Louisiana Carpenters Health Benefit Plan

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

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

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 by calling **1-888-922-3002 or 225-927-6068**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$650** person/ **$1,950** family; Out-of-Network: **$1,300** person/ **$3,900** family. Doesn't apply to preventive care, prescription drugs, or dental. Balance billing, excluded services, copayments, and **deductibles** for specific services 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 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. Dental: **$100** person/**$300** family; Prescription drugs: **$50** person. 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. Medical In-Network: **$6,350** person/**$12,700** family; Medical Out-of-Network: no out-of-pocket limit. Prescription Drug In-Network: **$800** person/**$1,600** family; Prescription Drug Out-of-Network: no out-of-pocket limit.	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.

Questions: Call **1-888-922-3002 or 225-927-6068**.

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 **1-888-922-3002 or 225-927-6068** to request a copy.

Important Questions	Answers	Why this Matters:
What is not included in the out-of-pocket limit?	Premiums, balance billing, health care this plan does not cover, dental deductibles and coinsurance, out-of-network coinsurance (except that out-of-network hospital emergency room expenses count toward the in-network out-of-pocket limit if due to an emergency medical condition), and penalties for failure to obtain pre-authorization.	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 3 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 **providers**, see **www.bcbsil.com** or call 1-800-810-2583. For mental health or substance abuse disorder providers, call 1-800-851-7498.	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 3 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 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 **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Service 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% coinsurance	50% coinsurance	-- None --
	Specialist visit	20% coinsurance	50% coinsurance	-- None --
	Other practitioner office visit	20% coinsurance for chiropractic and acupuncture services	50% coinsurance for chiropractic and acupuncture services	Acupuncture limited to 6 visits per calendar year. Chiropractic and acupuncture limited to combined maximum of 25 visits per calendar year.
	Preventive care/ screening/immunization	No charge for preventive services covered as required by law	Not covered	Age and frequency limits apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	-- None --
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	-- None --
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	$13 copayment retail, $25 copayment mail order	Not covered	Limited to 30-day supply for retail and 90-day supply for mail order, except all specialty drugs are limited to 30-day supply. If generic is available but pharmacy dispenses brand, you also pay the difference in cost between the brand and generic. Maintenance drugs must be filled through mail order beginning with the 3rd refill.
	Preferred brand drugs	$35 copayment retail, $87.50 copayment mail order	Not covered	
	Non-preferred brand drugs	$50 copayment retail, $125 copayment mail order	Not covered	
	Specialty drugs	$150 copayment retail, $125 copayment mail order	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copayment, then 20% coinsurance	$100 copayment, then 50% coinsurance	-- None --
	Physician/surgeon fees	20% coinsurance	50% coinsurance	-- None --
If you need immediate medical attention	Emergency room services	$100 copayment, then 20% coinsurance	$100 copayment, then 20% coinsurance	Must be due to an emergency medical condition.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Must be due to an emergency medical condition.
	Urgent care	20% coinsurance	50% coinsurance	-- None --

Common Medical Event	Service 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 a hospital stay	Facility fee (e.g., hospital room)	$100 copayment, then 20% coinsurance	$100 copayment, then 50% coinsurance	$500 penalty per admission if not precertified.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	$500 penalty if not precertified.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	50% coinsurance	-- None --
	Mental/Behavioral health inpatient services	$100 copayment, then 20% coinsurance	$100 copayment, then 50% coinsurance	$500 penalty per admission if not precertified.
	Substance use disorder outpatient services	20% coinsurance	50% coinsurance	-- None --
	Substance use disorder inpatient services	$100 copayment, then 20% coinsurance	$100 copayment, then 50% coinsurance	$500 penalty per admission if not precertified.
If you are pregnant	Prenatal and postnatal care	No charge for prenatal care as required by law; 20% coinsurance for postnatal care	50% coinsurance	Prenatal care for dependent children not covered, except in-network, as required by law. Postnatal care for dependent children not covered.
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	Not covered for dependent children.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 60 visits per calendar year. $500 penalty per course of treatment if not precertified.
	Rehabilitation services	20% coinsurance	50% coinsurance	Limited to 60 visits per calendar year.
	Habilitation services	20% coinsurance	50% coinsurance	Covered under limited circumstance, subject to Plan provisions.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per calendar year. $500 penalty if not precertified.
	Durable medical equipment	20% coinsurance	50% coinsurance	Limited to standard equipment; rental charges limited to purchase price.
	Hospice service	20% coinsurance	50% coinsurance	Limited to 180 days per 36-consecutive-month period. $500 penalty if not precertified.

Common Medical Event	Service 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 your child needs dental or eye care	Eye exam	Not covered	Not covered	You must pay 100% of these expenses, even in-network. Vision screening for children under 5 covered as preventive service.
	Glasses	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
	Dental check-up	20% coinsurance, deductible waived	30% coinsurance	Limited to 2 visits per 12-month period.

