coinsurance	Pre-certification is required. No coverage for developmental therapy.
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	10% coinsurance	30% coinsurance	Pre-certification is required.
	Durable medical equipment	10% coinsurance	30% coinsurance	Pre-certification is required.
	Hospice service	10% coinsurance	30% coinsurance	Pre-certification is required.
If your child needs dental or eye care	Eye exam	$10 co-pay	Amount in excess of $ 150 for exam, lenses & frames combined	Benefit limited to once per calendar year. Charges for services provided by Wal-Mart or Sam's Club are not covered.
	Glasses	$20 co-pay for single & lined multi-focal lenses; amount in excess of $130 for frames		
	Dental check-up	0% coinsurance	50% coinsurance	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Cosmetic surgery	• Developmental therapy
• Genetic testing	• Habilitation services	• Hearing aids
• Infertility treatment	• Long-term care	• Out-of-network surgical centers
• Weight loss programs		
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery subject to specific criteria	• Chiropractic care up to $1,000/year	• Dental care (Adult)
• Non-emergency care when traveling outside the U.S., but only for persons who are absent from the U.S. for fewer than 60 days	• Private duty nursing when determined by the review organization to be medically necessary and appropriate	• Routine eye care (Adult)
• Routine foot care, meaning medical care for diseases such as diabetes, and medical conditions of the foot		

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-312-372-9870. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

IUOE Local 399 Health and Welfare Fund
Attn: Fund Administrator
2260 S. Grove Street
Chicago, IL 60616-1823

Does This Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-312-372-9870.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-312-372-9870.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-312-372-9870.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-312-372-9870.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,440
- **Patient pays** $1,100

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Copays	$
Coinsurance	$760
Limits or exclusions	$40
Total	**$1,100**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,920
- **Patient pays** $1,480

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$
Coinsurance	$1,080
Limits or exclusions	$100
Total	**$1,480**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.