Utah Pipe Trades Welfare Trust Fund: Medical Plan

Coverage Period: 01/01/2015 – 09/30/2015

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.utpipetradesbenefits.org or by calling the Administrative Office (BeneSys) at **1-877-416-8181.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	PPO Provider: **$450**/person per calendar year. Non-PPO Provider: **$900**/person per calendar year. Does not apply to preventive care, the temporary dental benefit option and outpatient prescription drugs. Copayments, non-covered expenses and coinsurance amounts 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, the medical plan has an **out-of-pocket limit on coinsurance** as follows: PPO Provider: **$2,000**/person per calendar year. Non-PPO Provider: **$4,000**/person per calendar year. The Plan has an **out-of-pocket limit on in-network cost-sharing** (medical plan deductibles, copayments, & coinsurance): **$6,350**/person per calendar year; **$12,700**/family per calendar plan year.	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?	For the **out-of-pocket limit on coinsurance**: premiums, balance-billed charges, health care this plan does not cover, copayments, and deductibles, the temporary dental benefit option, outpatient prescription drugs do not count toward the limit. For the **out-of-pocket limit on in-network cost-sharing**: premiums, balance-billed charges, health care this plan does not cover, charges in excess of benefit maximums and allowed charges, the temporary dental benefit option, outpatient prescription drugs and out-of-network cost-sharing.	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 **PPO providers**, see: **Inside Utah: www.wiseprovider.net or call 1-866-485-5205. Outside Utah: www.myfirsthealth.com or call 1-888-685-7774.**	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 5. 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 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 PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copayment/visit plus 20% coinsurance.	$35 copayment/visit plus 40% coinsurance.	Applies to covered plan benefits only.
	Specialist visit	$35 copayment/visit plus 20% coinsurance.	$35 copayment/visit plus 40% coinsurance.	Applies to covered plan benefits only.
	Other practitioner office visit	$35 copayment/visit plus 20% coinsurance.	$35 copayment/visit plus 40% coinsurance.	Chiropractic care payable up to 30 visits/year. You pay 100% for acupuncture.
	Preventive care/screening/ immunization	No charge.	Not covered.	Plan covers preventive services and supplies required by Health Reform law. Age and frequency guidelines apply to covered preventive care.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance.	40% coinsurance.	Applies to covered plan benefits only.
	Imaging (CT/PET scans, MRIs)	20% coinsurance.	40% coinsurance.	Applies to covered plan benefits only.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available from **Caremark** at 1-877-819-9364.	Generic drugs	Retail Pharmacy for 30-day supply: $8 copayment; Mail Order for 90-day supply: $15 copayment. FDA approved contraceptives: No charge.	You pay 100%. Plan reimburses no more than it would have paid had you used an In-network pharmacy.	Applies to covered plan benefits only. No charge for: a) FDA-approved tobacco cessation drugs (up to 12 weeks, available 2x/year); b) tamoxifen or raloxifene.
	Formulary (preferred) brand drugs	Retail Pharmacy for 30-day supply: 30% coinsurance; Mail Order for 90-day supply: $45 copayment.		If you purchase a brand drug when generic drug is available you pay a higher coinsurance. FDA approved contraceptives: No charge for preferred brand drug if generic drug is medically inappropriate.
	Non-Formulary (non-preferred) brand drugs	Retail Pharmacy for 30-day supply: 50% coinsurance; Mail Order for 90-day supply: $60 copayment.		If you purchase a brand drug when generic drug is available you pay a higher coinsurance.
	Specialty drugs	Up to a 30-day supply you pay 50% coinsurance up to $60.		Specialty drugs require pre-approval by calling Caremark at 1-800-237-2767.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$35 copayment plus 20% coinsurance.	$35 copayment plus 40% coinsurance.	Coverage limited to services only at a licensed ambulatory surgical facility.
	Physician/surgeon fees	20% coinsurance.	40% coinsurance.	Applies to covered plan benefits only.
If you need immediate medical attention	Emergency room services	$250 copayment/visit plus 20% coinsurance.	$250 copayment/visit plus 20% coinsurance.	Applies to covered plan benefits only.
	Emergency medical transportation	20% coinsurance.	40% coinsurance.	You pay 100% of non-emergency transportation.
	Urgent care	$40 copayment/visit plus 20% coinsurance.	$40 copayment/visit plus 40% coinsurance.	Applies to covered plan benefits only.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copayment plus 20% coinsurance.	$500 copayment plus 40% coinsurance.	Applies to covered plan benefits only.
	Physician/surgeon fee	20% coinsurance.	40% coinsurance.	Applies to covered plan benefits only.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 copayment/visit plus 20% coinsurance.	$35 copayment/visit plus 40% coinsurance.	Applies to covered plan benefits only.
	Mental/Behavioral health inpatient services	$250 copayment plus 20% coinsurance.	$500 copayment plus 40% coinsurance.	Applies to covered plan benefits only.
	Substance use disorder outpatient services	$35 copayment/visit plus 20% coinsurance.	$35 copayment/visit plus 40% coinsurance.	You pay 100% of expenses for treatment of nicotine addiction
	Substance use disorder inpatient services	$250 copayment plus 20% coinsurance.	$500 copayment plus 40% coinsurance.	Applies to covered plan benefits only.
If you are pregnant	Prenatal and postnatal care	No charge for office visits.	40% coinsurance.	Applies to covered plan benefits only.
	Delivery and all inpatient services	$250 copayment plus 20% coinsurance.	$500 copayment plus 40% coinsurance.	Applies to covered plan benefits only. You pay 100% for delivery fees for a pregnant dependent child.
If you need help recovering or have other special health needs	Home health care	20% coinsurance.	40% coinsurance.	Coverage only part-time or intermittent skilled nursing care.
	Rehabilitation services	20% coinsurance.	40% coinsurance.	Applies to covered plan benefits only.
	Habilitation services	No coverage.	No coverage.	You pay 100% of habilitation services.
	Skilled nursing care	$250 copayment plus 20% coinsurance.	$500 copayment plus 40% coinsurance.	Covered in lieu of hospitalization for up to 60 days per calendar year.
	Durable medical equipment	20% coinsurance.	40% coinsurance.	Rental of DME payable up to the allowed purchase price. Replacement covered once every 5 years.
	Hospice service	20% coinsurance.	40% coinsurance.	Covered if terminally ill.
If your child needs dental or eye care	Eye exam	No charge when obtained during a preventive care office visit.	Not covered.	Covered for children up to 19 yrs. Adults pay 100% of these expenses.
	Glasses	Not covered.	Not covered.	You pay 100% of these expenses.
	Dental check-up	Not covered.	Not covered.	You pay 100% of these expenses.

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)
- Dependent Child: delivery fees
- Eyeglasses
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-emergency transportation
- Private duty nursing
- Routine eye care (Adult)
- 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 once per lifetime.
- Chiropractic care up to 30 visits/year.
- Routine foot care except when treating 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 BeneSys 1-877-416-8181. 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 (BeneSys) at 1-877-416-8181. 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 1-877-416-8181.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-416-8181.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-877-416-8181.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-416-8181.

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** $5,920
- **Patient pays** $1,620

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	$450
Copays	$260
Coinsurance	$880
Limits or exclusions	$30
Total	**$1,620**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,780
- **Patient pays** $1,620

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	$450
Copays	$500
Coinsurance	$300
Limits or exclusions	$370
Total	**$1,620**

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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