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 (except for reconstructive surgery related to trauma, infection, disease or functional defect)
- Eye exam (Child)
- Glasses (Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult) (except for on-the-job safety glasses for employees only, reimbursed up to $150 once every 2 calendar years)
- 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.)

- Acupuncture (limited to 6 visits per calendar year)
- Chiropractic care (chiropractic and acupuncture limited to combined maximum of 25 visits per calendar year)
- Dental care (Adult) (limited to $500 per calendar year for out-of-network services and $1,000 for in- and out-of-network services combined)
- Hearing aids (limited to maximum of $1,500 per ear including professional charges, payable once every 36 months)

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 1-888-922-3002 or 225-927-6068. 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 1-888-922-3002 or 225-927-6068. 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.**

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** $5,750
- **Patient pays** $1,790

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	$670
Copays	$100
Coinsurance	$870
Limits or exclusions	$150
Total	**$1,790**

You may be eligible for coverage under the Plan's employer-sponsored Health Reimbursement Arrangement (HRA). The HRA may be used to offset deductibles, copays and coinsurance for which you are responsible. Note: Accruals toward the HRA will be discontinued as of January 1, 2017. However, accruals earned through December 31, 2016 may be retained in accordance with Plan rules.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,810
- **Patient pays** $1,590

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	$700
Copays	$570
Coinsurance	$280
Limits or exclusions	$40
Total	**$1,590**

You may be eligible for coverage under the Plan's employer-sponsored Health Reimbursement Arrangement (HRA). The HRA may be used to offset deductibles, copays and coinsurance for which you are responsible. Note: Accruals toward the HRA will be discontinued as of January 1, 2017. However, accruals earned through December 31, 2016 may be retained in accordance with Plan rules.

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.

SUMMARY OF BENEFITS AND ELIGIBILITY CHANGES

July 1, 2017 Plan Provision*	Millwrights (Local 729)	Carpenters (Locals 1098 and 1846)
Initial Eligibility – Required number of hours of work in Covered Employment	No change, current rules continue to apply	375 hours
Continued Eligibility – Required number of hours of work in Covered Employment or banked hours	No change, current rules continue to apply	125 hours per month
COBRA Self-Pay	If a participant elects COBRA and then subsequently enrolls in Medicare, COBRA ends.	
Extended Self-Pay	Ends when participant is enrolled in Medicare.	
Calendar Year In-Network Medical Deductible	\$850 per person \$2,550 per family	\$1,200 per person \$3,600 per family
Out-of-Network Medical Benefits	All out-of-network medical benefits are eliminated, with limited exceptions, as listed in the Summary of Material Modification.	
Emergency Room Copayment – Per visit	\$200	\$200
	Applies prior to and in addition to the Calendar Year In-Network Medical Deductible. The Emergency Room Copayment is waived if admitted into the Hospital.	
Calendar Year Limit on Outpatient Physical Therapy, Occupational Therapy, Speech Therapy and Pulmonary Rehabilitation Therapy	No change, current limits continue to apply	45 visits combined limit for all forms of therapy, which includes a limit of 25 visits per calendar year for Chiropractic Therapy
Calendar Year Limit on Chiropractic Therapy	No change, current limits continue to apply	
Calendar Year Prescription Drug Deductible – Applies to all drugs received through retail network, mail order or specialty pharmacy	\$150 per person	\$150 per person
Calendar Year Prescription Drug Out of Pocket Maximum - Effective January 1, 2018	\$1,000 per person \$2,000 per family	\$1,000 per person \$2,000 per family
Retail Network Pharmacy Copayments – Per prescription, up to 30 day supply	No change, current Copayments continued to apply	\$25 Generic \$75 Formulary \$150 Non-formulary \$300 Specialty
Mail Order & Specialty Pharmacy Copayments – Per script, up to a 90 day supply, except specialty drugs are limited to a 30 day supply	No change, current Copayments continued to apply	\$62.50 Generic \$187.50 Formulary \$375 Non-formulary \$250 Specialty Drug
Expanded Clinical Programs for Prescription Drugs	Prior authorization, step therapy and drug quantity management will apply to certain Prescription Drugs.	
Health Reimbursement Arrangement	December 31, 2017 claims filing deadline; thereafter, any unused account balances will be forfeited.	

* The effective date for the listed changes is generally July 1, 2017, unless otherwise noted. The above is intended as a brief summary of the changes. For additional information regarding the eligibility rules or the plan of benefits, please refer to the accompanying Summary of Material Modification ("SMM"). Benefits described herein and in the SMM are subject to all terms, exclusions and limitations of the Plan.