Insulators 84 Health Care Plan: Board of Trustees

Coverage Period: 06/01/2014-5/31/2015
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 at www.yourunionbenefits.com or by calling (800) 435-2388. The Uniform Glossary can be accessed at www.yourunionbenefits.com.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$350**/person **$700** family; Separate deductible for In-Network/Out-of-Network	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your Plan document to see when the **deductible** starts over (usually, but not always, January 1st). The deductible does not apply to In-Network preventive care or prescription drugs. 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. In-Network **$2,000**	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. There is no limit on Out-of-Network.
What is not included in the out–of–pocket limit?	Premiums, 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 plan will only pay for covered services during each coverage period. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. For a list of In-Network providers see www.supermednetwork.com or call 800-601-9208.	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 4. See your plan document for additional information about **excluded services**.

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- **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	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	20% coinsurance	40% coinsurance	None.
	Specialist visit	20% coinsurance	40% coinsurance	None.
	Other practitioner office visit (Chiropractic)	20% coinsurance	40% coinsurance	20 visits per year for all combined physical therapy, chiropractic, occupational therapy, or rehabilitation visits unless treatment is necessary for illness, injury or rehabilitation following surgery.
	Preventive care/screening/immunization	No cost	No cost	Annual Physical – one visit maximum per eligible person per year
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	One colonoscopy every 5 years for persons over age 50 if provided In-Network. Additional colonoscopies may be covered if medically or reasonably necessary. Colonoscopies are not covered Out-of-Network. One mammogram per eligible person per year.

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 have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	One mammogram per year is covered if In-Network. Additional mammograms may be covered if medically or reasonably necessary. Mammograms are not covered Out-of-Network.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at: http://envisionrx.com/	Generic drugs	$15 co-pay retail; $35 co-pay mail order		Participants must try generic drugs first before brand name drugs are covered. If a participant chooses a brand name drug when a generic version is available, they must pay the difference of the cost between the brand name and generic drug. For specialty drugs, participants must first try the preferred brand name drugs prior to trying a non-preferred brand unless overridden in writing by a physician.
	Preferred brand drugs	$40 co-pay retail; $60 co-pay mail order		
	Non-preferred brand drugs	$65 co-pay retail; $85 co-pay mail order		
	Specialty Drugs (e.g., high-cost injectable, infused, oral, or inhaled drugs that may require special storage, handling or close monitoring of the patient.)	25% copay		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None.
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	None.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None.
	Urgent care	20% coinsurance	40% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	None.
	Physician/surgeon fee	20% coinsurance	40% 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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	None.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	None.
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	None.
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	None
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	None.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	None.
If you need help recovering or have other special health needs	Rehabilitation services	20% coinsurance	40% coinsurance	Limited to 20 visits per year for all combined physical therapy, chiropractic, occupational therapy, or rehabilitation unless treatment is necessary for illness, injury or rehabilitation following surgery. Limited to 20 visits per year for all combined physical therapy, chiropractic, occupational therapy, or rehabilitation unless treatment is necessary for illness, injury or rehabilitation following surgery.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	None.
	Durable medical equipment	20% coinsurance	40% coinsurance	None.
	Hospice service	20% coinsurance	40% coinsurance	None.
If your child needs dental or eye care	Eye exam	No Coverage	No Coverage	EyeMed is elective each year
	Glasses	No Coverage	No Coverage	EyeMed is elective each year
	Dental check-up	No Cost	No Cost	100% of the reasonable and customary charge for dental checkups once every 6 months per person.

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
- Hearing aids
- Routine foot care
- Infertility treatment
- Acupuncture (unless provided by physician)
- Bariatric Surgery
- Weight loss programs
- Long-term care
- Bulk powders as ingredients for compounds

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.)

- Dental care (Adult and Child)
- Private duty nursing
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Elective)

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 (330) 753-5909 or www.yourunionbenefits.com. 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 x 61565 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 Benefit Funds Office at (330) 753-5909. You can also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa.

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.**

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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** $5,715
- **Patient pays** $1,825

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	$700
Copays	$115
Coinsurance	$1,010
Limits or exclusions	$0
Total	**$1,825**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,960
- **Patient pays** $2,440

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	$350
Copays	$825
Coinsurance	$965
Limits or exclusions	$300
Total	**$2,440**

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.