Blasters Drillrunners & Miners Union Local 29 Welfare Plan

Coverage Period: 1/1/2017-12/31/2017

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

Coverage for: Eligible Members & Dependents | **Plan Type:** Self Insured

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 by calling 1-718-278-5800.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$** 0.00	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes. $250 deductible for out-of-network services under this plan, does not apply to emergency services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers $7,150 (single)/$14,300(family)	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-billed charges, out-of-network cost sharing and health care this plan doesn't 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?	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. The plan uses the BlueCross Network. Go to www.Anthem.com or call 1-800-810-Blue for a list of In Network providers.	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 4. See your policy or plan documents for additional information about excluded services.

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- **Copayments** are fixed dollar amounts (for example, $20) 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.
- 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 BlueCross **providers** by charging you only a $20 **co-payment** for covered services.

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	$20 co-pay/visit	20% co-insurance	---None---
	Specialist visit	$20 co-pay/visit	20% co-insurance	---None---
	Other practitioner office visit	$20 co-pay/visit	20% co-insurance	---None---
	Preventive care/screening/immunization	$0	20% co-insurance	---None---
If you have a test	Diagnostic test (x-ray, blood work)	$0	20% co-insurance	---None---
	Imaging (CT/PET scans, MRIs)	$0	20% co-insurance	---None---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling 1-800-788-4863	Generic drugs	$5 co-pay	$5 co-pay	---None---
	Preferred brand drugs	$20 co-pay	$20 co-pay	---None---
	Non-preferred brand drugs	$20 co-pay	$20 co-pay	---None---
	Specialty drugs	$20 co-pay	$20 co-pay	---The Plan does not cover Compound drugs.---
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0	$0	---None---
	Physician/surgeon fees	$0	20% co-insurance	---None---
If you need immediate medical attention	Emergency room services	$0	$0	No coverage for non-emergency care.
	Emergency medical transportation	$0	$0	No coverage for non-emergency care
	Urgent care	$0	$0	No coverage for non-emergency care.
If you have a hospital stay	Facility fee (e.g., hospital room)	$0	$0	---None---
	Physician/surgeon fee	$0	20% co-insurance	---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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not Covered	Not Covered	
	Mental/Behavioral health inpatient services	Not Covered	Not Covered	
	Substance use disorder outpatient services	Not Covered	Not Covered	
	Substance use disorder inpatient services	Not Covered	Not Covered	
If you are pregnant	Prenatal and postnatal care	$0	20% co-insurance	
	Delivery and all inpatient services	$0	20% co-insurance	
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	
	Rehabilitation services	$20 co-pay/visit	20% co-insurance	
	Habilitation services	$20 co-pay/visit	20% co-insurance	
	Skilled nursing care	Not Covered	Not Covered	
	Durable medical equipment	$0	20% co-insurance	
	Hospice service	Not Covered	Not Covered	
If your child needs dental or eye care	Eye exam	$0	20% co-insurance	Optical Benefit limited to $250 per family member per calendar year.
	Glasses	$0	20% co-insurance	Optical Benefit limited to $250 per family member per calendar year.
	Dental benefits	$0	20% co-insurance	Dental Benefit limited to $3,000 per family member per calendar year.

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.)**

Bariatric Surgery
Cosmetic Surgery
Infertility Treatment
Long-term Care
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.)**

- Acupuncture
- Chiropractic Care
- Dental Care
- Hearing Aids
- Non-emergency Care when traveling outside the U.S.
- Private duty nursing
- Routine eye care
- Routine foot care

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 718-278-5800. 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 Local 29 Welfare Fund at 718-278-5800. 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. Additionally, a consumer assistance program can help you file your appeal. Contact the Community Service Society of New York, Community Health Advocates at 1-888-614-5400 or http://www.communityhealthadvocates.org/ for further assistance.

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 1-888-808-9008 (PIN 10826771)

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** $7,340
- **Patient pays** $200

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	$0
Copays	$200
Coinsurance	$0
Limits or exclusions	$0
Total	**$200**

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

- **Amount owed to providers:** $4,100
- **Plan pays** $3,760
- **Patient pays** $340

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$0
Copays	$340
Coinsurance	$0
Limits or exclusions	$0
Total	**$340**

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.