Heat and Frost Insulators Local 34 Health and Welfare Plan

Coverage Period: Beginning on or after April 1, 2021

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Coverage for: Participants and Beneficiaries | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document describes your health plan. The SBC shows you how you and the plan would share the cost for covered health care services. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact the Plan's Administrator, Wilson-McShane Corporation at 952-854-0795. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other **underlined** terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform.com or call 1-800-535-6373 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $400 individual/$800 family Out-of-Network: $800 individual/$1,600 family	Generally, you must pay all the costs from providers up to the **deductible** amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet me the **deductible** amount. For example, preventive care benefits, emergency care, in-network office visits and prescription benefits are not subject to the **deductible**. See a list of preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes.	$25 dental expense calendar year **deductible**. There are no other specific **deductibles**.
What is the out-of-pocket limit for this plan?	In Network: $2,400 individual/$4,800 family Out-of-Network: $4,800 individual/$9,600 family Prescription Drugs: $5,000 individual/$10,000 family	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their **out-of-pocket limits** until the overall family **out-of-pocket** limit has been met.
What is not included in the out-of-pocket limit?	Any required premiums for coverage and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes, through Blue Cross Blue Shield of Minnesota Aware Network. **Call 952-541-6321 or go to www.bluecrossmn.com** for a list of network providers.	This plan uses a **provider** network. You will pay less if you use a **provider** in the plan's network. You will pay the most if you use an out-of-network **provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your plan pays (**balance billing**). Be aware, your network **provider** might use an out-of-network **provider** for some services (such as lab work). Check with your **provider** before you get services.

Do you need a referral to see a specialist?	No.	You can see a **specialist** you choose without permission from this plan.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment	30% coinsurance	----------None----------
	Specialist visit	$20 copayment $30 copayment for Physical, Occupational and Speech Therapy	30% coinsurance	----------None----------
	Preventive care/screening/ immunization	100% coverage	30% coinsurance	----------None----------
If you have a test	Diagnostic test (x-ray, blood work)	80% after the deductible.	30% coinsurance	Coverage in inpatient or outpatient settings is subject to deductible and coinsurance.
	Imaging (CT/PET scans, MRIs)	80% after the deductible.	30% coinsurance	Coverage in inpatient or outpatient settings is subject to deductible and coinsurance.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.proactrx.com	Generic drugs	15% copayment subject to minimum copayment Retail: $5 copayment Mail Order: $10 copayment	100% coinsurance	34-day supply limitation for retail prescriptions; 90-day supply limitation for mail order prescriptions and certain approved retail pharmacies.
	Preferred brand drugs	15% copayment subject to minimum copayment Retail: $20 copayment (formulary) Mail Order: $40 copayment (formulary)	100% coinsurance	34-day supply limitation for retail prescriptions; 90-day supply limitation for mail order prescriptions and certain approved retail pharmacies.

	Non-preferred brand drugs	15% copayment subject to minimum copayment Retail: $35 copayment (non-formulary) Mail Order: $70 copayment (non-formulary)	100% coinsurance	34-day supply limitation for retail prescriptions; 90-day supply limitation for mail order prescriptions and certain approved retail pharmacies.
	Specialty drugs	15% copayment subject to minimum copayment $40 copayment (Brand Name – formulary) $70 copayment (Brand Name –non-formulary)	100% coinsurance	30-day supply limitation available only through Noble Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	----------None----------
	Physician/surgeon fees	20% coinsurance	30% coinsurance	----------None----------
If you need immediate medical attention	Emergency room care	$100 copayment	$100copayment	----------None----------
	Emergency medical transportation	20% coinsurance	20% coinsurance	Must be provided through a licensed ambulance service to nearest qualified facility to treat condition.
	Urgent care	$20 copay then 100%	30% coinsurance	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	100% coinsurance	Limited to hospital's average daily semi-private rate, unless private room is approved as Medically Necessary.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	----------None----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	In-network office visits only subject to $20 copayment.
	Inpatient services	20% coinsurance	100% coinsurance	----------None----------

If you are pregnant	Office visits	20% coinsurance; $20 copay then 100% when done in an in-network office setting	30% coinsurance	----------None----------
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	----------None----------
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Limit of 180 visits per calendar year.
	Rehabilitation services	20% coinsurance	30% coinsurance	----------None----------
	Skilled nursing care	20% coinsurance	30% coinsurance	Limit of 30 days confinement per illness.
	Durable medical equipment	20% coinsurance	30% coinsurance	Repairs of durable medical equipment excluded from coverage.
	Hospice services	20% coinsurance	30% coinsurance	Coverage is limited to those who meet the definition of terminally ill.
If your child needs dental or eye care	Children's eye exam	0% coinsurance for dependents under age 19	0% coinsurance for dependents under age 19	----------None----------
	Children's glasses	0% coinsurance on first $200 and 50% thereafter.	0% coinsurance on first $200 and 50% thereafter.	Plan provides one set of contact lenses or one pair of eyeglasses per calendar year subject to the vision benefit coinsurance requirements for individuals under age 19.
	Children's dental check-up	$25 deductible per calendar year. 0% coinsurance.	100% coinsurance	$1,500 calendar year maximum does not apply to individuals under age 19. $1,500 lifetime maximum for orthodontia does not apply to non-cosmetic orthodontia benefits for individuals under age 19.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture.
- Cosmetic surgery.
- Non-network inpatient services
- Long-term care.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing.
- Weight loss programs.
- Orthotics

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (when medically necessary for treatment of obesity). • Chiropractic care.	• Dental care. • Hearing aids. (Cochlear Implants or Bone Anchored Hearing Aids only) • Infertility treatment.	• Routine eye care. • Routine foot care.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-44-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: The Plan's Administrator, Wilson-McShane Corporation at 1-800-535-6373 or 952-854-0795. You may also contact the U.S. Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$400**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$45
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$1,495**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$400**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$520
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,240**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$400**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**%20**
Other coinsurance	**%20**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$125
Coinsurance	$460
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$985**

The plan would be responsible for the other costs of these EXAMPLE covered services.