Line Construction Benefit Fund: Base Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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

Coverage for: 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.lineco.org** or by calling **1-800-323-7268.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$400** person/**$1,200** family. Does not apply to preventive.	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?	Yes, **$250** for hospital review program non-compliance and **$150** for emergency room visits. 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. **$2,500** person/**$7,500** 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?	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 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.bcbsil.com or call 1-800-810-2583 for a list of participating providers. For mental health/substance abuse see www.beaconhealthoptions.com/ or call Beacon Health Option at 1-(800)-332-2191.	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 the plan doesn't cover are listed on page 5. See your policy or plan documents for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 (in-network) **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** 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	20% co-insurance	30% co-insurance	----------none----------
	Specialist visit	20% co-insurance	30% co-insurance	----------none----------
	Other practitioner office visit	50% co-insurance for spinal manipulations/adjustments (and related services) and 20% co-insurance for acupuncture		Coverage is limited to $600 annual max for spinal manipulations/adjustments, including related services, and 12 visits/year for acupuncture.
	Preventive care/screening/immunization	No charge	30% co-insurance	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	No charge for first $150/year, 20% co-insurance thereafter	No charge for first $150/year, 30% co-insurance thereafter	The $150 benefit applies to employees and spouses only.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition	Generic drugs	20% co-insurance retail, $10 co-pay mail	20% co-insurance	Coverage is limited to 30-day supply retail and 31-90-day supply mail. If generic substitution declined, you pay the difference in cost between the brand and generic equivalent.

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
More information about **prescription drug coverage** is available at www.express-scripts.com.	Preferred brand drugs	20% co-insurance retail, $20 co-pay mail	20% co-insurance	
	Non-preferred brand drugs	20% co-insurance retail, $35 co-pay mail	20% co-insurance	
	Specialty drugs	Generic: 10%, $100 maximum co-pay. Preferred brand: 20%, $250 max. Non-preferred brand: 20%, no max.	Not covered	Use of Accredo Specialty Pharmacy is required. Coverage is limited to 30-day supply. Variable co-pay program may apply if assistance program is available. Step therapy applies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	30% co-insurance	Pre-certification and in-network providers required for bariatric & TMJ surgery or services are not covered.
	Physician/surgeon fees	20% co-insurance	30% co-insurance	
If you need immediate medical attention	Emergency room services	20% co-insurance	20% co-insurance	Additional $150 deductible.
	Emergency medical transportation	20% co-insurance	20% co-insurance	----------none----------
	Urgent care	20% co-insurance	30% co-insurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	30% co-insurance	Additional $250 deductible applies if inpatient confinement not pre-certified. Pre-certification and in-network providers required for bariatric & TMJ surgery or services are not covered.
	Physician/surgeon fee	20% co-insurance	30% co-insurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance Primary network is through BeaconHealth Options	30% co-insurance	Pre-certification is required for intensive outpatient treatment, psychological testing and electroconvulsive therapy or services are 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
	Mental/Behavioral health inpatient services	20% co-insurance Primary network is through BeaconHealth Options	30% co-insurance	Additional $250 deductible applies if inpatient confinement not pre-certified. Pre-certification is required for inpatient, residential and partial inpatient treatment and electroconvulsive therapy or services are not covered.
	Substance use disorder outpatient services	20% co-insurance Primary network is through BeaconHealth Options	30% co-insurance	Pre-certification is required for intensive outpatient treatment, psychological testing or services are not covered.
	Substance use disorder inpatient services	20% co-insurance Primary network is through BeaconHealth Options	30% co-insurance	Additional $250 deductible applies if inpatient confinement not pre-certified. Pre-certification is required for inpatient, residential and partial inpatient treatment or services are not covered.
If you are pregnant	Prenatal and postnatal care	20% co-insurance	30% co-insurance	No charge for in-network prenatal office visits. Maternity benefits are not provided for children (other than prenatal visits).
	Delivery and all inpatient services	20% co-insurance	30% co-insurance	
If you need help recovering or have other special health needs	Home health care	20% co-insurance	30% co-insurance	Coverage is limited to 40 visits /year.
	Rehabilitation services	20% co-insurance	30% co-insurance	Speech therapy allowable amount is $90/visit, and plan allows 50 visits/year max.
	Habilitation services	Not covered	Not covered	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
	Skilled nursing care	20% co-insurance	30% co-insurance	Coverage is limited to 30-day annual max.
	Durable medical equipment	20% co-insurance	30% co-insurance	----------none----------
	Hospice service	20% co-insurance	30% co-insurance	Coverage is limited to 180 days.
If your child needs dental or eye care	Eye exam	Provider network is Vision Service Plan. The Plan provides covered exams and contracted eyewear in full.	Amount over $35	You pay for in-network upgrades.
	Glasses		Amount over $35 for frame and over $30 for lenses	
	Dental check-up	No charge	No charge	----------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
- Habilitation services, except for speech therapy for children for treatment of congenital medical defects and acute diseases, including hearing deficits caused by specifically diagnosed illnesses, cerebral palsy, and neurological disorders
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot 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 up to 12 visits/year	• Bariatric surgery if pre-certified (only one per lifetime and not covered for children)	• Chiropractic care, subject up to $600 annual maximum for all spinal manipulations/adjustments (and related services)
• Dental care (Adult)	• Hearing aids up to $2,500 (bilateral) every 5 years (every 2 years for children)	• Non-emergency care when traveling outside the U.S.
• Routine eye care (Adult)		

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 1-800-323-7268. You may also contact 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 1-800-323-7268. 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 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.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-323-7268.
Tagalog (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-800-323-7268.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-323-7268.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-323-7268.

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** $5,600
- **Patient pays** $1,940

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	$400
Co-pays	$0
Co-insurance	$1,390
Limits or exclusions	$150
Total	**$1,940**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,960
- **Patient pays** $1,440

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	$400
Co-pays	$0
Co-insurance	$960
Limits or exclusions	$80
Total	**$1,440**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.