

IBEW Local 102 Welfare Fund: Plan A

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

Coverage Period: 01/01/2017 - 12/31/2017
 Coverage for: Family | Plan Type: Direct Access



: 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.ibewlocal102.org or by calling 1-888-423-9102.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$500 person / \$1,000 family Doesn't apply to facility claims, anesthesia claims or participating claims.	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 <u>out-of-pocket</u> limit on my expenses?	Yes, \$5,000 individual / \$10,000 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 <u>out-of-pocket</u> limit?	Premiums, balance billed charges, co-payments, out-of-network co-pays for facilities, in-network co-pays and coinsurances, deductibles, penalties for failure to obtain pre-authorization for services and health care that this plan does not 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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of preferred providers see www.horizonblue.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 <u>specialist</u> ?	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 4. See your policy or plan document for additional information about excluded services .

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- **Copayments** are fixed dollar amounts (for example, \$25) 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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 co-pay/visit	30% coinsurance after deductible	Coverage is limited to \$1,500/accident for automobile accidents. No coverage for workmen's compensation claims or out of network pain management services.
	Specialist visit	\$25 co-pay/visit	30% coinsurance after deductible	
	Other practitioner office visit	\$25 co-pay/visit	30% coinsurance after deductible 100% cost to member for all out of network pain management services	Coverage is limited to 26 visits/person/calendar year, 80 visits/family/calendar year for in-network chiropractic/acupuncture claims and 20 visits/person, 40 visits/family for out of network chiropractic/acupuncture claims. Coverage is limited to 36 combined physical therapy/occupational therapy visits, 12 speech therapy visits and 30 cardiac rehab visits/calendar year.
	Preventive care/screening/immunization	No charge	No coverage for preventative care/screening/immunizations	No coverage if you use an out of network provider.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance after deductible	All testing and outpatient care is subject to a \$100 co-pay if services are rendered in a facility. No out of network benefits for pain management and drug testing.
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance after deductible	

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<p>If you need drugs to treat your illness or prescription</p> <p>More information about prescription drug coverage is available by calling Global Pharmaceutical Benefits, LLC at: 1-800-341-2234</p> <p>If you are interested in obtaining prescriptions with a \$0.00 co-pay and/or 90 day supply for maintenance medications call Global Pharmaceutical Benefits, LLC for further information on Horizon Health Center .</p> <p>For more information regarding specialty drugs, call: Global Pharmaceutical Benefits LLC at: 800 341-2234</p>	Generic drugs	\$10 co-pay	<p>\$15 co-pay for the Walgreen/Duane Reade pharmacy network.</p> <p>\$20 co-pay for CVS/Caremark pharmacy network</p>	<p>30 day supply on all medications available at all retail pharmacies.</p> <p>All proton pump inhibitors, schedule II substances except attention deficit disorder drugs and compounded medications are not covered under the Plan.</p>
	Preferred brand drugs	50% coverage with a \$60 maximum	<p>55% co-pay for the Walgreen/ Duane Reade and Target pharmacy network with a \$150 maximum.</p> <p>60% co-pay for CVS/Caremark pharmacy network with a \$150 maximum</p>	<p>There is an additional cost to members for using the Walgreen/Duane Reade or Target pharmacy network. The co-pay for generic drugs is \$15 and the co-pay for preferred or non preferred brand and specialty drugs is 55% with maximum co-pay listed under each section.</p>
	Non- preferred brand drugs	50% coverage with a \$300 maximum	<p>55% co-pay for the Walgreen/ Duane Reade and Target pharmacy network with a \$350 maximum.</p> <p>60% co-pay for CVS/Caremark pharmacy network with a \$350 maximum</p>	<p>There is an additional cost to members for using the CVS/Caremark pharmacy network. The co-pay for generic drugs is \$20 and the co-pay for preferred or non f preferred brand and specialty drugs is 60% with maximum co-pay listed under each section.</p>
	Specialty drugs	Processed under applicable preferred/ non-preferred rate	Processed under applicable preferred/ non- preferred rate	<p>You may view your formulary (preferred) brand drug list online at: www.globalpharmaceuticalbenefits.com</p> <p>You will be prompted to create a user name and password.</p>

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If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 co-pay	\$100 co-pay plus 20% coinsurance	Out of network pain management services are not covered.
	Physician/surgeon charges	No charge	30% coinsurance after deductible	Bariatric surgery has limitations. See page 7. Pre authorization required.
If you need immediate medical attention	Emergency room services	\$100 co-pay	\$100 co-pay plus 20% coinsurance	For non-participating professional providers, coverage is limited to the first \$500 paid at 100% and the balance paid at 80% of UCR if hospital is participating.
	Emergency medical transportation	No charge	30% coinsurance after deductible	Coverage for ground ambulance service only, to transport an individual from the place where injury or illness occurred to the closest hospital where treatment can be given.
	Urgent care	\$25 co-pay	30% coinsurance after deductible	Coverage is limited to \$1,500/accident for automobile accidents. No coverage for workmen's compensation claims.
If you have a hospital stay Must be pre-authorized through Horizon BCBS at: 1-800-664-2583	Facility fee (e.g., hospital room)	No charge	20% coinsurance 100% cost to member for all out of network pain management services	Coverage is limited to 120 inpatient days per calendar year for all services, combined. Failure to pre-authorize will result in up to a \$500 reduction for admissions approved as Medically Necessary. Admissions not approved as Medically Necessary will not be covered and the covered person will be responsible for 100% of the non-covered charges.
	Physician/surgeon fee	No charge	30% coinsurance after deductible	Must be medically necessary.

