Mahoning & Trumbull County Building Trades Insurance Fund

33 Fitch Boulevard • Austintown, Ohio 44515

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Summaries of Benefits and Coverage (SBC)

Dear Participant and Family;

Enclosed you will find the Mahoning & Trumbull County Building Trades Insurance Fund's Summary of Benefits and Coverage (SBC). This document which provides a general description of the health benefits provided by our Plan is now a required mailing under the Affordable Care Act (ACA). Please share the SBC with your family members who are eligible for Plan coverage.

The federal government developed the SBC form primarily to help people who will be shopping for individual coverage thru the health care exchanges. They are designed so that individuals can compare "apples to apples" when comparing plans. For that reason, we were not allowed to customize much of the SBC. Fortunately, you have coverage based on a Collective Bargaining Agreement between your employer(s) and your union. Therefore, you don't need to shop for coverage.

ACA Requirements for SBCs

To best understand the benefits provided by the Plan, we recommend that you refer to the materials that the Plan has created which includes the full Summary Plan Description (SPD). The SPD along with other documents that you are used to seeing can be found on the Plan's website, www.yourunionbenefits.com.

Also included in the SBC are two examples—one for having a baby and one for managing type 2 diabetes. The examples show the health care costs for you and the Plan associated with each of these two situations. **As you read these examples, it's very important to note that these costs are estimates; they do not necessarily reflect what the actual services might cost in your area.** Similarly, your course of treatment might also be very different depending on your doctor's approach, whether your doctor is a PPO Provider or a Non-PPO Provider (the examples show only PPO Provider costs), your age, your other health issues, and many other factors. These examples are included to help you compare how different health plans might cover the same condition—not for predicting your own actual health care expenses.

You may find that the SBC discusses the Plan's benefits in ways that may seem unfamiliar to you. For instance, there may be terms you haven't seen before, or terms that you have seen before but are being used differently. The SBC also refers to a "Glossary of Health Coverage and Medical Terms," which cannot be customized for our Plan. If you read the SBC or the Glossary and find yourself confused at any time, we recommend that you refer to your SPD.

For More Information
Please keep the SBC with your SPD for easy reference. Receipt of this document does not constitute a determination of your eligibility. If you have any questions about Plan coverage, please call the Fund Office at (800)435-2388. If you have general questions about the SBC or the Glossary, you may want to contact the Employee Benefits Security Administration of the U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (877) 267-2323 Ext. 61565 or www.cciio.cms.gov.

Statement of Grandfathered Status
The Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act, which means that our Plan existed when the health care reform law was signed on March 23, 2010, and that we can preserve certain basic health coverage that was already in effect when the law was passed. As with all grandfathered health plans, we must still comply with certain consumer protections in the Affordable Care Act (for example, the elimination of the Plan's lifetime maximums). However, because this Plan is "grandfathered" and not required to adopt other changes required by the Affordable Care Act, this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

Sincerely,

The Board of Trustees

September 1, 2014

Mahoning & Trumbull Bldg Trades: PPO

Coverage Period:10/01/2014 - 09/30/2015

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 yourunionbenefits.com or by calling 1-800-435-2388.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Both In and Out-of-Network: **$300** person/**$600** family. Balance billing, 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?	Yes, **$1,100** per person In-Network. **$1,500** per person Out-of-Network.	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 billing, health care this plan does not 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. For a list of in-network **providers**, call 1-800-601-9208 or visit www.supermednetwork.com	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.

Questions: Call 1-800-435-2388 or visit us at yourunionbenefits.com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-435-2388 to request a copy.

Important Questions	Answers	Why this Matters:
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document 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 In Network providers by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

