Utah Laborers' Health& Welfare Fund: Medical Plan

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

Coverage Period: 01/01/2015 – 06/30/2015

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.utl.compusysut.com or by calling **1-800-928-1001**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$750**/person/calendar year; **$2,250**/family/calendar year. Does not apply to preventive care and outpatient prescription drugs. Copayments and non-covered expenses 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?	Yes. There is a $25 annual dental plan deductible for dental services that are not diagnostic and preventive.	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, the **Out-of-Pocket Limit for cost-sharing for in-network PPO deductibles, copayment and coinsurance per calendar year is $6,350**/person; **$12,700**/family (these amounts will be adjusted in accordance with law). This plan has no **Out-of-Pocket Limit** for cost-sharing for Non-PPO (out-of-network) providers.	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?	The **Out-of-Pocket Limit** for in-network cost-sharing does not accumulate these: premiums, balance-billed charges, non-covered expenses, charges in excess of benefit maximums and allowed charges, a penalty for failure to obtain precertification, outpatient retail/mail order prescription drug expenses and out-of-network deductibles, copayments and coinsurance.	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 **in-network PPO providers, for inside Utah see www.wiseprovider.net or call 1-866-485-5205. For PPO providers outside Utah, see www.firsthealth.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.

Questions: Call **1-800-928-1001**or visit us at www.utl.compusysut.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.utl.compusysut.com or www.dol.gov/ebsa/healthreform **or call 1-800-928-1001** to request a copy.

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**.

- **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 in-network PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

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	You pay a $50 copayment/visit, plus the deductible, then you pay 20% coinsurance until you have paid $2,000/person/year (or $6,000/family/year) then you pay 10% coinsurance.	You pay a $50 copayment/visit, plus the deductible, then you pay 50% coinsurance until you have paid $5,000/person/year (or $15,000/family/year) then you pay 10% coinsurance.	Chiropractor: maximum benefit is 20 visits/calendar year. You pay 100% of acupuncture expenses.
	Specialist visit			
	Other practitioner office visit			
	Preventive care/screening/ immunization	No charge.	You pay a $50 copayment/visit, plus the deductible, then you pay 50% coinsurance until you have paid $5,000/person/year (or $15,000/family/year) then you pay 10% coinsurance.	Plan covers preventive services and supplies required by the Health Reform law. Details at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/. Age and frequency guidelines apply to covered preventive care.
If you have a test	Diagnostic test (x-ray, blood work)	After deductible met, you pay 20% coinsurance until you have paid $2,000/person/year (or $6,000/family/year) then you pay 10% coinsurance.	After deductible met, you pay 50% coinsurance until you have paid $5,000/person/year (or $15,000/family/year) then you pay 10% coinsurance.	Precertification is suggested for imaging tests like MRI, CT scan, myelogram and angiogram.
	Imaging (CT/PET scans, MRIs)			

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available from **Express Scripts** at www.express-scripts.com or call **1-866.544.6849.**	Generic drugs	Retail Pharmacy for 30-day supply: you pay the greater of $10 or 20% coinsurance; Mail Order for 90-day supply: $30 copayment. No charge for FDA-approved generic contraceptives.	You pay 100%. Plan reimburses no more than it would have paid had you used an In-Network Retail pharmacy.	If the cost of the drug is less than the copay, you pay just the drug cost. Some prescriptions are subject to preapproval, quantity limits or step therapy requirements. Certain over the counter (OTC) drugs are payable at no charge with a prescription, in compliance with Health Reform.
	Preferred brand drugs	Retail Pharmacy for 30-day supply: you pay the greater of $40 or 20% coinsurance; Mail Order for 90-day supply: $60 copayment. No charge for FDA-approved preferred brand contraceptive only if a generic contraceptive is medically inappropriate.		
	Non-preferred brand drugs	Retail Pharmacy for 30-day supply: you pay 50% coinsurance; Mail Order for 90-day supply: $120 copayment.		
	Specialty drugs	Up to a 30-day supply you pay 50% coinsurance up to a maximum of $120 per fill.	Not covered.	Specialty drugs require preapproval by calling Express Scripts at 1-866.544.6849.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	After deductible met, you pay 20% coinsurance until you have paid $2,000/person/year (or $6,000/family per year) then you pay 10% coinsurance.	After deductible met, you pay 50% coinsurance until you have paid $5,000/person/year (or $15,000/family per year) then you pay 10% coinsurance.	Precertification is suggested for Outpatient surgery.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	You pay a $300 copay/visit plus the deductible and 20% coinsurance until you have paid $2,000 per person/year (or $6,000/family/year) then you pay 10% coinsurance.	You pay a $300 copay/visit plus the deductible and 20% coinsurance until you have paid $2,000 per person/year (or $6,000/family/year) then you pay 10% coinsurance.	Copayment waived if hospitalized as an inpatient. Copayments do not apply to the deductible.

