Board of Trustees of North Central States Regional Council of Carpenters' Health Fund: Retired Employee Plan

Coverage Period: Beg. on or after 01/01/2017 **Coverage for:** Class P, R, S, T, U, & V

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Plan Type:** PPO Employee & Dependents

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.ncscbf.com or by calling 1-800-424-3405.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$200** person/**$600** family in-network, **$400** person/ **$1,200** family out-of-network. Doesn't apply to hospice care, home health care, skilled nursing facility care, and 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 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Dental Care Benefits for Classes P, S, and T only. 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: **$1,500** person/ **$4,500** family in-network, **$2,500** person/ **$7,500** family out-of-network. Preferred Provider Pharmacy: **$5,350** person / **$9,200** family.	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.

Important Questions	Answers	Why this Matters:
What is not included in the out–of–pocket limit?	Coinsurance reduction of 5% for each non-emergency hospital confinement or inpatient surgical procedure which is not precertified as required; coinsurance for out-of-network preventive care in excess of maximum; amounts in excess of the maximum for out-of-network chiropractic visits; 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 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. See: www.anthem.com for a list of in-network providers.	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 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 11. 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 encourages you to use in-network **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	10% coinsurance	30% coinsurance	None
	Specialist visit	10% coinsurance	30% coinsurance	None
	Other practitioner office visit	10% coinsurance for chiropractor and acupuncture	30% coinsurance for chiropractor and acupuncture	Chiropractor visits for treatment of musculoskeletal and neuromusculoskeletal conditions limited to $40/visit. Chiropractic care is not payable for infants and dependent children age 5 and under, unless medical necessity is established by a physician, and is payable only for the treatment of documented injuries for dependent children ages 6 to 12, unless medical necessity is established by a physician. Acupuncture limited to $500/year.
	Preventive care/screening/immunization for preventive care services prescribed by the Patient Protection and Affordable Care Act of 2010 (PPACA)	No charge	Not covered	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
If you visit a health care provider's office or clinic (continued)	Preventive care/screening/immunization for preventive care services that are not prescribed by PPACA	See limitations & exceptions	See limitations & exceptions	Well child care age 2 and over payable in full up to $200/year (excess at 80% coinsurance). Routine physical exams for employee and dependent spouse payable in full up to $531/year (excess at 80% coinsurance), except Preferred Provider Preventive Care Program not limited. Routine colonoscopy and EKGs at 10% coinsurance, no deductible or maximum. Non-covered routine immunizations at 100%.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Preauthorization recommended.

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 at www.express-scripts.com	Generic drugs	$8 copay/ prescription (retail) and $16 copay/ prescription (mail order)	Not covered	In-network: Covers up to a 30-day supply (retail); 90-day supply (mail order); 30-day supply (specialty pharmacy). Drugs excluded from the Plan's Formulary are not covered unless approved in advance through a Formulary exception process managed by Express Scripts. Contraceptives covered are those that require a physician's written prescription, except for emergency (Plan B). Smoking cessation products limited to two 90-day supplies per 365-day period. Out-of-network: Not covered.
	Brand name drugs (including multi-source brand name contraceptives)	Greater of $15 or 25% of cost, to maximum of $35/prescription (retail) and greater of $30 or 25% of cost, to maximum of $70/prescription (mail order)	Not covered	
	Specialty medications (through specialty pharmacy)	25% of cost, to maximum of $50/ prescription	Not covered	
	Generic and single source brand name contraceptives (including oral, emergency, diaphragm, patch, and ring)	No charge (retail and mail order)	Not covered	

