Massachusetts Laborers' Health Fund: Plan A

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 at **www.mlbf.org** or by calling **781-272-1000** or **800-342-3792 (toll-free)**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	PPO Provider: **$250/**person, **$500/**family; Non-PPO Provider: **$750/**person, **$1,500/**family. Doesn't apply to prescription drugs, annual physical exams, dental, or vision. Balance billing and excluded 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 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This plan has no **out-of-pocket limit**.	Not applicable because there's no **out-of-pocket limit** on your expenses.
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.

Questions: Call **781-272-1000 or 800-342-3792 (toll-free)** or visit us at **www.mlbf.org**.
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 **781-272-1000** or **800-342-3792 (toll-free)** to request a copy.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. For a list of PPO providers see www.bcbs.com or call 800-810-2583 (toll free).	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 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $20) 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 PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Service You May Need	Your Cost if You Use a PPO Provider	Your Cost if You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment	20% of lesser of charges or R&C fees	-- None --
	Specialist visit	$20 copayment	20% of lesser of charges or R&C fees	-- None --
	Other practitioner office visit	Chiropractic, acupuncture, biofeedback, homeopathy, massage therapy, naturopathy, and oriental medicine: 20% of provider's charges; Plan pays up to a max of $50 per visit. Nutrition: 20% of BCBS PPO allowance	Acupuncture, biofeedback, homeopathy, massage therapy, naturopathy, and oriental medicine: 20% of provider's charges; Plan pays up to a max of $50 per visit	Chiropractic: max 30 visits/year; acupuncture: max 30 visits/year; all others: combined max 40 visits/year. Massage therapy: max 12 visits/year. Nutrition: max 12 visits/year. Pre-authorization required for all except acupuncture, massage therapy and nutrition; services denied until pre-authorization received. Chiropractic and nutrition provided by BCBS PPO network providers only

Common Medical Event	Service You May Need	Your Cost if You Use a PPO Provider	Your Cost if You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Preventive care/ screening/immunization	$20 copayment for annual physical exam and well baby care	$20 copayment for annual physical exam and well baby care	Annual physical exam includes certain labs and x-rays; immunizations: $20 provider copayment (non-PPO provider: you pay any amount over the lesser of charges or R&C fees) if separate visit from physical exam
If you have a test	Diagnostic test (x-ray, blood work)	No cost	20% of lesser of charges or R&C fees	-- None --
	Imaging (CT/PET scans, MRIs)	$20 copayment (if test performed at hospital)	20% of lesser of charges or R&C fees	-- 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	$5 copayment retail; $10 copayment mail order	ESI will reimburse you for the allowable amount minus the in-network copay	Covers a 30-day supply retail and 90-day supply mail order; only initial fill and two refills of the same prescription (three 30-day supplies) will be covered per copayment; copayment for additional refills at retail is 50% of the cost; certain drugs must be pre-authorized and/or may be part of the step therapy program
	Preferred brand drugs	$15 copayment retail; $30 copayment mail order	ESI will reimburse you for the allowable amount minus the in-network copay	
	Non-preferred brand drugs	$25 copayment retail; $50 copayment mail order	ESI will reimburse you for the allowable amount minus the in-network copay	
	Specialty drugs	Same as non-specialty drugs	Same as non-specialty drugs	Same as non-specialty drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No cost for the first $50,000 of charges then 15% of the excess, up to an out-of pocket maximum of $2,000 per admission	10% of the first $50,000 of charges then 25% of the excess, up to an out-of-pocket maximum of $7,000 per admission	-- None --
	Physician/surgeon fees	$20 copayment	20% of lesser of charges or R&C fees	-- None --

