GCC/IBT LOCAL 14-M Health & Welfare Plan – PLAN A

Plan Year: 5/1/2017 – 4/30/2018
Benefit Period: 5/1/2017-12/31/2017

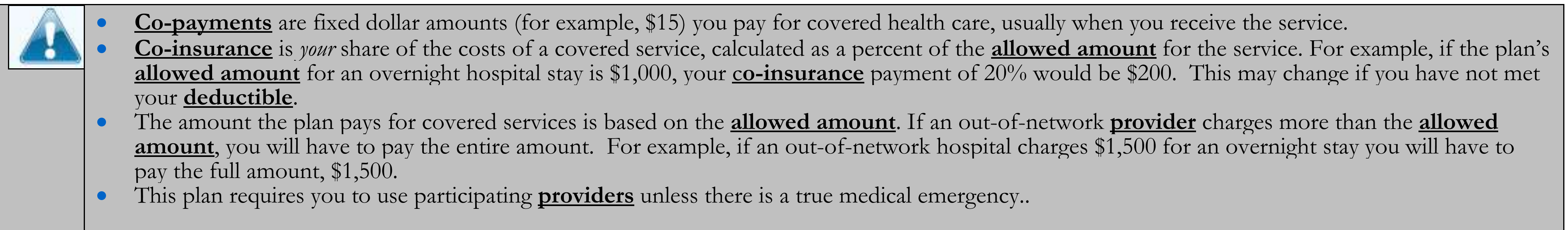
Coverage Examples

Coverage for: All Levels | **Plan Type:** HMO

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.aetna.com or by calling your **Benefits Administrator at** (215) 773-0900.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**For Each Calendar Year** **$0** person/**$0** Family	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?	**Prescription - Annual Deduct of $50 person/$150 Family** **Dental - Annual Deductible of $25 person/$75 Family**	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 annual out–of–pocket limit on my expenses?	Yes. **Medical** in-network **$1,000/ individual $2,000/**family **Rx in-network $1,000**person/**$2,000** family annually.	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 annual out–of–pocket limit?	Out-of-Network Costs, Premiums, Balance-billed charges, and health care services this plan does not 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 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. Visit **www.aetna.com or call (800) 370-4526** for a list of participating 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?	Yes. You need a referral to see a specialist.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan does not cover?	Yes.	Some of the services this plan does not cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: If you are not clear about any of the bolded terms used in this form, see the Glossary at www.HealthReformPlanSBC.com or call your Benefits Administrator at 1-215-773-0900 to request a copy.



- **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 have not 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 will have to pay the entire amount. For example, if an out-of-network hospital charges $1,500 for an overnight stay you will have to pay the full amount, $1,500.
- This plan requires you to use participating **providers** unless there is a true medical emergency..

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 co-pay/visit	Not covered	——————none——————
	Specialist visit	$25 co-pay/visit	Not covered	Includes Internist, General Physician, Family Practitioner or Pediatrician **if** the physician is not the Member's selected PCP.
	Other practitioner office visit (e.g. therapies)	$25 co-pay/visit	Not covered	——————none——————
	Preventive care/screening/immunization	No charge	Not covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	$25 co-pay	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$25 co-pay	Not covered	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.benecardpbf .com**	Generic drugs	$10 co-pay/retail $20 co-pay/mail	Not covered	Deductible $50 Person/$150 Family Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription **2 co-pays**). Mail order **required** after 2 fills at pharmacy for maintenance drugs.
	Preferred Brand drugs	$25 co-pay/retail $50 co-pay/mail	Not covered	
	Non-Preferred Brand drugs	$45 co-pay/retail $90 co-pay/mail	Not covered	
	Specialty drugs	Generic $20 Pref Brand $30 Non-Pref Brand $60	Not covered	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	Not covered	——————none——————
	Physician/surgeon fees	10% co-insurance	Not covered	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$100 co-pay	Not covered	Copay not waived if admitted. No coverage for non-emergency use.
	Emergency medical transportation	No charge	No charge	———————none———————
	Urgent care	$35 co-pay	Not covered	No coverage for non-emergency use.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	Not covered	———————none———————
	Physician/surgeon fee	10% co-insurance	Not covered	———————none———————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 co-pay/visit	Not covered	———————none———————
	Mental/Behavioral health inpatient services	10% co-insurance	Not covered	———————none———————
	Substance use disorder outpatient services	$25 co-pay/visit	Not covered	———————none———————
	Substance use disorder inpatient services	10% co-insurance	Not covered	———————none———————
If you are pregnant	Prenatal and postnatal care	Prenatal-$0 co-pay 1st visit, then 10% co-insurance; Post-natal- $25 co-pay	Not covered	———————none———————
	Delivery and all inpatient services	10% co-insurance	Not covered	Includes outpatient postnatal care
If you need help recovering or have other special health needs	Home health care	$25 co-pay/visit	Not covered	Limited to 100 visits per calendar yr
	Rehabilitation Services	$25 co-pay/visit	Not covered	Limited to 60 consecutive days per condition for physical, speech, and occupational therapy.
	Habilitation Services	Not Covered	Not Covered	———————none———————
	Skilled nursing care-Inpatient	10% co-insurance	Not covered	———————none———————
	Durable medical equipment	Not covered	Not covered	———————none———————
	Hospice Service - Inpatient	10% co-insurance	Not covered	———————none———————
	Hospice Service – Outpatient	$25 co-pay/visit	Not covered	———————none———————

