Insulators Local 84 Health Care Plan (Non-grandfathered)

Coverage Period: June 1, 2018-May 31, 2019

Summary of Benefits and Coverage: What This Plan Covers & What you Pay for Covered Services

Coverage for: Individual & Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, get a copy of the complete terms of coverage at www.insulators84benefits.org. or by calling 800-435-2388 or 800-576-2583. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary at MedMutual.com/SBC or call 800-576-2538.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,500 / $3,000 (single/family) In-network $3,000 / $6,000 (single/family) Non-network	Generally, you must pay all the costs up to the deductible amount before this Plan begins to pay. Check your Plan document to see when the deductible starts over). If you have other family members on the Plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and all services with co-payments are covered and paid by the plan before your deductible.	Since this is a non-grandfathered plan, some services are covered without cost-sharing, including deductibles under the Preventive Care provisions of the Affordable Care Act. But a copayment or coinsurance may apply. See a list of covered preventive services at: www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$7,150/single, $14,300/family *combined* medical and prescription drugs. In-network for Medical: $5,650 / $11,300 (single/family) for Prescription Drugs: $1,500 / $3,000 (single/family)	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for covered services. If you have other family members in this plan, they must meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. There is no out-of-pocket limit on Out-of-Network Medical Expenses. Please note the separate out-of-pocket limit for prescription drug coverage.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover like out-of-network medical expenses and charges for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. See a list of Network Providers at: www.supermednetwork.com or call 800-576-2583.	This Plan uses a provider network. You will pay less if you use a provider in the Plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your Plan pays (balance billing).
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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. Coinsurance is on Allowed Amount.
	Specialist visit	20% coinsurance	40% coinsurance	None. Coinsurance is on Allowed Amount.
	Preventive care/screening/ immunization	No Charge	No charge	Annual Physical – one visit maximum per eligible person per year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
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. Coinsurance is on Allowed Amount.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	One mammogram per year is covered per eligible person if In-Network. Additional mammograms may be covered if medically or reasonably necessary. Mammograms are not covered Out-of-Network. Coinsurance is on Allowed Amount.
If you need drugs to treat your illness or condition More information about	Generic drugs	$15 co-pay retail; $38 co-pay mail order (Aspirin and other over the counter	Not covered.	*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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
prescription drug coverage is available at www.caremark.com.		drugs are covered without copays only when prescribed as preventive care.)		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. Compounds costing $200.00 or more, per claim, require a letter of medical necessity before being covered.
	Preferred brand drugs	$40 co-pay retail; $100 co-pay mail order	Not covered.	*See restrictions above
	Non-preferred brand drugs	$65 co-pay retail; $163 co-pay mail order	Not covered.	*See restrictions above.
	Specialty drugs	25% copay. Specialty Drugs (high-cost injectable, infused, oral, or inhaled drugs that may require special storage, handling or close monitoring of the patient) *PCSK9 Inhibitors are not covered	Not covered.	*See restrictions above
If you have outpatient surgery	Facility Fee	20% coinsurance	40% coinsurance	Check Plan for Prior Authorization Rules or prior approval.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Check Plan for Prior Authorization Rules or prior approval.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Co-insurance and Co-pays may be higher for non-emergencies. Coinsurance is on Allowed Amount.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None. Check Plan for Prior Authorization Rules or prior approval. Coinsurance is on Allowed Amount.
	Urgent care	20% coinsurance	40% coinsurance	None. Coinsurance is on Allowed Amount.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Check Plan for Prior Authorization Rules. Coinsurance is on Allowed Amount.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Check Plan for Prior Authorization Rules. Coinsurance is on Allowed Amount.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Check Plan for Prior Authorization Rules or prior approval. Coinsurance is on Allowed Amount.
	Inpatient services	20% coinsurance	40% coinsurance	Check Plan for Prior Authorization Rules or prior approval. Coinsurance is on Allowed Amount.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	None. Coinsurance is on Allowed Amount.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Check Plan for Prior Authorization Rules or prior approval. Coinsurance is on Allowed Amount.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Check Plan for Prior Authorization Rules or prior approval. Coinsurance is on Allowed Amount.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Check Plan for Prior Authorization Rules or prior approval. Coinsurance is on Allowed Amount.
	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. Check Plan for Prior Authorization Rules or prior approval. Coinsurance is on Allowed Amount.
	Habilitation 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. Check Plan for Prior Authorization Rules or prior approval. Coinsurance is on Allowed Amount.
	Skilled nursing care	20% coinsurance	40% coinsurance	Check Plan for Prior Authorization Rules or prior approval. Coinsurance is on Allowed Amount.
	Durable medical equipment	20% coinsurance	40% coinsurance	Check Plan for Prior Authorization Rules or prior approval.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Coinsurance is on Allowed Amount.
	Hospice services	20% coinsurance	40% coinsurance	Check Plan for Prior Authorization Rules or prior approval. Coinsurance is on Allowed Amount.
If your child needs dental or eye care	Children's eye exam	No charge	No coverage	See Plan Summary. Inclusive with a preventive well child visit.
	Children's glasses	No coverage	No coverage	
	Children's dental check-up	No charge	No coverage	See Plan Summary. Inclusive with a preventive well child visit.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture (unless provided by physician)
- Bariatric Surgery
- Bulk powders as ingredients for compounds
- Cosmetic Surgery
- Dental Care
- Hearing aids
- Infertility Treatments
- Long-term care
- Routine Eye Care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (only when prescribed by a physician for rehabilitative purposes)
- Chiropractic care (Check Plan for limits)
- Non-emergency care if traveling outside U.S
- Private duty nursing (check Prior Approval rules in Plan)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan's administrator at 800-435-2388 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace..

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800-435-2388.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-435-2388.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 800-435-2388.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-435-2388.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist Coinsurance	20%
Hospital (facility) *Coinsurance*	20%
Other *Coinsurance*	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$100
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$4,160

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist Coinsurance	20%
Hospital (facility) Coinsurance	20%
Other Coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$800
Coinsurance	$300
What isn't covered	
Limits or exclusions	$70
The total Joe would pay is	$2,670

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist Coinsurance	20%
Hospital (facility) *Coinsurance*	20%
Other *Coinsurance*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$250
What isn't covered	
Limits or exclusions	$50
The total Mia would pay is	$1,800

The plan would be responsible for the other costs of these EXAMPLE covered services.