Common Medical Event	Service You May Need	Your Cost if You Use a PPO Provider	Your Cost if You Use a Non-PPO Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	Initial $20 copayment then no cost after $75 additional copayment for each emergency treatment	Initial $75 copayment then 20% of lesser of charges or R&C fees for each emergency treatment	$75 copayment waived if admitted to the hospital
	Emergency medical transportation	No cost for the first $50,000 of charges then 15% of the excess, up to an out-of pocket maximum of $2,000 per admission	10% of the first $50,000 of charges then 25% of the excess, up to an out-of-pocket maximum of $7,000 per admission	-- None --
	Urgent care	$20 copay	20% of lesser of charges or R&C fees	-- None --
If you have a hospital stay	Facility fee (e.g., hospital room)	No cost for the first $50,000 of charges then 15% of the excess, up to an out-of pocket maximum of $2,000 per admission	10% of the first $50,000 of charges then 25% of the excess, up to an out-of-pocket maximum of $7,000 per admission	Contact BCBS at least 10 days before non-emergency admissions (services denied until pre-authorization received), and within 48 hours of an emergency admission; semi-private room charges are covered
	Physician/surgeon fee	$20 copay (surgeon only)	20% of lesser of charges or R&C fees	-- None --
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copayment	20% of lesser of charges or R&C fees	-- None --
	Mental/Behavioral health inpatient services	No cost for the first $50,000 of charges then 15% of the excess, up to an out-of pocket maximum of $2,000 per admission	10% of the first $50,000 of charges then 25% of the excess, up to an out-of-pocket maximum of $7,000 per admission	Pre-authorization required except in emergency; services denied until pre-authorization received. Contact the MAP program within 48 hours of an emergency admission
	Substance use disorder outpatient services	No cost	20% of lesser of charges or R&C fees	-- None --
	Substance use disorder inpatient services	No cost for the first $50,000 of charges then 15% of the excess, up to an out-of pocket maximum of $2,000 per admission	10% of the first $50,000 of charges then 25% of the excess, up to an out-of-pocket maximum of $7,000 per admission	Pre-authorization required except in emergency; services denied until pre-authorization received. Contact the MAP program within 48 hours of an emergency admission
If you are pregnant	Prenatal and postnatal care	Global fee per pregnancy	Global fee per pregnancy	-- None --

Common Medical Event	Service You May Need	Your Cost if You Use a PPO Provider	Your Cost if You Use a Non-PPO Provider	Limitations & Exceptions
If you are pregnant	Delivery and all inpatient services	No cost for the first $50,000 of charges then 15% of the excess, up to an out-of pocket maximum of $2,000 per admission	10% of the first $50,000 of charges then 25% of the excess, up to an out-of-pocket maximum of $7,000 per admission	Pre-certification required for extended hospital stay; cost for certified nurse midwife or birthing center covered if treatment would have been rendered by licensed practitioner at a hospital
If you need help recovering or have other special health needs	Home health care	No cost for up to 90 visits per calendar year	No cost for up to 90 visits per calendar year	Pre-certification required; services denied until pre-authorization received; PPO and non-PPO benefit limits are combined
	Rehabilitation services	$20 copayment	20% of lesser of charges or R&C fees	-- None --
	Habilitation services	$20 copayment	20% of lesser of charges or R&C fees	Physical, occupational and speech therapy. Combined 60 visit limit/year
	Skilled nursing care	No cost for up to 90 visits per calendar year	No cost for up to 90 visits per calendar year	Pre-certification required; services denied until pre-authorization received; PPO and non-PPO benefit limits are combined
	Durable medical equipment	No cost for up to $5,000 of charges then 15% of the excess, renewable annually	No cost for up to $5,000 of charges then 25% of the excess, renewable annually	$5,000 per year benefit amount applies to all DME rental and purchase; motorized wheelchairs and scooters covered up to $2,500; wigs covered for specified medical reasons once per calendar year
	Hospice service	No cost for covered services and supplies up to a six-month period	No cost for covered services and supplies up to a six-month period	Pre-certification required; services denied until pre-authorization received; PPO and non-PPO benefit limits are combined
If your child needs dental or eye care	Eye exam	No cost	No cost up to $20 for optometrist; no cost up to $30 for ophthalmologist	Every 12 months for children under age 19 and every 24 months if over age 19 (non-PPO provider: no frequency limits under age 19)
	Glasses	No cost for certain lenses and frames	Scheduled reimbursement for lenses and frames	
	Dental check-up	No cost	No cost up to lesser of charges or R&C fees	Limited to an oral exam every six months and cleanings twice per year

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.)**

- Cosmetic surgery (Generally excluded with certain exceptions)
- Long-term care
- Private-duty nursing
- 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 (Max 30 visits/year)
- Bariatric surgery (Gastric bypass surgery and removal of excess skin following weight loss with pre-certification)
- Chiropractic care (Max 30 visits/year; network only)
- Dental care (Adult)
- Hearing aids (Limits apply)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (only through a podiatrist)

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 781-272-1000 or 800-342-3792 (toll-free). 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 781-272-1000 or 800-342-3792 (toll-free). 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** $7,130
- **Patient pays** $410

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	$250
Copays	$10
Coinsurance	$0
Limits or exclusions	$150
Total	**$410**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,670
- **Patient pays** $730

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	$250
Copays	$400
Coinsurance	$0
Limits or exclusions	$80
Total	**$730**

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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