International Association of Heat & Frost Insulators: Active & Pre-Medicare Retirees

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

Coverage Period: 01/01/2017 – 12/31/2017

Coverage for: 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.local17fund.com or by calling 1-708-468-8000.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$200** per person/**$600** per family per calendar year.	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?	Yes. **$25** dental care deductible. 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. **$1,250** per person/**$6,250** per family for PPO; **$4,000** per person for Non-PPO.	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?	Non-PPO co-pays, prescription drug co-pays, certain non-PPO expenses, premiums, balance-billed charges, 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 *specified* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see www.bcbsil.com or call 1-800-571-1043.	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**.

Questions: Call 1-708-468-8000 or visit us at www.local17fund.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-708-468-8000 to request a copy.

- **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 a Preferred Provider		Your Cost If You Use a Non-Preferred 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/office visit		$25 co-pay/office visit; 20% co-insurance	----------none----------**
	Specialist visit	$15 co-pay/office visit		$25 co-pay/office visit; 20% co-insurance	
	Other practitioner office visit	$15 co-pay/office visit		$25 co-pay/office visit; 20% co-insurance	$15 co-pay and $25 co-pay does not apply for chiropractic and naprapathy care; chiropractic and naprapathy care limited to maximum of 18 visits per year per person (combined).**
	Preventive care/screening/immunization	No charge		Not covered	No coverage for non-PPO preventive care/screening/immunizations.**
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance		20% co-insurance	No charge for pre-admission testing; deductible and co-insurance do not apply.**
	Imaging (CT/PET scans, MRIs)	10% co-insurance		20% co-insurance	----------none----------**
If you need drugs to treat your illness or condition More information		**Retail**	**Mail**		
	Generic drugs	$8 co-pay	$16 co-pay	25% after co-pay	$5,900 per person/$8,050 per family out-of-pocket maximum per calendar year. Mail order prescriptions are available for up to a 90-day supply. The Plan will permit an initial fill of a maintenance prescription for
	Brand drugs without generic equivalent	$20 co-pay	$50 co-pay	25% after co-pay	
	Brand drugs with generic equivalent	$50 co-pay	$150 co-pay	25% after co-pay	

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
about **prescription drug coverage** is available at www.caremark.com.	Specialty drugs	$50 co-pay	$50 co-pay	30-days and one refill for an additional 30-day supply at a retail pharmacy. Thereafter, the Participant must use the mail-order pharmacy to fill such prescriptions. A 90-day supply of a prescription drug that would otherwise be required to be filled by mail-order may be filled at a CVS retail pharmacy.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	20% co-insurance	**PPO** - Pre-certification required ($250 penalty).** **Non-PPO** - Pre-certification required ($500 penalty).**
	Physician/surgeon fees	10% co-insurance	20% co-insurance	----------none---------- **
If you need immediate medical attention	Emergency room services	$35 co-pay per emergency room visit		Emergency hospitalization must be reported no later than the business day following admission ($150 penalty).**
	Emergency medical transportation	10% co-insurance	20% co-insurance	Coverage limited to necessary transportation provided by a hospital or professionally licensed ambulance service: (1) from your home, the scene of an accident or a medical emergency to a hospital; (2) between hospitals; (3) between a hospital and a skilled nursing facility; or (4) from a hospital or skilled nursing facility to your home.**
	Urgent care	$15 co-pay/office visit	$25 co-pay/office visit; 20% co-insurance	----------none---------- **
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	20% co-insurance	Coverage limited to semi-private daily room rate; limitation does not apply if private room is necessary for isolation purposes; pre-certification required ($250 penalty).**
	Physician/surgeon fee	10% co-insurance	20% co-insurance	----------none---------- **