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 (continued) More information about **prescription drug coverage** is available at www.express-scripts.com	OTC aspirin, smoking cessation products (including OTC nicotine replacement therapy and federal legend drugs), federal legend fluoride, OTC iron supplements, and OTC folic acid upon a physician's written prescription	No charge (retail and mail order)	Not covered	In-network: Covers up to a 30-day supply (retail); 90-day supply (mail order); 30-day supply (specialty pharmacy). Drugs excluded from the Plan's Formulary are not covered unless approved in advance through a Formulary exception process managed by Express Scripts. Contraceptives covered are those that require a physician's written prescription, except for emergency (Plan B). Smoking cessation products limited to two 90-day supplies per 365-day period. Out-of-network: Not covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Preauthorization for certain outpatient surgeries/ procedures recommended. Preauthorization recommended for prophylactic mastectomies.
If you need immediate medical attention	Emergency room services	$50 copay/visit, then 10% coinsurance	$50 copay/visit, then 10% coinsurance	None
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	10% coinsurance	30% 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
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Precertification required for non-emergency hospital stay (and emergency admissions within 48 hours) or additional 5% coinsurance, up to $500 maximum penalty.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	Precertification required for non-emergency inpatient surgery (or emergency surgery within 48 hours) or additional 5% coinsurance, up to $500 maximum penalty. Preauthorization recommended for prophylactic mastectomies.

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	30% coinsurance	None
	Mental/Behavioral health inpatient services	10% coinsurance	30% coinsurance	Precertification required for non-emergency hospital stay (and emergency admissions within 48 hours) or additional 5% coinsurance, up to $500 maximum penalty.
	Substance use disorder outpatient services	10% coinsurance	30% coinsurance	None
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance	Precertification required for non-emergency hospital stay (and emergency admissions within 48 hours) or additional 5% coinsurance, up to $500 maximum penalty.
If you are pregnant	Prenatal and postnatal care	10% coinsurance	30% coinsurance	None
	Delivery and all inpatient services	10% coinsurance	30% coinsurance	Precertification required or additional 5% coinsurance, up to $500 maximum penalty.

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 help recovering or have other special health needs	Home health care	No charge	No charge	Preauthorization recommended.
	Rehabilitation services	10% coinsurance	30% coinsurance	Preauthorization recommended for physical therapy and occupational therapy after initial evaluation and 8 sessions. Precertification required for inpatient rehabilitation or additional 5% coinsurance, up to $500 maximum penalty.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	No charge	No charge	Limited to 30 days per period of disability. Precertification required or additional 5% coinsurance, up to $500 maximum penalty.
	Durable medical equipment	10% coinsurance	30% coinsurance	Preauthorization for certain equipment recommended. CPAP, BiPAP, and AutoPAP supplies covered up to $200/year.
	Hospice service	No charge	No charge	Preauthorization recommended for home hospice. Precertification required for hospice care in a hospice facility or additional 5% coinsurance, up to $500 maximum penalty.

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 your child needs dental or eye care	Eye exam	10% coinsurance	10% coinsurance	No maximum for 1 exam every 2 calendar years, up to age 19. (Classes P, S, and T only)
	Glasses	10% coinsurance	10% coinsurance	Limited to $400 each 2 consecutive calendar year period; then 90% coinsurance. (Classes P, S, and T only)
	Dental check-up	$25 deductible/year, then 10% coinsurance	$25 deductible/year, then 10% coinsurance	Limited to 2 check-ups per year, up to age 19, no maximum. (Classes P, S, and T only)

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 the repair or reconstruction of injuries within 12 months of the date of the injury or breast reconstruction following mastectomy
- Habilitation services
- Infertility treatment (only infertility testing covered up to $4,000/lifetime)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs, except physician services, lab work, and patient education in a medical setting for treatment of morbid obesity are covered up to $500/lifetime subject to certain criteria

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, subject to medical guidelines which specify certain conditions and diagnoses for which acupuncture is recognized to be effective, up to $500/year
- Chiropractic care for treatment of musculoskeletal and neuromusculoskeletal conditions, up to $40/visit
- Dental care, up to $1,200/calendar year and orthodontic up to $2,000/lifetime (Classes P, S, and T only)
- Hearing aids, limited to one per ear/ 3 years, up to $2,000
- Routine eye care (Adult, Classes P, S, and T only)

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 1-800-424-3405. 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: 1-800-424-3405. You also may 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** $6,620
- **Patient pays** $920

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	$10
Coinsurance	$710
Limits or exclusions	$0
Total	**$920**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,660
- **Patient pays** $740

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	$320
Coinsurance	$220
Limits or exclusions	$0
Total	**$740**

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.