IUOE Local 14-14B Welfare Fund: Actives

Coverage Period: 1/01/2017 - 12/31/2017

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

Coverage for: Individual + Family | **Plan Type:** EPO

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.local14funds.org** or by calling **the Fund Office at (718) 939-1489**.

Important Question	Answers	Why this Matters:
What is the overall deductible?	In-Network: **None**; Out-of-Network Medical: **$100** person/**$200** family. Doesn't apply to emergency room, prescription drugs, x-ray, laboratory, surgical, in-network benefits and out-of-network hospital benefits. Balance billing, excluded services do not count toward the **deductible**.	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?	Yes. **$50** person/**$100** family Out-of-Network Dental. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. In-Network: Medical: **$5,600** Individual/ **$11,200** Family; Prescription Drug: **$1,000** Individual/ **$2,000** Family; Out-of-Network Major Medical: **$2,000** individual/ **None** family.	The **out-of-pocket limit** 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.
What is not included in the out–of–pocket limit?	In-Network and Out-of-Network: Balance billing and health care this plan does not cover; Out-of-Network does not include copayments, deductible and prescription drugs.	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 *specific* coverage limits, such as limits on the number of office visits.

Questions: Call the **Fund Office at (718) 939-1489** or visit us at **www.local14funds.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.local14funds.org** or call **the Fund Office at (718) 939-1489** to request a copy.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. For a list of in-network **providers**, visit **www.local14funds.org** or call the Fund Office at (718) 939-1489.	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 6. See your policy or plan document for additional information about **excluded services**.

- **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 In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Service 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	$20 copay/visit	$20 copay/visit plus 10% coinsurance after deductible plus balances above allowed amount	-- None --
	Specialist visit	$30 copay/visit	$30 copay/visit plus 10% coinsurance after deductible plus balances above allowed amount	-- None --
	Other practitioner office visit	$30 copay/visit for chiropractic care and acupuncture	Chiropractic: $30 copay/visit plus balances above allowed amount; Acupuncture: $30 copay/visit plus 10% coinsurance plus balances above allowed amount	Chiropractic limited to 40 visits per calendar year (spouse and member only); acupuncture limited to 12 visits per calendar year.
	Preventive care/ screening/immunization	No charge	10% coinsurance after deductible plus balances above allowed amount for well child; balances above allowed amount for screening	Age and frequency limits apply. Out-of-network only covers well child visits, mammography, pap smear, adult exams and immunizations.

Common Medical Event	Service 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 have a test	Diagnostic test (x-ray, blood work)	No charge	Balances above allowed amount	---None---
	Imaging (CT/PET scans, MRIs)	$50 copay/test	$50 copay/test plus balances above allowed amount	Provider must precertify in-network benefits.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cvshealth.com.	Generic drugs	Retail: $5 copay/prescription Mail order: $10 copay/prescription	Retail only: $5 copay per prescription plus balances over allowed amount	Retail: 30-day supply; Mail order: 90 day supply. Certain drugs require prior authorization from CVS Health. No copay for generic drugs for women's contraceptives and other ACA-required preventive services prescriptions. Any over-the-counter drugs that are payable under this provision require a prescription to be covered.
	Formulary Brand Drugs	Retail: $20 copay/prescription Mail order: $40 copay/prescription	Retail only: $20 copay/ prescription plus balances over allowed amount	
	Non-Formulary Brand Drugs	Retail: $35 copay/prescription Mail order: $70 copay/prescription	Retail only: $35 copay/ prescription plus balances over allowed amount	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Free-standing facility: No charge; Outpatient hospital facility: $100 copay/visit	Free-standing facility: 20% coinsurance plus balances above allowed amount; Outpatient hospital facility: $100 copay/visit plus 20% coinsurance after deductible plus balances above allowed amount	Only one copay applies for radiation therapy and chemotherapy per covered person per year. Provider must precertify in-network benefits.
	Physician/surgeon fees	No charge	Balances above allowed amount	Assistant surgeon paid at 25% of schedules allowance for out-of-network surgeon.
If you need immediate medical attention	Emergency room services	$200 copay/visit	$200 copay/visit plus balances above allowed amount	Copay is waived if admitted.
	Emergency medical transportation	No charge	10% coinsurance plus balances above allowed amount	Emergency ambulance only.
	Urgent care	$20 copay/visit	$20 copay/visit plus 10% coinsurance plus balances above allowed amount	Treated in same manner as office visit.