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 co-pay/office visit	$25 co-pay/office visit; 20% co-insurance	$35 co-pay if treatment provided in hospital emergency room; no charge for services after $35 co-pay.**
	Mental/Behavioral health inpatient services			
	Substance use disorder outpatient services			
	Substance use disorder inpatient services			
If you are pregnant	Prenatal and postnatal care	$15 co-pay/office visit	$25 co-pay/office visit; 20% co-insurance	No charge for certain preventive care services.**
	Delivery and all inpatient services			----------none----------**
If you need help recovering or have other special health needs	Home health care	10% co-insurance	20% co-insurance	Must be prescribed by a Physician in writing; pre-certification required ($250 penalty).**
	Rehabilitation services	10% co-insurance	20% co-insurance	Cardiac rehabilitation covered if provided immediately following hospital discharge, but only for Phase I and Phase II rehabilitation.** Coverage of speech therapists limited for treatment of a Sickness or Accident, or after corrective surgery for a congenital defect; pre-certification required ($250 penalty).** Pre-certification required for physical and occupational therapy ($250 penalty).**
	Habilitation services	10% co-insurance	20% co-insurance	Must be medically necessary and services cannot be rendered by a close relative or by a person who resides in the same household of the Participant.** ABA therapy for treatment of autism limited to Dependent children under the age of 26; pre-certification required ($250 penalty).**

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Skilled nursing care	10% co-insurance	20% co-insurance	Coverage limited to 45-day lifetime maximum per person; pre-certification required ($250 penalty).**
	Durable medical equipment	10% co-insurance	20% co-insurance	Replacement of equipment will follow Medicare guidelines; pre-certification required for equipment over $1,000 ($250 penalty).**
	Hospice service	10% co-insurance	20% co-insurance	Participant's life expectancy must not exceed 6 months; pre-certification required ($250 penalty).**
If your child needs dental or eye care	Eye exam	50% of balance over $400 for eye exams, lenses and one pair of frames in conjunction with a new prescription*		*Payment is made on a reimbursement basis only. Claims must be filed within 24 months of incurring the expense.
	Glasses			
	Dental check-up	No charge*	No charge*	*No charge for preventive and diagnostic services. $2,000 per person/$8,000 per family calendar year limit will apply for all other covered services.**

** Amounts paid by the Participant for Internal Revenue Code Section 213(d) expenses may be reimbursed from the Participant's HRA account.

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 (unless medically necessary)**
- Cosmetic surgery (except for the repair of congenital defects of a Dependent child or for conditions resulting from accidental injuries due to Accidents or illnesses, including scars, tumors or diseases that occur)**
- Long-term care (unless provided by a Skilled Nursing Facility as defined by the Plan)**
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing**
- Routine foot care
- Weight loss programs (unless considered a Preventive Service)**

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 (PPO only – pre-certification required; non-PPO not covered)**
- Chiropractic care (limited to 18 visits per year per person)**
- Dental Care (Adult) (Actives - $25 per person/calendar year deductible for basic and restorative coverages; $2,000 per person/$8,000 per family calendar year maximum) (Retirees - $25 per person/calendar year deductible for basic and restorative coverages; $600 per person calendar year maximum)**
- Hearing aids ($2,000 max/year per ear (limit does not apply to bone anchored hearing aids for Dependent children under age 19); excludes replacement hearing aid within 36 months following the purchase of existing hearing aid, cost of replacing a lost or damaged hearing aid, hearing aid batteries, and the cost of eyeglass frames with a built-in hearing aid)**
- Infertility treatment ($50,000 per family lifetime maximum; limit does not apply to diagnostic tests and procedures done solely to identify the cause or causes of infertility (participant and spouse))**
- Routine eye care (Adult) ($400 maximum benefit per person per year)**

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 1-708-468-8000. 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 1-708-468-8000. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at 1-877-527-9431 or visit www.insurance.illinois.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 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 1-708-468-8000.

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** $6,660
- **Patient pays** $880

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
Copays	$30
Coinsurance	$500
Limits or exclusions	$150
Total	**$880**

Note: These numbers do not consider any possible reimbursement from your HRA account.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,530
- **Patient pays** $870

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
Copays	$460
Coinsurance	$130
Limits or exclusions	$80
Total	**$870**

Note: These numbers do not consider any possible reimbursement from your HRA account.

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.