New England Carpenters Health Benefits Fund: Plan 3

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

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.carpentersfund.org** or by calling **1-800-344-1515**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$350** member/**$700** family. Does not apply to most in-network office visits, therapy visits, mental health visits; emergency room, inpatient hospital facility charges.	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?	Yes. **$3,000** member/**$6,000** family; Prescriptions: **$3,600** member/**$7,200** 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.
What is not included in the out–of–pocket limit?	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 2 describes any limits and what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.bluecrossma.com/findadoct or or call 1-800-810-BLUE (2583) for a list of preferred medical 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 2 for how this plan pays different kinds of **providers**.

Questions: Call the Fund Office at **1-800-344-1515** or visit us at **www.carpentersfund.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.bluecrossma.com/sbcglossary** or call **1-800-344-1515** to request a copy.

Important Questions	Answers	Why this Matters:
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**.)
- Your cost sharing does not depend on whether a provider is in a network.

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	$15/visit office or health center; 20% coinsurance after deductible/hospital	20% coinsurance after deductible	None
	Specialist visit	$15/visit office or health center; 20% coinsurance after deductible/hospital	20% coinsurance after deductible	None
	Other practitioner office visit	$15/chiropractor visit	20% coinsurance after deductible/chiropractor visit	Limited to 20 visits per calendar year
	Preventive care/ screening/immunization	No charge	20% coinsurance after deductible	Limited to age based and/or frequency

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 test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance after deductible	Deductible applies first for out-of-network
	Imaging (CT/PET scans, MRIs)	PET scans: No charge. CT scans & MRIs: $150/hospital; no charge/freestanding imaging facilities	PET scans: 20% coinsurance after deductible. CT scans & MRIs: $150 + 20% coinsurance after deductible/hospital; 20% coinsurance after deductible/free-standing imaging facilities	Deductible applies first for out-of-network; copayment applies per category of test/day; copayment waived for CT scans and MRIs if no free-standing imaging facility within 30 mile radius of home
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	25% copayment (Retail: $8 minimum, $16 maximum); Mail Order: $20 minimum, $40 maximum)	Not covered	Covers 34-day supply (retail); 90-day supply (mail order). Only three fills of a maintenance drug at retail will be covered per copayment: Penalty for utilizing retail after three fills is 100% member copayment. If a generic is available, and you elect a brand name drug, you are responsible for the copayment plus the difference in cost
	Preferred brand drugs	25% copayment (Retail: $20 minimum, $40 maximum; Mail Order: $50 minimum, $100 maximum)	Not covered	
	Non-preferred brand drugs	25% copayment (Retail: $35 minimum, $70 maximum; Mail Order: $88 minimum, $175 maximum)	Not covered	
	Specialty drugs	25% copayment (Retail: $100 minimum, $200 maximum). Information about specialty drugs is available at www.diplomatpharmacy.com	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250/admission, plus 20% coinsurance	$250/admission plus 20% coinsurance	None
	Physician/surgeon fees	No charge	20% coinsurance after deductible	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 need immediate medical attention	Emergency room services	$100/visit	$100/visit	Copayment waived if admitted
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	None
	Urgent care	No charge	20% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250/admission, plus 20% coinsurance	$250/admission plus 20% coinsurance	Pre-authorization required
	Physician/surgeon fee	No charge for surgeon and anesthesia; 20% coinsurance after deductible for other services	20% coinsurance after deductible	Pre-authorization required
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15/visit	20% coinsurance after deductible	None
	Mental/Behavioral health inpatient services	$250/admission, plus 20% coinsurance	$250/admission plus 20% coinsurance	Pre-authorization required
	Substance use disorder outpatient services	$15/visit	20% coinsurance after deductible	None
	Substance use disorder inpatient services	$250/admission, plus 20% coinsurance	$250/admission plus 20% coinsurance	Pre-authorization required
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance after deductible	None
	Delivery and all inpatient services	No charge for delivery and anesthesia; 20% coinsurance after deductible for other services; facility charges paid the same as "If you have a hospital stay," above	20% coinsurance after deductible; facility charges paid the same as "If you have a hospital stay," above	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 need help recovering or have other special health needs	Home health care	No charge after deductible if services begin within 7 days of hospital discharge; otherwise 20% coinsurance after deductible	20% coinsurance after deductible	Pre-authorization required
	Rehabilitation services	$15/visit for physical and occupational therapy, no deductible; 20% coinsurance after deductible for speech therapy	20% coinsurance after deductible for physical and speech therapy	Out-of-network occupational therapy: Member pays balance of allowed charge, deductible and coinsurance do not apply
	Habilitation services	Rehabilitation services cost share applies	Rehabilitation services cost share applies	Rehabilitation services cost share applies
	Skilled nursing care	$250 copayment/admission plus 20% coinsurance thereafter	$250 copayment/ admission plus 20% coinsurance thereafter	Pre-authorization required; only covered if at an Acute Level of Care
	Durable medical equipment	20% coinsurance after deductible	20% coinsurance after deductible	None
	Hospice service	No charge after deductible	15% coinsurance after deductible	Pre-authorization required except for inpatient hospice service
If your child needs dental or eye care	Eye exam	BCBSMA: not covered; Davis Vision/Carpenters Vision Center: $0/visit	BCBSMA: Not covered; Davis Vision/Carpenters Vision Center: Reimbursement up to $50	One every 12 months through Davis Vision or the Carpenters Vision Center up to age 19
	Glasses	BCBSMA: Not covered; Davis Vision/Carpenters Vision Center: No charge for certain lenses and frames	BCBSMA: Not covered; Davis Vision/Carpenters Vision Center: Reimbursement schedule	Up to two pairs every 12 months up to age 19
	Dental check-up	Not covered	Not covered	None

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	● Infertility treatment	● Private-duty nursing
● Dental care (Adult)	● Long-term 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	● Hearing aids	● Routine eye care (Adult) (covered through Davis Vision/Carpenters Vision Center)
● Bariatric surgery		
● Chiropractic care (limited to 20 visits per calendar year)	● Non-emergency care when traveling outside the U.S.	● Routine foot care (only for patients with systemic circulatory disease)

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 1-800-344-1515. 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 1-800-344-1515. 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 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** $5,950
- **Patient pays** $1,590

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	$0
Copays	$500
Coinsurance	$1,060
Limits or exclusions	$30
Total	**$1,590**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,130
- **Patient pays** $1,270

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	$350
Copays	$150
Coinsurance	$690
Limits or exclusions	$80
Total	**$1,270**

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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