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	20% co-ins. of 1st $4,000	30% co-ins. of 1st $4,000	-- None --
	Specialist visit	20% co-ins. of Ist $4,000	30% co-insur. of 1st $4,000	-- None --
	Other practitioner office visit	20% co-ins. of 1st $4,000	30% co-insur. of 1st $4,000	-- None --
	Preventive care/screening/immunization	20% co-ins. of 1st $4,000	30% co-ins. of 1st $4,000	-- None --
If you have a test	Diagnostic test (x-ray, blood work)	20% co-ins. of 1st $4,000	30% co-ins. of 1st $4,000	-- None --
	Imaging (CT/PET scans, MRIs)	20% co-ins. of 1st $4,000	30% co-ins. of 1st $4,000	-- 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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$10 co-pay retail, $20 co-pay mail	$10 co-pay retail, $20 co-pay mail	30-day supply retail; 90 days mail
	Preferred brand drugs	25% co-ins. retail, 20% co-ins. mail	25% co-ins. retail, 20% co-ins. mail	If there is a generic equivalent, you will pay 50% retail and 35% mail order.
	Non-preferred brand drugs	50% co-ins. retail, 35% co-ins. mail	50% co-ins. retail, 35% co-ins. mail	-- None --
	Specialty drugs	50% co-ins. retail, 35% co-ins. mail	50% co-ins. retail, 35% co-ins. mail	-- None --
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance of 1st $4,000	30% co-ins. of 1st $4,000	-- None --
	Physician/surgeon fees	20% co-ins. of 1st $4,000	30% co-ins. of 1st $4,000	-- None --
If you need immediate medical attention	Emergency room services	20% co-ins. of 1st $4,000	20% co-ins. of 1st $4,000	All emerg. care treated as in-network
	Emergency medical transportation	20% co-ins. of 1st $4,000	30% co-ins. of 1st $4,000	--None--
	Urgent care	20% co-ins. of 1st $4,000	30% co-ins. of 1st $4,000	-- None --
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins. of 1st $4,000	30% co-ins. of 1st $4,000	Semi-private room rate. Limited to $25 for first day day for non-accredited hospital and $10 per day thereafter.
	Physician/surgeon fee	20% co-ins. of 1st $4,000	30% co-ins. of 1st $4,000	-- 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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-ins. of 1st $4,000	30% co-ins. of 1st $4,000	-- None --
	Mental/Behavioral health inpatient services	20% co-ins. of 1st $4,000	30% co-ins. of 1st $4,000	-- None --
	Substance use disorder outpatient services	20% co-ins. of 1st $4,000	30% co-ins. of 1st $4,000	-- None --
	Substance use disorder inpatient services	20% co-ins. of 1st $4,000	30% co-ins. of 1st $4,000	-- None --
If you are pregnant	Prenatal and postnatal care	20% co-ins. of 1st $4,000	30% co-ins. of 1st $4,000	-- None --
	Delivery and all inpatient services	20% co-ins. of 1st $4,000	30% co-ins. of 1st $4,000	-- None --
If you need help recovering or have other special health needs	Home health care	20% co-ins. of 1st $4,000	30% co-ins. of 1st $4,000	Only for skilled nursing visits.
	Rehabilitation services	20% co-ins. of 1st $4,000	30% co-ins. of 1st $4,000	-- None --
	Habilitation services	20% co-ins. of 1st $4,000	30% co-ins. of 1st $4,000	-- None --
	Skilled nursing care	20% co-ins. of 1st $4,000	30% co-ins. of 1st $4,000	-- None --
	Durable medical equipment	20% co-ins. of 1st $4,000	30% co-ins. of 1st $4,000	-- None --
	Hospice service	Not covered	Not covered	-- None --
If your child needs dental or eye care	Eye exam	Not covered	Not covered	-- None --
	Glasses	Not covered	Not covered	-- None --
	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.)		
• Acupuncture	• Hearing aids	• Routine eye care (Adult)
• Cosmetic surgery (Some exceptions like congenital defects.)	• Infertility treatment	• Routine foot care
• Dental care (Adult) (Some exceptions related to accidental injury.)	• 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 those services.)	
• Bariatric surgery (Must be pre-certified.)	• Non-emergency care when traveling outside the U.S.
• Chiropractic care	• Private-duty nursing

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 1-800-435-2388. 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 Administrator at 33 Fitch Boulevard, Austintown, Ohio 44515 or Phone 1-800-435-2388. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) www.dol/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** $6,040
- **Patient pays** $1,500

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	$600
Co-pays	$0
Co-insurance	$900
Limits or exclusions	$0
Total	**$1,500**

You may also be eligible for reimbursement of your costs through your Personal Care Account. Call the Plan Administator at 1-800-435-2388 if you have questions about applying.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,000
- **Patient pays** $1,400

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	$300
Co-pays	$0
Co-insurance	$800
Limits or exclusions	$300
Total	**$1,400**

You may also be eligible for reimbursement of your costs through your Personal Care Account. Call the Plan Administrator at 1-800-435-2388 if you have questions about applying.

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.

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