Operating Engineers Local #49 Health and Welfare Fund – Active Employees, Retirees Under Age 65, and Dependents (Non-West River)

Coverage Period: 06/01/20 to 05/31/21

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact Plan's Administrator Wilson-McShane Corporation at 1-800-535-6373 or 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 1-866-EBSA(3272) or www.dol.gov/ebsa/healthreform.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500** individual/**$1,000** family.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your 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 services covered before you meet your deductible?	**Yes**	Primary care visits to treat an injury or illness and specialist visits are subject to a $25 copayment.
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 for this plan covers.
What is the out-of-pocket limit for this plan?	**Individual: $2,500** medical and **$2,500** prescription drugs. **Family: $6,000** medical, **$5,900** prescription drugs, and **$1,800** specialty drugs.	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?	Health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	**Yes**	Non-network providers are subject to 30% coinsurance rather than 20% coinsurance in-network; no coverage for non-network inpatient 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	$25 copayment	30% co-insurance	----------None----------
	Specialist visit	$25 copayment	30% co-insurance	----------None----------
	Other practitioner office visit	0% co-insurance for chiropractic services	0% co-insurance for chiropractic services	Limit of 19 visits per calendar year.
	Preventive care/screening/ immunization	Routine Immunizations: 0% coinsurance Preventive care/Screening: 0% co-insurance	Routine Immunizations: 20% co-insurance Preventive care/Screening: 20% co-insurance	Physicals covered at 100% if obtained through Health Dynamics or a participating provider.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	30% co-insurance	Examinations for routine check-up purposes are excluded.
	Imaging (CT/PET scans, MRIs)	20% co-insurance	30% co-insurance	----------None----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.health49.org	Generic drugs	20% co-insurance	20% co-insurance	$2,500 individual/$5,900 family Out-of-Pocket limit.
	Preferred brand drugs	20% co-insurance	20% co-insurance	$2,500 individual/$5,900 family Out-of-Pocket limit.
	Non-preferred brand drugs	20% co-insurance	20% co-insurance	$2,500 individual/$5,900 family Out-of-Pocket limit.
	Specialty drugs	20% co-insurance	20% co-insurance	$2,500 individual/$5,900 family Out-of-Pocket limit. Additional $1,800 family Out-of-Pocket limit for specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	30% co-insurance	----------None----------
	Physician/surgeon fees	20% co-insurance	30% co-insurance	----------None----------
If you need immediate medical attention	Emergency room care	20% co-insurance	20% co-insurance	----------None----------
	Emergency medical transportation	20% co-insurance	20% co-insurance	Transportation must be to nearest local facility as medically necessary.
	Urgent care	20% co-insurance	30% co-insurance	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	Not covered	----------None----------
	Physician/surgeon fees	20% co-insurance	Not covered	----------None----------

[* For more information about limitations and exceptions, see the plan or policy document at [www.health49.org].]

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 need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance	Physician: 20% co-insurance Facility Fee: 30% co-insurance	----------None----------
	Inpatient services	20% co-insurance	Not covered	----------None----------
If you are pregnant	Office visits	Prenatal: 0% Postnatal: 20% co-insurance	Prenatal: 30% co-insurance Postnatal: 30% co-insurance	Coverage is excluded for individuals acting as surrogate mothers.
	Childbirth/delivery professional services	20% co-insurance	Not covered	Coverage is excluded for individuals acting as surrogate mothers.
	Childbirth/delivery facility services	20% co-insurance	Not covered	Coverage is excluded for individuals acting as surrogate mothers.
If you need help recovering or have other special health needs	Home health care	20% co-insurance	20% co-insurance	Maximum of 90 visits per calendar year.
	Rehabilitation services	20% co-insurance	30% co-insurance	Rehabilitation services must be prescribed by a physician.
	Habilitation services	20% co-insurance	30% co-insurance	Habilitation services must be prescribed by a physician.
	Skilled nursing care	20% co-insurance	20% co-insurance	Maximum of 2 days of skilled nursing care for each day of Hospital confinement, up to a cumulative maximum of 60 days of care.
	Durable medical equipment	20% co-insurance	20% co-insurance	----------None----------
	Hospice services	0% co-insurance, up to 180 days of hospice service	0% co-insurance, up to 180 days of hospice service	Maximum of 180 days of hospice service; maximum may be waived when continued hospice care would be a cost savings to this plan.
If your child needs dental or eye care	Children's eye exam	$500 benefit replenished on the first day of every even calendar year.	$500 benefit replenished on the first day of every even calendar year.	----------None----------
	Children's glasses	Above maximum applies to exam, glasses and contact lenses.	Above maximum applies to exam, glasses and contact lenses.	----------None----------
	Children's dental check-up	0% co-insurance	0% co-insurance	----------None----------

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.)

- Cosmetic surgery.
- Infertility treatment.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing.
- Routine foot care.
- Weight loss programs.

[* For more information about limitations and exceptions, see the plan or policy document at [www.health49.org].]

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture. • Bariatric surgery.	• Chiropractic care. • Dental care (subject to plan limits).	• Hearing aids. • Routine eye care (subject to plan limits).

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 Laborer's Employee Benefits Security Administration at 1-866-444-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 Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? [Yes]
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

[* For more information about limitations and exceptions, see the plan or policy document at [www.health49.org].]

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** **$500**
- **Specialist copayment** **$25**
- **Hospital (facility) co-insurance** **20%**
- **Other co-insurance** **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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$25
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,025**

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$25**
- **Hospital (facility) co-insurance** **20%**
- **Other co-insurance** **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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$25
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,925**

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$25**
- **Hospital (facility) co-insurance** **20%**
- **Other co-insurance** **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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$25
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$825**

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