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
	Emergency medical transportation	After deductible met, you pay 20% coinsurance until you have paid $2,000/person/year (or $6,000/family per year) then you pay 10% coinsurance.	After deductible met, you pay 50% coinsurance until you have paid $5,000/person/year (or $15,000/family per year) then you pay 10% coinsurance.	---none---
	Urgent care	You pay a $50 copayment/visit, plus the deductible, then you pay 20% coinsurance until you have paid $2,000/person/year (or $6,000/family per year) then you pay 10% coinsurance.	You pay a $50 copayment/visit, plus the deductible, then you pay 50% coinsurance until you have paid $5,000/person/year (or $15,000/family per year) then you pay 10% coinsurance.	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	After deductible met, you pay 20% coinsurance until you have paid $2,000/person/year (or $6,000/family per year) then you pay 10% coinsurance.	After deductible met, you pay 50% coinsurance until you have paid $5,000/person/year (or $15,000/family per year) then you pay 10% coinsurance.	Precertification is suggested for an elective hospital admission.
	Physician/surgeon fee			
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	You pay a $50 copayment/visit, plus the deductible, then you pay 20% coinsurance until you have paid $2,000/person/year (or $6,000/family per year) then you pay 10% coinsurance.	You pay a $50 copayment/visit, plus the deductible, then you pay 50% coinsurance until you have paid $5,000/person/year (or $15,000/family per year) then you pay 10% coinsurance.	---none---
	Mental/Behavioral health inpatient services	After deductible met, you pay 20% coinsurance until you have paid $2,000/person/year (or $6,000/family per year) then you pay 10% coinsurance.	After deductible met, you pay 50% coinsurance until you have paid $5,000/person/year (or $15,000/family per year) then you pay 10% coinsurance.	Precertification is suggested for an elective hospital admission.
	Substance use disorder outpatient services	You pay a $50 copayment/visit, plus the deductible, then you pay 20% coinsurance until you have paid $2,000/person/year (or $6,000/family per year) then you pay 10% coinsurance.	You pay a $50 copayment/visit, plus the deductible, then you pay 50% coinsurance until you have paid $5,000/person/year (or $15,000/family per year) then you pay 10% coinsurance.	---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
	Substance use disorder inpatient services	After deductible met, you pay 20% coinsurance until you have paid $2,000/person/year (or $6,000/family per year) then you pay 10% coinsurance.	After deductible met, you pay 50% coinsurance until you have paid $5,000/person/year (or $15,000/family per year) then you pay 10% coinsurance.	Precertification is suggested for an elective hospital admission.
If you are pregnant	Prenatal and postnatal care	Prenatal and postnatal visits: No charge. All other services including ultrasounds and delivery: After the deductible, you pay 20% coinsurance until you have paid $2,000/person/year (or $6,000/family per year) then you pay 10% coinsurance.	After the deductible you pay 50% coinsurance until you have paid $5,000/person/year (or $15,000/family per year) then you pay 10% coinsurance.	You pay 100% for ultrasounds and delivery expenses for a pregnant dependent child.
	Delivery and all inpatient services	After deductible met, you pay 20% coinsurance until you have paid $2,000/person/year (or $6,000/family per year) then you pay 10% coinsurance.	After deductible met, you pay 50% coinsurance until you have paid $5,000/person/year (or $15,000/family per year) then you pay 10% coinsurance.	Precertification is suggested if hospital stay exceeds 48 hrs. for vaginal delivery or 96 hrs. for C-section. You pay 100% for delivery expenses for a pregnant dependent child.
If you need help recovering or have other special health needs	Home health care	After deductible met, you pay 20% coinsurance until you have paid $2,000/person/year (or $6,000/family per year) then you pay 10% coinsurance.	After deductible met, you pay 50% coinsurance until you have paid $5,000/person/year (or $15,000/family per year) then you pay 10% coinsurance.	Plan covers part-time or intermittent skilled nursing care. Precertification is suggested for Home health services.
	Rehabilitation services	After deductible met, you pay 20% coinsurance until you have paid $2,000/person/year (or $6,000/family per year) then you pay 10% coinsurance.	After deductible met, you pay 50% coinsurance until you have paid $5,000/person/year (or $15,000/family per year) then you pay 10% coinsurance.	Precertification is suggested for inpatient rehab admissions and outpatient therapy.
	Habilitation services	Not covered.	Not covered.	You pay 100% of these expenses.

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
	Skilled nursing care	After deductible met, you pay 20% coinsurance until you have paid $2,000/person/year (or $6,000/family per year) then you pay 10% coinsurance.	After deductible met, you pay 50% coinsurance until you have paid $5,000/person/year (or $15,000/family/year) then you pay 10% coinsurance.	Maximum benefit is 60 days per calendar year.
	Durable medical equipment	After deductible met, you pay 20% coinsurance until you have paid $2,000/person/year (or $6,000/family per year) then you pay 10% coinsurance.	After deductible met, you pay 50% coinsurance until you have paid $5,000/person/year (or $15,000/family/year) then you pay 10% coinsurance.	Precertification is suggested for equipment over $200 per item.
	Hospice service	After deductible met, you pay 20% coinsurance until you have paid $2,000/person/year (or $6,000/family/year) then you pay 10% coinsurance.	After deductible met, you pay 50% coinsurance until you have paid $5,000/person/year (or $15,000/family/year) then you pay 10% coinsurance.	Covered if terminally ill.
If your child needs dental or eye care	Eye exam	Not covered.	Not covered.	You pay 100% of these expenses.
	Glasses	Not covered.	Not covered.	You pay 100% of these expenses.
	Dental check-up	For a dental check-up once every 6 months, no deductible.		Covered for individuals under 19 yrs.

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
- Eyeglasses
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Maternity: You pay 100% for ultrasound and delivery expenses for a pregnant dependent child.
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult) (Child)
- Routine foot 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.)

- Chiropractic care (up to 20 visits per calendar year).
- Dental care (Adult maximum is $200/yr. Individual under 19 years, no 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 1-800-928-1001. 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 at 1-800-928-1001. 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 1-800-928-1001.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-928-1001.

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** $4,990
- **Patient pays** $2,550

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	$1,500
Copays	$0
Coinsurance	$1,020
Limits or exclusions	$30
Total	**$2,550**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,390
- **Patient pays** $2,010

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	$750
Copays	$300
Coinsurance	$880
Limits or exclusions	$80
Total	**$2,010**

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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