Operating Engineers: Local 70 PPO Plan

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

Coverage Beginning: 01/01/2017

Coverage for: Members & Dependents | **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 plan document at https://www.healthplansinc.com/members/Benefits.aspx or by calling 1-800-532-7575.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: $250 person/$500 family Out-of-network: $500 person/$1000 family	You generally must pay all the costs up to your share of the **deductible** before this plan begins to pay for covered services you use. Your **deductible** starts over January 1st. See the chart starting on p.2 for your costs 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 p.2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Medical out-of-pocket limit: In-network: $2500 person/$5000 family Out-of-network: $2500 person/$5000 family Prescription drug out-of-pocket limit: $3500 person/$7000 family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services.
What is not included in the out–of–pocket limit?	Precertification penalties, premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on p.2 describes any limits on what the plan will pay for specific covered services.
Does this plan use a network of providers?	Yes, for a list of in-network providers, visit **https://www.healthplansinc.com/members/Benefits.aspx**	If you use network health care **providers**, this plan will pay more of the costs of covered services. See the chart starting on p. 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 shown on the following pages. See your 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 **preferred 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	$15 copay	Deductible then 20% coinsurance	None
	Specialist visit	$15 copay	Deductible then 20% coinsurance	None
	Other practitioner office visit: Acupuncture Chiropractor	No charge $15 copay	No charge $15 copay	Up to $500/yr combined with alternative care Up to 30 visits/yr
	Preventive care Screening—Mammogram Colonoscopy Immunization	No charge	Deductible then 20% coinsurance	See your plan document for age or frequency limits
If you have a test	Diagnostic test (x-ray, blood work)	Deductible	Deductible then 20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	Deductible	Deductible then 20% 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 need drugs to treat your illness or condition - More information about **prescription drug coverage** is available at **https://www.healthplansinc.com/members/Benefits.aspx.**	Generic drugs: Retail Mail Order	$15 copay $30 copay	Not covered	Covers up to a 34-day supply (retail); 34-90 day supply (mail order)
	Preferred brand drugs: Retail Mail Order	$30 copay $60 copay	Not covered	
	Non-preferred brand drugs: Retail Mail Order	$60 copay $90 copay	Not covered	
	Specialty drugs: Purchased from pharmacy— Retail Mail Order Provided in Physician's office Provided in Hospital	 $60 copay $90 copay $15 copay Deductible	 Not covered Not covered Deductible then 20% coinsurance Deductible then 20% coinsurance	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible	Deductible then 20% coinsurance	None
	Physician/surgeon fees	Deductible	Deductible then 20% coinsurance	None
If you need immediate medical attention	Emergency room services	$100 copay	$100 copay	Copay is waived if admitted to hospital or for life-threatening condition
	Emergency medical transportation	Deductible	In-Network Deductible	See your plan document for details.
	Urgent care	$15 copay	Deductible then 20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible	Deductible then 20% coinsurance	Call 1-866-325-1550 for precertification or you pay 20% more
	Physician/surgeon fee	Deductible	Deductible then 20% coinsurance	

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	No charge	Deductible then 20% coinsurance	For out-of-network providers call 1-800-878-2004 for precertification in order to receive the in-network level of benefits
	Mental/Behavioral health inpatient services	Deductible	Deductible then 20% coinsurance	Call 1-800-878-2004 for precertification or you pay 20% more
	Substance use disorder outpatient services	No charge	Deductible then 20% coinsurance	For out-of-network providers call 1-800-878-2004 for precertification in order to receive the in-network level of benefits
	Substance use disorder inpatient services	Deductible	Deductible then 20% coinsurance	Call 1-800-878-2004 for precertification or you pay 20% more
If you are pregnant	Prenatal care Postnatal care	$15 copay for initial visit only $15 copay	Deductible then 20% coinsurance Deductible then 20% coinsurance	None None
	Delivery and all inpatient services	Deductible	Deductible then 20% coinsurance	Call 1-866-325-1550 for precertification for stays in excess of 48 hrs (normal delivery)/96 hrs (caesarean) or you pay 20% more

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 need help recovering or have other special health needs	Home health care	Deductible	Deductible then 20% coinsurance	Up to lesser of 100 visits or 200 hours/yr. Precertification recommended--call 1-866-325-1550
	Inpatient: Rehabilitation services	Deductible	Deductible then 20% coinsurance	Up to 90 days/yr combined with Skilled nursing care; call 1-866-325-1550 for precertification or you pay 20% more
	Outpatient: Occupational therapy Physical therapy Speech therapy	$15 copay	Deductible then 20% coinsurance	None
	Habilitation services: Early intervention Developmental delay	$15 copay Deductible	Deductible then 20% coinsurance	None Precertification recommended for treatment--call 1-866-325-1550
	Skilled nursing care	Deductible	Deductible then 20% coinsurance	Up to 90 days/yr combined with Inpatient rehabilitation; call 1-866-325-1550 for precertification or you pay 20% more
	Durable medical equipment	Deductible	Deductible then 20% coinsurance	Precertification recommended for equipment rental over 3 months, TENS units and equipment exceeding $1000–call 1-866-325-1550
	Hospice service Inpatient Outpatient	No charge	Deductible then 20% coinsurance	Precertification recommended--call 1-866-325-1550
If your child needs dental or eye care	Eye exam	No charge	No charge	Up to 1 exam/yr
	Glasses	Not covered	Not covered	n/a
	Dental check-up	Not covered	Not covered	n/a

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan document for other excluded services.)		
• Cosmetic surgery • Hearing Aids • Non-emergency care outside the U.S.	• Dental care (routine child & adult) • Infertility treatment • Routine foot care	• Glasses (child & adult) • Long-term care
Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)		
• Acupuncture ($500/yr combined with Alternative/Complementary Care) • Private duty nursing	• Bariatric surgery (to treat morbid obesity)* • Routine eye care (adult-up to 1 exam/yr)	• Chiropractic care (up to 30 visits/yr) • Weight loss programs ($500/yr combined with Alternative/Complementary Care)
***Call 1-866-325-1550 for precertification**		

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 1-800-532-7575. 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 plan at 1-800-532-7575. You may also contact the U.S. Department of Labor, 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:

Para obtener asistencia en Español, llame al 1-800-532-7575. Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-532-7575.

如果需要中文的帮助，**请拨打这个号码**1-800-532-7575. Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-532-7575.

*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:** $7540
- **Plan pays** $7,120
- **Patient pays** $420

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	$250
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$420**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,380
- **Patient pays** $1,020

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	$250
Copays	$690
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,020**

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.