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If you have mental health, behavioral health or substance abuse needs	Mental/behavioral health outpatient services	\$25 co-pay/visit	\$100 co-pay plus 20% coinsurance at a facility. 30% coinsurance after deductible at a doctor's office.	The network is: Concern Plus 25 Lindsley Place, Suite 100 Morristown, NJ 07960 Contact Concern Plus at: 1-800 242-7371 for pre-authorization and claim filing information. Co-pays apply to behavioral health Intensive Outpatient and Partial Hospitalization Program services. Out of network drug testing is not covered.
	Substance use disorder outpatient services	Not covered	Not covered	
	Mental/behavioral health inpatient services	No charge	20% coinsurance and excess UCR charges	Coverage is limited to 120 inpatient days/calendar year for all services combined. Out of network drug testing is not covered. Pre-authorization must be obtained through Concern Plus at 1-800 242-7371. Failure to pre-authorize will result in up to a \$500 reduction for admissions approved as Medically Necessary. Admissions not approved as Medically Necessary will not be covered and the covered person will be responsible for 100% of the non-covered charges.
	Substance use disorder inpatient services	Not covered	Not covered	
If you are pregnant	Prenatal and postnatal care	\$25 co-pay	30% coinsurance after deductible	No coverage for pregnancy related charges and complications of pregnancy for dependent children.
	Delivery and all inpatient services	No charge	30% coinsurance after deductible	
If your child needs dental or eye care	Eye exam	Not covered	Not covered	-----none-----
	Glasses	Not covered	Not covered	-----none-----
	Dental check -up	Not covered	Not covered	-----none-----

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If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance after deductible	Coverage is limited to 3 days for full time home care services and 120 annual visits for combined home care services and a \$10,000 annual max for home care nursing. Pre-authorization required. Service must begin within 14 days of a hospital discharge.
	Rehabilitation services	No charge for inpatient facility claims	\$100 co-pay plus 20% coinsurance for outpatient services at a facility.	Coverage is limited to 120 inpatient days/calendar year for all services combined. Failure to pre-authorize will result in up to a \$500 reduction for admissions approved as Medically Necessary.
		\$25 co-pay/visit for outpatient claims	30% coinsurance after deductible at a doctor's office. 20% coinsurance for inpatient facility.	Admissions not approved as Medically Necessary will not be covered and the covered person will be responsible for 100% of the non-covered charges. Coverage for outpatient services is limited to 36 combined physical therapy/occupational therapy visits, 12 speech therapy and 30 cardiac rehab visits/calendar year.
	Habilitation services	Not covered	Not covered	-----none-----
	Skilled nursing care	No charge	20% coinsurance	Coverage is limited to 120 days/calendar year combined with the Home health care benefit. Pre-authorization required.
	Durable medical equipment	20% coinsurance	30% coinsurance after deductible	Pre-authorization is required for all charges exceeding \$1,500.
	Hospice Service	No charge	Excess UCR charges	Pre-authorization required.

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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.)

Workmen's compensation injuries; Routine Vision; Hearing; TMJ; Substance Abuse; Infertility; Massage Therapy; Cosmetic Surgery; Pregnancy related charges and complications of pregnancy for any dependent other than a spouse; Habilitation services; Long Term Care; Gym Memberships; Weight Loss Programs; Orthotics; All routine preventive and well care visits with a non participating provider; All pain management services with a non participating provider including professional services (the doctor), facility (the surgery center or hospital), anesthesia and /or any other related charges, including office visits and testing; All drug testing by an out of network provider; All durable medical equipment prescribed by a chiropractor; Air and Sea Ambulance Service; Non-Emergency Ambulance Services (for example, from hospital to rehab would not be covered); Services that are deemed to be Investigational; Services that are not Medically Necessary; All Compounded drugs; Proton Pump Inhibitors including, but not limited to Omeprazole, Prilosec, Prevacid, Zegerid, Aciphex, Dexilant, and Nexium, along with any other drugs classified as proton pump inhibitors; Any prescription available over the counter; All Schedule II substances including, but not limited to Codeine, Morphine, Hydrocodone, Oxycodone, and Percocet, with the exception of attention deficit disorder drugs.

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.)

Wigs, covered up to \$500.
Full Bony Impacted Wisdom Teeth – Limited benefit
Nutritional counseling – up to 3 visits per year, participating providers only
Bariatric surgery and complications of bariatric surgery are limited to \$15,000 lifetime. Pre-authorization is required.
Breast pumps, covered up to \$50

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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 1-800-792-3666. 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 1-888-423-9102.

For group health coverage subject to ERISA, contact the plan at 1-888-423-9102 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Language access Services:

Spanish: Para obtener asistencia en Español, llame al 888 423-9102

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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 \$7,465
- Patient pays \$75

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:	\$75
Deductibles	\$0
Co-pays	\$75
Coinsurance	\$0
Limits or exclusions	\$0
Total	\$75

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

- Amount owed to providers: \$5,400
- Plan pays \$5,325
- Patient pays \$75

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:	\$75
Deductibles	\$0
Co-pays	\$75
Coinsurance	\$0
Limits or exclusions	\$0
Total	\$75

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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.