Eighth District Electrical Benefit Fund: Actives & Retirees

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

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

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.8thdist.org or by calling the Administrative Office at **1-800-628-6562**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network PPO Provider and Out-of-Network Provider combined per calendar year: $400/person; $1,200/family. Does not apply to preventive care, and outpatient prescription drugs obtained at a network retail pharmacy. Copayments, non-covered expenses, and a penalty for failure to obtain precertification, 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?	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 the Medical Plan the out-of-pocket limit for coinsurance per calendar year for In-network PPO Providers and Out-of-Area providers is $2,000/person. Out-of-Network: Unlimited meaning there is no out-of-pocket limit on the use of Out-of-Network providers. For the Medical Plan the out-of-pocket limit for cost-sharing for in-network PPO copayments, coinsurance (including the above noted out-of-pocket limit for coinsurance) and deductibles per calendar year is $2,500/person; $5,000/family. This Plan has no out-of-pocket limit for cost-sharing for Out-of-Network providers, but emergency services in an emergency room accumulate to the in-network out-of-pocket limit. See also the separate out-of-pocket limit for cost-sharing for outpatient drugs explained on page 3.	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 pay for health care expenses.
What is not included in the out–of–pocket limit?	The out-of-pocket limit for coinsurance does not accumulate these: premiums, balance-billed charges, non-covered expenses, copayments, deductibles, charges in excess of benefit maximums and allowed charges, expenses for out-of-network providers and outpatient retail/mail order prescription drug expenses. The Medical Plan out-of-pocket limit for in-network cost-sharing does not accumulate these: premiums, balance-billed charges, non-covered expenses, charges in excess of benefit maximums and allowed charges, outpatient retail/mail order prescription drug expenses, and out-of-network deductibles, copayments and coinsurance (but emergency services in an emergency room accumulate to the in-network out-of-pocket limit).	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 in-network PPO providers for residents of Utah, see www.wiseprovidernetworks.com or call 1-866-485-5205. For residents of Utah, the PPO Network if traveling outside of Utah is First Health Network at www.myfirsthealth.com or call 1-888-685-7774. For a list of in-network PPO providers for residents of Colorado, Idaho, Montana and Wyoming, see www.cigna.com or call 1-800-244-6224.	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 25% 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 PPO **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 PPO 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	25% coinsurance.	50% coinsurance.	Certain services and transplant services including testing may require precertification to avoid non-payment of services. Refer to your Plan Document/SPD or contact the Administrative Office at 1-800-628-6562.
	Specialist visit	25% coinsurance.	50% coinsurance.	Certain services and transplant services including testing may require precertification to avoid non-payment of services. Refer to your Plan Document/SPD or contact the Administrative Office at 1-800-628-6562.
	Other practitioner office visit	Chiropractor: 25% coinsurance.	Chiropractor: 50% coinsurance.	Chiropractor: maximum benefit is 20 visits/year. You pay 100% for acupuncture services.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network PPO Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Preventive care/screening/ immunization	No charge.	Not covered.	Plan covers preventive services and supplies required by the Health Reform law. Age and frequency guidelines apply to covered preventive care.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance.	50% coinsurance.	Transplant related services including testing may require precertification.
	Imaging (CT/PET scans, MRIs)	25% coinsurance.	50% coinsurance.	Diagnostic radiology like CT, PET, MRI scans and transplant related services including testing may require precertification to avoid non-payment of services.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available from OptumRx at www.optumrx.com or call 1-800-797-9791.	Generic drugs	Retail Pharmacy for 30-day supply: 10% coinsurance to a minimum $10 and maximum $20; Mail Order for 90-day supply: $20 copayment. FDA approved Generic Contraceptives: No charge.	You pay 100% coinsurance and later can send your claim to OptumRx for reimbursement.	• If the cost of the drug is less than the copay, you pay just the drug cost. • Some prescriptions are subject to preapproval, quantity limits or step therapy requirements. • FDA approved Generic Contraceptives: no charge. FDA approved brand name contraceptives will be subject to the applicable coinsurance/copayment. • The out-of-pocket limit on outpatient drugs is the most you pay for covered generic, preferred brand, non-preferred brand & specialty drugs from in-network retail & mail order locations per calendar year is $4,100/person; $8,200/family.
	Preferred brand drugs	Retail Pharmacy for 30-day supply: 25% coinsurance to a minimum $25 and maximum $50; Mail Order for 90-day supply: $50 copayment.		
	Non-preferred brand drugs	Retail Pharmacy for 30-day supply: you pay the greater of 50% coinsurance or a $50 copayment; Mail Order for 90-day supply: 50% coinsurance.		
	Specialty drugs	Up to a 30-day supply you pay a $35 copayment.	No coverage	Specialty drugs require preapproval by calling OptumRx at 1-866-218-5445.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance.	50% coinsurance.	A stay in a health care facility after outpatient surgery for more than 24 hours is considered to be an inpatient hospital service.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network PPO Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Physician/ surgeon fees	25% coinsurance.	50% coinsurance.	Certain outpatient services require precertification to avoid non-payment of services. Refer to your Plan Document/SPD or contact the Administrative Office at 1-800-628-6562.
If you need immediate medical attention	Emergency room services	$200 copayment/visit, then 25% coinsurance.	$200 copayment/visit, then 25% coinsurance.	---none---
	Emergency medical transportation	25% coinsurance.	50% coinsurance.	---none---
	Urgent care	25% co-insurance.	50% coinsurance.	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/admission plus 25% coinsurance.	$200 copay/admission plus 50% coinsurance.	Elective hospital admission including transplant related services including testing may require precertification to avoid non-payment of services.
	Physician/ surgeon fee	25% coinsurance.	50% coinsurance.	Elective hospital admission including transplant related services including testing may require precertification to avoid non-payment of services.
If you have mental health, behavioral health, or substance abuse needs	Mental/ Behavioral health outpatient services	25% coinsurance.	50% coinsurance.	---none---
	Mental/ Behavioral health inpatient services	Inpatient and Residential Treatment Program: $200 copay/admission plus 25% coinsurance.	Inpatient: $200 copay/admission plus 50% coinsurance. Residential Treatment Program: Not covered.	Elective hospital admission and residential treatment program admission requires precertification to avoid non-payment of services. You pay 100% for an out-of-network residential treatment program.
	Substance use disorder outpatient services	25% coinsurance.	50% coinsurance.	---none---
	Substance use disorder inpatient services	Inpatient and Residential Treatment Program: $200 copay/admission plus 25% coinsurance.	Inpatient: $200 copay/admission plus 50% coinsurance. Residential Treatment Program: Not covered.	Elective hospital admission and residential treatment program admission requires precertification to avoid non-payment of services. You pay 100% for an out-of-network residential treatment program.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network PPO Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge for office visits for all pregnant females.	50% coinsurance.	Ultrasound payable as a diagnostic test.
	Delivery and all inpatient services	$200 copay/admission plus 25% coinsurance.	$200 copay/admission plus 50% coinsurance.	Precertification for delivery required only if hospital stay is more than 48 hours for vaginal delivery or 96 hours for C-section. The deductible applies separately to both the mother and baby.
If you need help recovering or have other special health needs	Home health care	25% coinsurance.	50% coinsurance.	Plan covers part-time or intermittent skilled nursing care. Home health and Home Infusion therapy requires precertification to avoid non-payment of services.
	Rehabilitation services	25% coinsurance.	Outpatient: 50% coinsurance. Inpatient rehab: Not covered.	Outpatient physical, occupational & speech therapy combined maximum benefit is 50 visits/yr. PPO inpatient rehabilitation admission and outpatient speech therapy requires precertification to avoid non-payment of services. You pay 100% for an out-of-network inpatient rehabilitation facility.
	Habilitation services	Speech therapy for childhood developmental delays: 25% coinsurance.	Speech therapy for childhood developmental delays: 50% coinsurance.	
	Skilled nursing care	25% coinsurance.	Not covered.	Maximum benefit is 70 days per calendar year. Elective admission requires precertification to avoid non-payment of services. You pay 100% for an out-of-network skilled nursing facility.
	Durable medical equipment	25% coinsurance.	50% coinsurance.	Equipment repair or replacement limited to payment once in a five calendar year period. DME requires precertification to avoid non-payment of services.
	Hospice service	25% coinsurance.	50% coinsurance.	Covered if terminally ill. Inpatient respite max 8 days per lifetime.
If your child needs dental or eye care	Eye exam	No charge up to $100 per year for an eye exam for active employees and their covered dependents age 19 years and older. For individuals under age 19 years, no charge up to $100 per year for an eye exam; thereafter, the Plan pays 10% coinsurance.		Individuals age 19 years and older pay 100% of the cost of an eye exam that exceeds the $100 benefit maximum. No coverage for retirees.
	Glasses	If your local union has a negotiated Vision Plan benefit: No charge up to $50/frame, $30/single vision lens, $40 for bifocals, $55 for trifocals or $80 for lenticular lenses, thereafter you pay 90% coinsurance.		No coverage for retirees.
	Dental check-up	No coverage under the Medical Plan.		Dental coverage is payable under the Dental Plan that is insured with MetLife.