Common Medical Event	**Services You May Need**	**Your cost if you use a Participating Provider**	**Your cost if you use a Non-Participating Provider**	**Limitations & Exceptions**
If you or your child needs eye care	Eye exam	$15 co-pay	Not Covered	Children and Adults – one exam every 12 months
	Glasses – Lenses and Frames (ACA Pediatric Services **for children up to age 19**, no annual limit)	Actual difference between wholesale cost/max allowance plus % of difference Lenses – 25% diff Frames – 20% diff	Not Covered	Children under age 19 – One pair of glasses every 12 months; lenses every 12 months; frames every 24 months. Adults - One pair of glasses every 24 months, including lenses and frames
If you or your child needs dental care ***Co-insurance is after deductible, subject to balance billing.**	Deductible	$25 person not to exceed $75 family	$25 person not to exceed $75 family	——————none——————
	Maximum Benefit	$1000 per person per calendar year	$1000 per person per calendar year	No maximum benefit on ACA pediatric services required to be covered.
	Diagnostic/Preventive	No charge	No charge	——————none——————
	Basic Restorative	20% co-insurance*	20% co-insurance*	Services performed by a Non-par provider will be paid on Delta's rate scale and paid to member. Member must pay any balance due to non-par provider.
	Major Restorative	50% co-insurance*	50% co-insurance*	
	Oral Surgery, Endodontics, Periodontics	20% co-insurance*	20% co-insurance*	
	Prosthodontics	50% co-insurance*	50% co-insurance*	
	Denture Repair	20% co-insurance*	20% co-insurance*	

Excluded Services and Other Covered Services:

Services Your Plan Does <u>NOT</u> Cover (This is not a complete list. Check your policy or plan document for other **excluded services**.)		
• Acupuncture • Bariatric Surgery • Chiropractic care • Certain Cosmetic surgery • Durable Medical Equipment	• Experimental Procedures not FDA approved • Habilitation services • Hearing Aids • Long-term care	• Private Duty Nursing • Routine foot care • Non-emergency care when traveling outside the U.S. • Weight Loss Programs

Other Covered Services (This is not a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Infertility Treatment – Coverage includes diagnosis and treatment of underlying medical condition only.	• Chiropractic care – (medically necessary) • Diagnostic foot care	• Most coverage provided outside the United States. **See www.aetna.com**

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 **Benefits Administrator at (215) 773-0900**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (877) 267-2323 Ext. 61565 or www.cciio.cms.gov.

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**.

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 **Benefits Administrator at (215) 773-0900.**

———*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 JUST AN ESTIMATOR

Do not 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)

In-Network

- **Amount owed to providers:** $7,540
- **Plan pays** $7,015
- **Patient pays** $525

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	$50
Co-pays	$75
Co-insurance	$400
Limits or exclusions	$0
Total	**$525**

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $3,800
- **Patient pays** $300

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	$50
Co-pays	$250
Co-insurance	$0
Limits or exclusions	$0
Total	**$300**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: **Aetna – (800) 370-4526.**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs do not include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and are not 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 not paid or 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 is not 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 cannot 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.