National Roofers Union: Medical Plan A and C

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

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

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 by calling Wilson-McShane Corporation at 952-854-0795 or 800-622-8780.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$400/person; $1,200/family per calendar year. Does not apply to preventive/wellness expenses and outpatient prescription drugs. Copayments, non-covered expenses, a penalty for failure to obtain precertification, the first $300 related to an accident incurred within 90 days of the accident, 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?	Yes, Dental Plan is $100/person/calendar year; $300/family per calendar year which is waived for preventive/diagnostic dental services. 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?	The out-of-pocket limit for Medical Plan cost-sharing for in-network PPO copayments, coinsurance and deductibles per calendar year is $5,000/person; $10,000/family. This Plan has no out-of-pocket limit for cost-sharing for Non-PPO providers, except for in an emergency. The plan has an Out-of-Pocket Limit on outpatient drugs, meaning the most you pay for covered generic, preferred brand, non-preferred brand and specialty drugs from in-network retail and mail order locations per calendar year is $1,600/person; $3,200/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 pay for health care expenses.
What is not included in the out–of–pocket limit?	For the medical plan, premiums, balance-billed charges, non-covered expenses, charges in excess of benefit maximums, a penalty for failure to obtain precertification, outpatient retail/mail order prescription drug expenses, dental plan and vision plan benefits, and the 90% coinsurance for eligible expenses for TMJ and infertility treatment do not count toward the out-of-pocket limit.	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 PPO providers using the CIGNA Open Access Plus (OAP) network, visit www.cignasharedadministration.com or call 1-800-768-4695.	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 **Wilson-McShane Corporation** at **952-854-0795** or **800-622-8780.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary www.dol.gov/ebsa/healthreform or call **1-800-622-8780** to request a copy.

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 7. 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.)
- This plan may encourage you to use in-network PPO providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-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 copay/office visit, no deductible. All other services performed and billed during an office visit you pay 20% coinsurance after the deductible is met.	50% coinsurance after deductible met.	---none---
	Specialist visit	$20 copay/office visit, no deductible. All other services performed and billed during an office visit you pay 20% coinsurance after the deductible is met.	50% coinsurance after deductible met.	---none---
	Other practitioner office visit	Chiropractic services: $20 copay/office visit, no deductible. All other services performed and billed during an office visit you pay 20% coinsurance after the deductible is met.	Chiropractic services: 50% coinsurance after deductible met.	Chiropractic Services: maximum benefit is 12 visits per person per calendar year. You pay 100% for Acupuncture services.
	Preventive care/screening/ immunization	No charge.	50% coinsurance after deductible met.	Plan covers preventive services and supplies required by Health Reform. Age and frequency guidelines apply to covered preventive care. Details at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible met.	50% coinsurance after deductible met.	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible met.	50% coinsurance after deductible met.	Imaging tests like CT/MRI/PET scans require precertification to avoid a $250 penalty.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available from CIGNA Pharmacy at www.mycigna.com or call 1-800-244-6224.	Generic drugs	Retail Pharmacy for 30-day supply: the greater of $5 copayment or 25% coinsurance; Mail Order for 90-day supply: $10 copayment.	You pay 100%. Plan reimburses the billed charges minus the appropriate In-Network Retail pharmacy copay/coinsurance.	• No medical plan deductible applies to outpatient drug benefits. • No charge for female FDA-approved generic contraceptives. No charge for FDA-approved preferred brand contraceptive only if a generic contraceptive is medically inappropriate. • Certain over the counter (OTC) drugs are payable at no charge with a prescription, in compliance with Health Reform. • Some prescriptions are subject to preapproval, quantity limits or step therapy requirements. • The plan has an Out-of-Pocket Limit on outpatient drugs, meaning the most you pay for covered generic, preferred brand, non-preferred brand and specialty drugs from in-network retail and mail order locations per calendar year is $1,600/person; $3,200/family.
	Preferred brand drugs	Retail Pharmacy for 30-day supply: the greater of $20 copayment or 25% coinsurance; Mail Order for 90-day supply: $40 copayment.		
	Non-preferred brand drugs	Retail Pharmacy for 30-day supply: the greater of $40 copayment or 50% coinsurance; Mail Order for 90-day supply: $80 copayment.		
	Specialty drugs	For up to a 30-day supply, you pay 5% coinsurance to a maximum of $75 for Generic drugs & 5% coinsurance to a maximum of $150 for Brand drugs.	You pay 100%. Plan reimburses the billed charges minus the appropriate In-Network Retail pharmacy copay/coinsurance.	Specialty drugs require preapproval by calling CIGNA Pharmacy at 1-800-244-6224.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible met.	50% coinsurance after deductible met.	---none---
	Physician/surgeon fees	20% coinsurance after deductible met.	50% coinsurance after deductible met.	---none---
If you need immediate medical attention	Emergency room services	After deductible met and you pay a $250 copay/visit, you pay 20% coinsurance.	After deductible met and you pay a $250 copay/visit, you pay 20% coinsurance.	Copay waived if admitted to a hospital from the emergency room. The Plan's payment of true emergency services in the emergency department of a hospital are in accordance with health reform.
	Emergency medical transportation	20% coinsurance after deductible met.	20% coinsurance after deductible met.	---none---
	Urgent care	After deductible met and you pay a $100 copay/visit, you pay 20% coinsurance.	50% coinsurance after deductible met.	Copay waived if admitted to a hospital from the urgent care facility.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible met.	50% coinsurance after deductible met.	Elective hospital admission and transplants require pre-certification to avoid a $250 penalty.
	Physician/surgeon fee	20% coinsurance after deductible met.	50% coinsurance after deductible met.	---none---

