Local Union No. 33: Health and Welfare Plan

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

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

Coverage for: Individual + 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 by calling 515-243-3246.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$750** person/**$1,500** family; Non-Network: **$1,500** person/**$3,000** family. Doesn't apply to prescription drugs, Network preventive care, dental, routine vision and hearing aids. Balance billing, excluded services, prescription drugs, dental, vision, and hearing aids do not count toward the **deductible.** If eligible, the HRA may be used to offset all or a portion of your out-of-pocket expenses.	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?	Yes. For medical, Network: **$2,750** person/**$5,500** family; Non-Network: **$5,500** person/**$11,000** family. For prescription drug, **$3,850** individual/**$7,700** family. If eligible, the HRA may be used to offset all or a portion of your out-of-pocket expenses.	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?	Premiums, balance billing, health care this plan does not cover, deductibles, dental, vision and hearing aids.	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.

Questions: Call 515-243-3246.

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.dol.gov/ebsa/healthreform or call 515-243-3246 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**, call 1-800-613-1124 or see www.ualocal33.org or call 515-243-3246.	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**.

- **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 a Network Provider	Your Cost If You Use a Non-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% coinsurance	30% coinsurance	-- None --
	Specialist visit	20% coinsurance	30% coinsurance	Chiropractic care expenses up to $1,000 is reimbursable from the member's HRA.
	Other practitioner office visit	Not covered	Not covered	No coverage for chiropractic care or acupuncture.
	Preventive care/ screening/immunization	No charge	30% coinsurance	The office visit is not covered for non-network. Annual deductible applies all other services for Non-Network providers.

Common Medical Event	Service You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance/test	30% coinsurance/test	-- None --
	Imaging (CT/PET scans, MRIs)	20% coinsurance/test	30% coinsurance/test	-- None --
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 515-243-3246.	Generic drugs	20% coinsurance	20% coinsurance	Generic drug and brand name drug when generic drug is not available. Prescription drugs are not covered if prescription drug card is not shown at time of purchase.
	Preferred brand drugs	20% coinsurance of generic drug cost, plus difference between the cost of the brand name and generic drug if generic is available	20% coinsurance of generic drug cost, plus difference between the cost of the brand name and generic drug if generic is available	Prescription drugs are not covered if prescription drug card is not shown at time of purchase.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	-- None --
	Physician/surgeon fees	20% coinsurance	30% coinsurance	-- None --
If you need immediate medical attention	Emergency room services	20% coinsurance plus $100 copayment	20% coinsurance plus $100 copaymen.	Copayment waived if you are admitted to the Hospital within 24 hours. Non-network inpatient hospital stays are not covered unless due to emergency medical condition. You must pay 100% of charges for these stays.
	Emergency medical transportation	20% coinsurance	30% coinsurance	Transportation to the nearest appropriate facility.
	Urgent care	20% coinsurance	30% coinsurance	You must pay 100% of charges for these stays.

Common Medical Event	Service You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered unless due to emergency; 30% coinsurance in case of emergency	Non-network inpatient hospital stays are not covered unless due to emergency medical condition. You must pay 100% of charges for these stays.
	Physician/surgeon fee	20% coinsurance	Not covered unless due to emergency; 30% coinsurance in case of emergency	Non-network inpatient hospital stays are not covered unless due to emergency medical condition. You must pay 100% of charges for these stays.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	30% coinsurance	Group and family therapy is not covered.
	Mental/Behavioral health inpatient services	20% coinsurance	Not covered unless due to emergency; 30% coinsurance in case of emergency	Group and family therapy is not covered. Non-network inpatient hospital stays are not covered unless due to emergency medical condition. You must pay 100% of charges for these stays.
	Substance use disorder outpatient services	20% coinsurance	30% coinsurance	-- None --
	Substance use disorder inpatient services	20% coinsurance	Not covered unless due to emergency; 30% coinsurance in case of emergency	Non-network inpatient hospital stays are not covered unless due to emergency medical condition. You must pay 100% of charges for these stays.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	30% coinsurance	Limited to an employee, retiree or dependent spouse.
	Delivery and all inpatient services	20% coinsurance	30% coinsurance	Limited to an employee, retiree or dependent spouse.

Common Medical Event	Service You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Must be medically necessary.
	Rehabilitation services	20% coinsurance	Outpatient 30% coinsurance. Inpatient not covered unless due to emergency; 30% coinsurance in case of emergency.	Physical therapy coverage is limited to $150/visit. You must pay 100% of charges for non-network inpatient stays if not due to emergency medical condition.
	Habilitation services	20% coinsurance	Not covered	Not covered.
	Skilled nursing care	20% coinsurance	Outpatient 30% coinsurance. Inpatient not covered unless due to emergency; 30% coinsurance in case of emergency.	Must be medically necessary. You must pay 100% of charges for non-network inpatient stays if not due to emergency medical condition.
	Durable medical equipment	20% coinsurance	30% coinsurance	-- None --
	Hospice service	20% coinsurance	Outpatient 30% coinsurance. Inpatient not covered unless due to emergency; 30% coinsurance in case of emergency.	Coverage is limited to a maximum of 210 days. You must pay 100% of charges for non-network inpatient stays if not due to emergency medical condition.
If your child needs dental or eye care	Eye exam	No charge	No charge	$150 calendar year maximum per person for eye exam and glasses combined.
	Glasses	No charge	No charge	$150 calendar year maximum per person for eye exam and glasses combined.
	Dental check-up	No charge	No charge	Limited to one every 6 months.

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Infertility treatment	• Private-duty nursing
• Bariatric surgery	• Long-term care	• Routine food care
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• 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 those services.)		
• Chiropractic care (reimbursable through member's HRA only up to $1,000)	• Hearing aids ($350 maximum per ear per person per four-year period)	• Routine eye care (Adult; $150 calendar year maximum per exam and glasses combined per person)
• Dental care (Adult; one exam every 6 months)		

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 515-243-3246. 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 515-243-3246. 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 515-243-3246.

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** $5,330
- **Patient pays** $2,210

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	$750
Co-pays	$0
Co-insurance	$1,310
Limits or exclusions	$150
Total	**$2,210**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,720
- **Patient pays** $1,680

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	$750
Co-pays	$0
Co-insurance	$850
Limits or exclusions	$80
Total	**$1,680**

Retired Persons Age 65 or Older: Only the dental, vision, hearing and Medicare program apply to retired persons age 65 or older.

A Health Reimbursement Arrangement (HRA) is also available under this Plan. The HRA generally covers expenses that qualify as allowable "medical care" by the Internal Revenue Code and satisfy any requirements imposed by the Plan. Please refer to the Summary Plan Description for additional details regarding covered services under the HRA.

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.

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