Sheet Metal Local 36 Welfare Fund: Non-Medicare Retiree B Coverage Period: 01/01/2016 – 01/01/2016

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.smw36benefits.org or by calling 314-652-8175.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Tier 1 - CMR Network:** **$600** person / **$1,800** family **Tier 2 – First Health/Wrap Network/Out of Area: $900** person / **$2,700** family **Tier 3 - Non-Network:** **$2,250** person / **$6,750** family The deductible applies to all services, unless otherwise noted in the chart starting on page 2.	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. Durable Medical Equipment is subject to a separate individual/family deductible of $600/$1,800 for Tier 1, $900/$2,700 for Tier 2 and $2,250/$6,750 for Tier 3.	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. **Tier 1: $4,000** person/ **$8,000** family **Tier 2: $4,000** person/ **$8,000** family **Prescription: $2,850** person/**$5,700** family **In-Network Specialty Drugs: $500** person	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?	Vision and dental charges; balance-billed charges; and other non-covered expenses.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. See **www.cmrnetwork.com** or call **1-800-755-3901** for a list of participating providers for all medical expenses. LDI Specialty Pharmacy is the Fund's exclusive specialty pharmacy.	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 don't need a referral to see a specialist.	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 (copays)** 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** or have an applicable **copayment**.
- 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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Network Provider	Your Cost If You Use a Tier 2 Network or Out of Area Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit	$50 copay/visit	50% coinsurance	———none———
	Specialist visit	$50 copay/visit	$65 copay/visit	50% coinsurance	———none———
	Other practitioner office visit	$35 copay/visit for chiropractor	$50 copay/visit for chiropractor	Chiropractor Not Covered	———none———
	Preventive care/screening/immunization	No Charge	No Charge	Not Covered	———none———

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Network Provider	Your Cost If You Use a Tier 2 Network or Out of Area Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance No deductible	40% coinsurance No deductible	50% coinsurance No deductible	———none———
	Imaging (CT/PET scans, MRIs)				
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ldi.com.	Generic drugs	$15 copay retail $37.50 copay mail order No deductible		Not Covered	LDI is the Pharmacy Network. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	$50 copay retail $125 copay mail order No deductible		Not Covered	
	Non-preferred brand drugs	$80 copay retail $200 copay mail order No deductible		Not Covered	
	Specialty drugs	If you obtain specialty medication from LDI Specialty Pharmacy and there is copay assistance you pay $0. If you obtain specialty medication from LDI Specialty Pharmacy and there is not copay assistance, you are responsible for a maximum of $500/year. If you obtain specialty medication from a source other that LDI Specialty Pharmacy you are responsible for any cost above the 30% paid by the Fund.			Specialty drugs must be filled through the Fund's exclusive Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$115 copay and 30% coinsurance	$170 copay and 40% coinsurance	Not Covered	———none———
	Physician/surgeon fees	30% coinsurance	40% coinsurance	50% coinsurance	———none———
If you need immediate medical attention	Emergency room services	$115 copay and 30% coinsurance	$115 copay and 30% coinsurance	$115 copay and 30% coinsurance	———none———
	Emergency medical transportation	30% coinsurance No deductible	35% coinsurance No deductible	35% coinsurance No deductible	———none———
	Urgent care	$55 copay and 30% coinsurance No deductible	$85 copay and 40% coinsurance No deductible	$115 copay and 50% coinsurance No deductible	———none———

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Network Provider	Your Cost If You Use a Tier 2 Network or Out of Area Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance	50% coinsurance	———none———
	Physician/surgeon fee	30% coinsurance	40% coinsurance	50% coinsurance	———none———
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 copay/visit	$50 copay/visit	50% coinsurance	———none———
	Mental/Behavioral health inpatient services	30% coinsurance	40% coinsurance	50% coinsurance	———none———
	Substance use disorder outpatient services	$35 copay/visit	$50 copay/visit	50% coinsurance	———none———
	Substance use disorder inpatient services	30% coinsurance	40% coinsurance	50% coinsurance	———none———
If you are pregnant	Prenatal and postnatal care	30% coinsurance	40% coinsurance	50% coinsurance	Pregnancy related charges are not covered for dependent children
	Delivery and all inpatient services	30% coinsurance	40% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	50% coinsurance	———none———
	Rehabilitation services	30% coinsurance	40% coinsurance	50% coinsurance	No deductible for O/T and P/T.
	Habilitation services	Not Covered	Not Covered	Not Covered	No coverage
	Skilled nursing care	30% coinsurance	40% coinsurance	50% coinsurance	Limited to 60 days per Calendar Year
	Durable medical equipment	30% coinsurance	40% coinsurance	50% coinsurance	Subject to separate deductible
	Hospice service	30% coinsurance No deductible	40% coinsurance No deductible	50% coinsurance No deductible	———none———
If your *child* needs dental or eye care **Please see Summary Plan Description for adult benefits.**	Eye exam	Coverage is limited to $60 and one exam/year			
	Glasses	Coverage is limited to $100 for frames and up to $100 for lenses for one pair of glasses **or** up to $170 for a 12-month supply of contacts/year			
	Dental check-up	No Charge	20% coinsurance No deductible	Not Covered	Delta Dental Plan of Missouri is the dental provider network.

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
- Habilitation Services
- Infertility treatment, except surgery to open tubes closed due to disease. Drug therapy covered/50% coinsurance/$2,500 max.
- Long-term care
- Routine foot care

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, obtained from a participating provider.
- Dental care (Adult)
- Hearing aids, limited to $1,000 per ear
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing, limited to 30 days immediately following hospital confinement
- Routine eye care (Adult)

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 314-652-8175. 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 Benefit Office at 314-652-8175. You may also contact the U.S. 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. In Missouri, contact the Missouri Department of Insurance, (800) 726-7390, www.insurance.mo.gov or consumeraffairs@insurance.mo.gov. A list of other states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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.**

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** $4,832
- **Patient pays** $2,708

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	$600
Copays	$90
Coinsurance	$2,018
Limits or exclusions	
Total	**$2,708**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,060
- **Patient pays** $1,340

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	$600
Copays	$390
Coinsurance	$350
Limits or exclusions	
Total	**$1,340**

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.