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/ Behavioral health outpatient services	$20 copay/office visit, no deductible. All other services performed and billed during an office visit you pay 20% coinsurance after the deductible is met.	50% coinsurance after deductible met.	---none---
	Mental/Behavioral health inpatient services	20% coinsurance after deductible met.	Residential treatment program: Not covered. Other inpatient admission: 50% coinsurance after deductible met.	Elective hospital admission and residential treatment admission requires precertification to avoid a $250 penalty.
	Substance use disorder outpatient services	$20 copay/office visit, no deductible. All other services performed and billed during an office visit you pay 20% coinsurance after the deductible is met.	50% coinsurance after deductible met.	---none---
	Substance use disorder inpatient services	20% coinsurance after deductible met.	Residential treatment program: Not covered. Other inpatient admission: 50% coinsurance after deductible met.	Elective hospital admission and residential treatment admission requires precertification to avoid a $250 penalty.
If you are pregnant	Prenatal and postnatal care	Office visits: no charge.	50% coinsurance after deductible met.	You pay 100% for ultrasounds and delivery expenses for a pregnant dependent child. Precertification required only if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section.
	Delivery and all inpatient services	Hospital: 20% coinsurance after deductible met. Physician Delivery Fee: 20% coinsurance after deductible met.	Hospital: 50% coinsurance after deductible met. Physician delivery fee: 50% coinsurance after deductible met.	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible met.	50% coinsurance after deductible met.	Home health maximum benefit: 100 visits/calendar year.
	Rehabilitation services	20% coinsurance after deductible met.	Inpatient Rehabilitation admission: Not covered. Other services: 50% coinsurance after deductible met.	Precertify inpatient rehab admissions to avoid a $250 penalty.
	Habilitation services	Not covered.	Not covered.	You pay 100% of these expenses.
	Skilled nursing care	20% coinsurance after deductible met.	Skilled nursing facility: Not Covered.	Maximum benefit is 60 days/calendar year. Precertify skilled nursing facility admission to avoid a $250 penalty.
	Durable medical equipment	20% coinsurance after deductible met.	50% coinsurance after deductible met.	---none---
	Hospice service	20% coinsurance after deductible met.	50% coinsurance after deductible met.	Covered if terminally ill.
If your child needs dental or eye care	Eye exam	Individuals under 19 years: no charge for one eye exam in 12 consecutive months.		You pay 100% for an eye exam unless you have elected the vision plan.
	Glasses	No charge up to $50/frame for $25/single lens. You pay any amount over $50 for frame and $25 for single vision lenses. One frame per person each 24 consecutive months. Not more than one pair of lenses in 12 months.		You pay 100% for glasses unless you have elected the vision plan.
	Dental check-up	No charge for individuals up to 19 yrs.		You pay 100% for dental services unless you have elected the dental plan.

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
- Bariatric Surgery
- Cosmetic surgery
- Habilitation services
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S. unless on temporary work assignment outside the U.S.
- Private duty nursing

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.)

- Chiropractic care (up to 12 visits per year).
- Dental care (Adult) (Child)
- Infertility treatment payable at normal cost-sharing to a maximum of $10,000/couple per lifetime, thereafter you pay 90% coinsurance and this coinsurance does not count toward the out-of-pocket limit.
- Routine eye care (Adult) (Child)
- Routine foot care payable when treating diabetic (metabolic) or neurological or vascular disease).
- Weight loss programs mandated by Health Reform.

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 1-800-622-8780. 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 Administrative Office (Wilson-McShane Corporation) at 952-854-0795 or 800-622-8780. 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 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.**

Language Access Services: **Spanish (Español):** Para obtener asistencia en Español, llame al 800-622-8780. **Tagalog (Tagalog):** Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-622-8780. **Chinese (中文):** 如果需要中文的帮助，请拨打这个号码 800-622-8780. **Navajo (Dine):** Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-622-8780.

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 $5,920
- Patient pays $1,620

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
Copays	$0
Coinsurance	$1,190
Limits or exclusions	$30
Total	$1,620

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

- Amount owed to providers: $5,400
- Plan pays $3,810
- Patient pays $1,590

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
Copays	$200
Coinsurance	$910
Limits or exclusions	$80
Total	$1,590

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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