

Eighth District Electrical Benefit Fund: Basic Medical Plan

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 <u>deductible</u> ? | In-network PPO Provider and Out-of-Network Provider combined: \$1,500/person/calendar year . 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 <u>deductible</u> . | You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> 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 limit</u> on my expenses? | Yes, for the Medical Plan the <u>out-of-pocket limit</u> for coinsurance per calendar year for In-network PPO Providers and Out-of-Area Providers is \$3,000/person . The Medical Plan the <u>out-of-pocket limit</u> for cost-sharing for in-network PPO Providers and Out-of-Area providers is \$3,000/person; \$6,000/family . For outpatient drugs, the <u>out-of-pocket limit</u> per calendar year is \$3,600/person; \$7,200/family . Out-of-Network: Unlimited, meaning there is no out-of-pocket limit on the use of Out-of-Network providers , but emergency services in an emergency room accumulate to the in-network <u>out-of-pocket limit</u> . | The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ? | The <u>out-of-pocket limit</u> for coinsurance does not accumulate toward these: premiums, balance-billed charges, non-covered expenses, copayments, deductibles, charges in excess of benefit maximums, expenses for out-of-network providers and outpatient retail/mail order prescription drug expenses do not count toward the <u>out-of-pocket limit</u> . The Medical Plan <u>out-of-pocket limit</u> for cost-sharing for in-network PPO Providers and Out-of-Area providers 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 <u>out-of-pocket limit</u>). | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| 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. |

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| | | |
|---|--|--|
| 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 who travel outside their state, use First Health Network as the in-network PPO at www.myfirsthealth.com or call 1-800-226-5116. For a list of in-network PPO providers for residents of Colorado, Idaho, Montana, & 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 30% 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 | 30% 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 | 30% coinsurance. | 50% coinsurance. | |
| | Other practitioner office visit | Not covered. | Not covered. | You pay 100% for chiropractic care and acupuncture. |
| | Preventive care/screening/immunization | No charge. | 50% coinsurance, no deductible applies. | Plan covers preventive services and supplies required by the Health Reform law. Age and frequency guidelines apply to covered preventive care. |

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| 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 have a test | Diagnostic test (x-ray, blood work) | 30% coinsurance. | 50% coinsurance. | Transplant related services including testing may require precertification. |
| | Imaging (CT/PET scans, MRIs) | 30% 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 \$100; Mail Order for 90-day supply: \$10 copayment. | You pay 100% coinsurance and later can send your claim to OptumRx for reimbursement of billed charges minus the appropriate coinsurance and copayment. | <ul style="list-style-type: none"> 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 \$3,600/person; \$7,200/family. |
| | Preferred brand drugs | Retail Pharmacy for 30-day supply: 25% coinsurance to a minimum \$25 and maximum \$100; 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 to a minimum \$50 and maximum \$100. Mail Order for 90-day supply: \$50 copayment. | | |
| | Specialty drugs | Up to a 30-day supply you pay 25% coinsurance to a minimum \$35 and maximum \$100. | No coverage | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 30% 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. |

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|--|--|---|---|--|
| | Physician/surgeon fees | 30% coinsurance. | 50% coinsurance. | Certain outpatient services require precertification to avoid non-payment of services. Refer to the amendments to your Plan Document/SPD on the Plan's website at www.8thdist.org or contact the Administrative Office at 1-800-628-6562. |
| If you need immediate medical attention | Emergency room services | 30% coinsurance. | 30% coinsurance. | ---none--- |
| | Emergency medical transportation | 30% coinsurance. | 50% coinsurance. | ---none--- |
| | Urgent care | 30% co-insurance. | 50% coinsurance. | ---none--- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% coinsurance. | 50% coinsurance. | Elective hospital admission including transplant related services including testing may require precertification to avoid non-payment of services. |
| | Physician/surgeon fee | 30% 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 | 30% coinsurance. | 50% coinsurance. | ---none--- |
| | Mental/Behavioral health inpatient services | Inpatient and residential treatment program: 30% coinsurance. | Inpatient: 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 | 30% coinsurance. | 50% coinsurance. | ---none--- |
| | Substance use disorder inpatient services | Inpatient and residential treatment program: 30% coinsurance. | Inpatient: 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. |
| 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. |

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| 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 |
|--|-------------------------------------|---|---|---|
| | Delivery and all inpatient services | 30% coinsurance. | 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 | 30% 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 | 30% coinsurance. | Outpatient: 50% coinsurance. Inpatient rehab: Not covered. | Outpatient physical, occupational & speech therapy combined maximum benefit is 50 visits/yr. Inpatient rehabilitation admission and outpatient speech therapy requires precertification to avoid non-payment of services. |
| | Habilitation services | Speech therapy for childhood developmental delays: 30% coinsurance. | Speech therapy for childhood developmental delays: 50% coinsurance. | You pay 100% for an out-of-network inpatient rehabilitation facility. |
| | Skilled nursing care | 30% 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 | 30% 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 | 30% coinsurance. | 50% coinsurance. | Covered if terminally ill. Inpatient respite max 8 days per lifetime. |
| If your child needs dental or eye care | Eye exam | You pay 100% for these expenses outside of the eye exam covered during a preventive office visit. | Not covered. | You pay 100% for these expenses. |
| | Glasses | Not covered. | Not covered. | You pay 100% for these expenses. |
| | Dental check-up | Not covered. | Not covered. | You pay 100% for these expenses. |

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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 <u>excluded services</u> .) | | |
|---|--|--|
| <ul style="list-style-type: none">AcupunctureChiropractic careCosmetic surgeryDental care (Adult) (Child)Eyeglasses | <ul style="list-style-type: none">Hearing aidsInfertility treatmentLong-term careNon-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">Out-of-network admission to a residential treatment program, skilled nursing facility and inpatient rehab facility.Private duty nursingRoutine eye care (Adult) (Child)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.) | |
|--|--|
| <ul style="list-style-type: none">Bariatric Surgery (max benefit one surgical procedure per lifetime) | <ul style="list-style-type: none">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, kwijigo 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 \$4,550
- Patient pays \$2,990

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 | \$1,500 |
| Copays | \$0 |
| Coinsurance | \$1,460 |
| Limits or exclusions | \$30 |
| Total | \$2,990 |

For the Maternity example under this plan, the deductible for the delivery applies to the mother and also to the baby; however in the example only \$900 is attributed to the baby's delivery bill, so deductible is \$1,500 + \$900.

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

- Amount owed to providers: \$5,400
- Plan pays \$3,110
- Patient pays \$2,290

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 | \$1,500 |
| Copays | \$0 |
| Coinsurance | \$710 |
| Limits or exclusions | \$80 |
| Total | \$2,290 |

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.

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