Oklahoma/Arkansas Health & Welfare Fund

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

Summary of Benefits and Coverage: What This Plan Covers & What It Costs

Coverage for: Individual | **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 1-866-675-4577.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$200** for calendar year. Doesn't apply to prescription drugs or preventive care.	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. **$50** for name brand prescription drug coverage. **$100** for dental coverage.	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. For participating **providers** $10,000	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?	Prescription drugs, premiums, balance-billed charges, 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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. Call Blue Cross Blue Shield of Illinois at **1-800-810-2583** for a list of participating providers or go to www.BCBSIL.com .	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 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-866-675-4577. 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 or call 1-866-675-4577 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 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 participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	25% of the first $10,000 of total reimbursable expenses and 20% after $10,000.	45% of the first $10,000 of total reimbursable expenses and 30% after $10,000.	None.
	Specialist visit	Same as above.	Same as above.	None.
	Other practitioner office visit	Same as above.	Same as above.	30 annual visits limit on specialized fields including chiropractors.
	Preventive care/screening/immunization	Specific Wellness Benefits covered 100%.	Specific Wellness Benefits covered 100%.	See the schedule of Wellness Benefits covered in your plan.
If you have a test	Diagnostic test (x-ray, blood work)	Same as primary care.	Same as primary care.	None.
	Imaging (CT/PET scans, MRIs)	Same as above.	Same as above.	None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-866-675-4577.	Generic drugs	Greater of 30% of cost, or $5.00 for 30-day supply at retail outlet.	Greater of 30% of cost, or $10.00 for 90-day supply from mail order.	None.
	Preferred brand drugs	Greater of 30% of cost, or $30.00 for 30-day supply at retail outlet.	Greater of 30% of cost, or $60.00 for 90-day supply from mail order.	None.
	Non-preferred brand drugs	Same as preferred brand drugs.	Same as preferred brand drugs.	Same as preferred brand drugs.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
	Specialty drugs	Same as preferred brand drugs.	Same as preferred brand drugs.	Same as preferred brand drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% of the first $10,000 of total reimbursable expenses and 20% after $10,000.	45% of the first $10,000 of total reimbursable expenses and 30% after $10,000.	None.
	Physician/surgeon fees	Same as above.	Same as above.	None.
If you need immediate medical attention	Emergency room services	Same as above.	Same as above.	None.
	Emergency medical transportation	Same as above.	Same as above.	None.
	Urgent care	Same as above.	Same as above.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	Same as above.	Same as above.	Average semi-private room rate.
	Physician/surgeon fee	Same as above.	Same as above.	None.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Same as above.	Same as above.	30 visits maximum per calendar year.
	Mental/Behavioral health inpatient services	Same as above.	Same as above.	None.
	Substance use disorder outpatient services	Not Covered.	Not Covered.	Not applicable.
	Substance use disorder inpatient services	Not Covered.	Not Covered.	Not applicable.
If you are pregnant	Prenatal and postnatal care	Same as Facility fee.	Same as Facility fee.	None.
	Delivery and all inpatient services	Same as above.	Same as above.	None.
If you need help recovering or have other special health needs	Home health care	Not Covered.	Not Covered.	Not applicable.
	Rehabilitation services	Same as Facility fee.	Same as Facility fee.	Covers physical therapy only.
	Habilitation services	Same as above.	Same as above.	Same as above.
	Skilled nursing care	Same as above.	Same as above.	None.
	Durable medical equipment	Same as above.	Same as above.	None.
	Hospice service	Same as above.	Same as above.	$25,000 maximum.
If your child needs dental or eye care	Eye exam	Same as above.	Same as above.	1 annual exam per child under age 19 (including one pair of glasses or contacts)
	Glasses	Same as above.	Same as above.	Same as above.
	Dental check-up	40% after $100 deductible.	40% after $100 deductible.	1exam every 6 months maximum per child under age 19.

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
- Hearing aids
- Infertility treatment
- Long-term Care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- 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 (30 annual visits combined other practitioner maximum per year)
- Dental care (Adult) ($1,600 calendar year maximum per person/$2,000 lifetime orthodontics maximum)
- Private-duty nursing
- Routine eye care (Adult) ($200 maximum 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 1-866-675-4577. 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, contact the plan at 1-866-675-4577. 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 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.**

SPANISH (Español): Para obtener asistencia en Español, llame al 1-866-675-4577.

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** $5,420
- **Patient pays** $2,120

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
Co-pays	$10
Co-insurance	$1,760
Limits or exclusions	$150
Total	**$2,120**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,360
- **Patient pays** $1,040

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
Co-pays	$200
Co-insurance	$560
Limits or exclusions	$80
Total	**$1,040**

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**, **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 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 **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.

Questions: Call 1-866-675-4577. 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 or call 1-866-675-4577 to request a copy.