Common Medical Event	Service 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 have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/admission	$100 copay/admission plus 20% coinsurance plus balances above allowed amount	Only semi-private room. Provider must precertify in-network benefits..
	Physician/surgeon fee	No charge	10% coinsurance plus balances above allowed amount	--None---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visit: $20 copay/visit; Outpatient Facility: No charge	Office Visit: $20 copay/visit plus 10% coinsurance after deductible plus balances above allowed amount; Outpatient Facility: 10% coinsurance plus balances above allowed amount	Provider must precertify in-network outpatient facility benefits.
	Mental/Behavioral health inpatient services	$100 copay/admission	$100 copay/admission plus 20% coinsurance plus balances above allowed amount	Only semi-private room. Provider must precertify in-network benefits.
	Substance use disorder outpatient services	Office Visit: $20 copay/visit; Outpatient Facility: No charge	Office Visit: $20 copay/visit plus 10% coinsurance plus balances above allowed amount; Outpatient Facility: 10% coinsurance after deductible plus balances above allowed amount	Provider must precertify in-network outpatient facility benefits.
	Substance use disorder inpatient services	$100 copay/admission	$100 copay/admission plus 20% coinsurance plus balances above allowed amount	Only semi-private room. Provider must precertify in-network benefits.
If you are pregnant	Prenatal and postnatal care	No charge	Balances above allowed amount	---None---
	Delivery and all inpatient services	No charge	Facility: 20% coinsurance plus balances above allowed amount Provider: Balances above allowed amount	Only semi-private room.

Common Medical Event	Service 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 help recovering or have other special health needs	Home health care	No charge	20% coinsurance after deductible plus balances above allowed amount	Limited to 40 visits per calendar year; up to 4 hours of service are counted as one visit. Provider must precertify in-network benefits.
	Rehabilitation services	Inpatient facility: $100 copay/admission Outpatient: $30 copay/visit	Inpatient facility: $100 copay/admission plus 20% coinsurance plus balances above allowed amount; Outpatient: $30 copay/visit plus 10% coinsurance after deductible plus amounts above allowed amount	Inpatient limited to 30 days per calendar year. Outpatient limited to 24 visits per diagnosis. Provider must precertify in-network benefits.
	Habilitation services	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
	Skilled nursing care	Inpatient facility only: $100 copay/admission	Not covered	Precertification is required. Limited to 30-days per calendar year following hospitalization only. Provider must precertify in-network benefits.
	Durable medical equipment	No charge	Not covered	Covers purchase if cost exceeds rental. Not covered out-of-network; provider must precertify in-network benefits.
	Hospice service	No charge	20% coinsurance plus balances above allowed amount	Limited to 210 days. Provider must precertify in-network benefits.
If your child needs dental or eye care	Eye exam	No charge	Balances over $250 per 24-months (combined with glasses)	Limited to $250 every 24 months for eye exams and glasses combined.
	Glasses	No charge	Balances over $250 per 24-months (combined with exam)	
	Dental check-up	No charge	Balances over allowed amount after dental deductible	Limited to $1,500 per person and $4,500 per family per calendar year.

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.)**

- Cosmetic surgery
- Habilitation services
- Hearing aids
- Long-term care
- Private-duty nursing
- Skilled Nursing Care (out-of-network)
- 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.)**

- Acupuncture (up to 12 visits per year)
- Bariatric surgery (to treat morbid obesity only)
- Chiropractic care (up to 40 visits per year Member & Spouse only)
- Dental care (Adult) (up to annual maximum of $1,500 person/$4,500 family per calendar year)
- Infertility treatment (one cycle per lifetime)
- Non-emergency care when traveling outside the U.S. (for in-network benefits only)
- Routine eye care (up to $250 per 24-months)
- Routine foot care (for Diabetics only)

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 (718) 939-1489. 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 the plan at 141-57 Northern Boulevard, Flushing, NY 11354; Telephone: (718) 939-1489; www.local14funds.org. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 or policy 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 1-877-267-2323.

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** $7,330
- **Patient pays** $210

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	$0
Copays	$60
Coinsurance	$0
Limits or exclusions	$150
Total	**$210**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,845
- **Patient pays** $555

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	$0
Copays	$475
Coinsurance	$0
Limits or exclusions	$80
Total	**$555**

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.
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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.

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