IWDC of WNY Welfare Fund: Active Coverage

Coverage Period:01/01/2013 - 12/31/2013

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.ironworkersdcwny.com or by calling 1-800-288-0782 or 1-585-424-3510.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: $200 person/$400 family; Out-of-Network: $200 person/$400 family. Doesn't apply to prescription drugs, and preventative care for children. Balance billing, and excluded services 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. $2,500 per person/In-Network; $2,500 per person/Out-of-Network	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.
What is not included in the out–of–pocket limit?	Premiums, balance billing, deductibles, all prescription drugs expenses and health care this plan does not 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?	Yes, $1.25 million through June 30, 2013. Beginning July 1, 2013, the overall annual limit is $2 million.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. 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.multiplan.com, call 1-888-987-7427.	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 don't need a referral to see a specialist.	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.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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, co-payments** and **co-insurance** amounts.

Common Medical Event	Service 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% co-insurance	30% co-insurance	-None-
	Specialist visit	20% co-insurance	30% co-insurance	-None-
	Other practitioner office visit	50% co-insurance for chiropractor	50% co-insurance for chiropractor	Maximum of $550 per person per calendar year. Back-related care only. Children not eligbile for chiropractic services unless medically necessary.

Common Medical Event	Service 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	Preventive care/screening/immunization	20% co-insurance	30% co-insurance	Maximum reimbursement of $150 per visit for member and spouse. Subject to age and frequency limits.
If you have a test	Diagnostic test (x-ray, blood work)	4% co-insurance	14% co-insurance	Must be order by a physician or other health practitioner.
	Imaging (CT/PET scans, MRIs)	4% co-insurance	14% co-insurance	Subject to precertification.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	$10 co-pay retail; $20 co-pay mail order	$10 co-pay retail only. Not covered for mail order.	Certain drugs subject to prior authorization and/or quantity limitations. Retail will provide greater of 30 days or 100 units supply; Mail order will provide 90-day supply. Fertility agents, legends vitamins and prescriptions for cosmetic problems are excluded.
	Brand name drugs without Generic Equivalent	$20 co-pay retail; $40 co-pay mail order	$20 co-pay retail only. Not covered for mail order.	
	Brand name drugs with Generic Equivalent	$20 co-pay retail; $40 co-pay mail order, plus difference in cost between generic and brand name drug.	$20 co-pay retail only, plus difference in cost between generic and brand name. Not covered for mail order.	
	Specialty Drugs	$40 co-pay mail order (pro-rated for supplies less than 90 days)	Not Covered	Must contact and use Accredo Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	10% co-insurance	Non-emergency services are subject to precertification.
	Physician/surgeon fees	4% co-insurance	14% co-insurance	-None-

Common Medical Event	Service You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	Physician's fees: 20% co-insurance; No Charge for facility	Physician's fees: 20% co-insurance; No Charge for facility	Non-emergency use of emergency room services is not covered, except for lab/x-ray fees, which are reduced to 4% coinsurance.
	Emergency medical transportation	No charge	No charge	Non-emergency use of emergency transportation services is not covered.
	Urgent care	20% co-insurance	20% co-insurance	Payable the same as a physician's office visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	10% co-insurance	Non-emergency services are subject to precertification.
	Physician/surgeon fee	4% co-insurance	14% co-insurance	-None-
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	4% co-insurance	14% co-insurance	-None-
	Mental/Behavioral health inpatient services	No charge	10% co-insurance	Subject to precertification.
	Substance use disorder outpatient services	4% co-insurance	14% co-insurance	Substance abuse services must be requested by calling 1-800-EAP-1984. Coverage limited to psychiatrists, psychologists, counselors with a master's degree or a master's prepared certified social worker.
	Substance use disorder inpatient services	No charge	10% co-insurance	
If you are pregnant	Prenatal and postnatal care	4% co-insurance	14% co-insurance	-None-
	Delivery and all inpatient services	No charge	10% co-insurance	Confinements over 48 hours following a normal birth or 96 hours following a caesarean section are subject to precertification.

Common Medical Event	Service You May Need	Your Cost if You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network	
If you need help recovering or have other special health needs	Home health care	No charge	10% co-insurance	Maximum 40 home health care visits per calendar year for skilled home health care. Subject to precertification.
	Rehabilitation services	No charge for Inpatient Rehabilitation facility fees; All other services: 20% co-insurance	10% co-insurance for Inpatient Rehabilitation facility fees; All other services: 30% co-insurance	Subject to precertification. Limited to short-term active progressive, physical, occupational and speech therapies. Inpatient services maximum of 60 consecutive days per injury or illness, and must be unable to be performed in outpatient or home setting.
	Habilitation services	Not covered	Not covered	Not covered.
	Skilled nursing care	No charge	10% co-insurance	Maximum of 60 days per calendar year. Subject to precertification.
	Durable medical equipment	20% co-insurance	30% co-insurance	Subject to precertification.
	Hospice service	No charge	10% co-insurance	Maximum of $30,000 per calendar year. Subject to precertification.
If your child needs dental or eye care	Eye exam	Amount over $200 for both exam and glasses or contacts.	Amount over $200 for both exam and glasses or contacts.	Limited to one exam every 24 months. Maximum allowance of $200 does not apply to eye exam benefit for participants under age 19.
	Glasses	Amount over $200 for both exam and glasses or contacts.	Amount over $200 for both exam and glasses or contacts.	Limited to one pair of eye glasses or supply of contact lenses every 24 months. Maximum allowance of $200. Sunglasses and non-prescription lenses are excluded.
	Dental check-up	20% co-insurance	20% co-insurance	Oral exams limited to once every six months.

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
- Bariatric surgery
- Cosmetic surgery
- Habilitation Services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S. or Canada
- 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 those services.)**

- Chiropractic care ($550 calendar year maximum. Must be for back-related care. Dependent children not eligible unless medically necessary.)
- Dental care (Adult) ($1,500 calendar year maximum for participants age 19 and older. $2,050 lifetime orthodontia maximum for all participants.)
- Hearing aids ($500 maximum per ear every three years.)
- Private-duty nursing (Calendar year maximum of 40 home care visits. Must be for skilled care. Subject to precertfication.)
- Routine eye care (Adult) (Maximum reimbursement of $200 every two years for exam and glasses or contact lenses. Maximum for exam does not apply for participants under age 19.)
- Routine foot care (Foot orthotics are subject to a $1,000 annual maximum.)

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 1-800-288-0782 or 1-585-424-3510. 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 Fund Office at 1-800-288-0728 or 1-585-424-3510. 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 for more information regarding your rights.

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** $6,990
- **Patient pays** $550

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	$200
Co-pays	$20
Co-insurance	$150
Limits or exclusions	$180
Total	**$550**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,160
- **Patient pays** $1,240

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	$200
Co-pays	$400
Co-insurance	$420
Limits or exclusions	$220
Total	**$1,240**

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, co-payments,** and **co-insurance** 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 **co-payments, deductibles,** and **co-insurance.** 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.

Questions: Call 1-800-288-0782 or 1-585-424-3510 or visit us at www.ironworkersdcwny.com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-288-0782 or 1-585-424-3510 to request a copy.