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.
- Dental care (Adult) (Child)
- Hearing aids.
- Infertility treatment.
- Long-term care.
- Non-emergency care when traveling outside the U.S.
- Out-of-network admission to a residential treatment program, skilled nursing facility and inpatient rehab facility.
- Private duty nursing.
- Routine eye care (Adult) (Child) for Retirees.
- 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 (max benefit one surgical procedure per lifetime).
- Chiropractic care (up to 20 visits/year).
- Routine eye care (eye exam) for Active employees and their covered dependents age 19 years and older, eye exam payable at no charge up to $100/year.
- Routine foot care payable when treating diabetic (metabolic) or peripheral vascular disease).

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 Administrative Office at 1-800-628-6562. 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 Administrative Office at 1-800-628-6562. 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 1-800-628-6562.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-628-6562.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-628-6562.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-628-6562.

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** $5,010
- **Patient pays** $2,530

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	$800
Copays	$400
Coinsurance	$1,300
Limits or exclusions	$30
Total	**$2,530**

NOTE: For the Maternity example under this plan, for the delivery, the deductible and the copay apply to the mother and also separately to the baby.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,980
- **Patient pays** $1,420

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	$400
Copays	$0
Coinsurance	$940
Limits or exclusions	$80
Total	**$1,420**

Keep in mind that for certain local unions, this Plan includes a **Personal Care Account (PCA)** that operates like a Health Reimbursement Arrangement (HRA). If you have available funds in your PCA, you may be reimbursed for certain eligible out-of-pocket costs as well as for certain types of medical expenses you incur that are not covered by the Plan.

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.

Keep in mind that for certain local unions, this Plan includes a **Personal Care Account (PCA)** that operates like a Health Reimbursement Arrangement (HRA). If you have available funds in your PCA, you may be reimbursed for certain eligible out-of-pocket costs as well as for certain types of medical expenses you incur that are not covered by the Plan.

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