The Steamfitters' Industry Fund Office

Construction & Metal Trades Divisions

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June 2016

SUMMARY OF BENEFITS AND COVERAGE (SBC)

Dear Participant and Family:

Please find enclosed the Metal Trades Branch Welfare Fund's Summary of Benefits and Coverage (SBC) for the period of July 1, 2016 - June 30, 2017.

This document provides a general description of the health benefits provided by our Fund. SBCs are required to be distributed annually by the Patient Protection and Affordable Care Act (PPACA) and we must use the government mandated format.

The federal government developed the SBC form primarily to help people who will be shopping for individual coverage through the "health care exchanges". The SBC format was designed so that individuals can compare "apples to apples" when comparing plans. Fortunately, you have coverage based on a Collective Bargaining Agreement between your employer(s) and your union. You don't need to shop for coverage unless you lose eligibility in the Welfare Fund.

To best understand the benefits provided by this Fund, we recommend that you refer to the materials that the Fund has created for you – our website (www.steamfitters.com), your Summary Plan Description (SPD) and the other Welfare Fund documents distributed periodically.

Please feel free to contact the Fund Office at 212.465.8888 if you have any questions or comments regarding the enclosed SBC.

METAL TRADES BRANCH WELFARE FUND

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Metal Trades Branch Local 638 Welfare Fund: EPO

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

Coverage Period: 07/01/2016 - 06/30/2017
Coverage for: Individual/Family | **Plan Type:** EPO

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.steamfitters.com/mtb-index.aspx** or by calling 1-212-465-8888.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes. **$100** person/**$200** family Dental for non-network providers. 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?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out-of-pocket limit?	This plan has no **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 providers** for medical see www.empireblue.com or call 1-800-553-9603. For a list of **in-network providers** for dental see www.metlife.com/dental or call 1-800-942-0854.	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 this plan doesn't cover are listed on page 5. 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 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 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/visit	Not Covered	none
	Specialist visit	$20/visit	Not Covered	none
	Other practitioner office visit	$20/visit	Not Covered	none
	Preventive care/screening/immunization	No Charge	Not Covered	Limited to well-child, mammograms and certain cancer screenings. Age and frequency limits apply.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	none
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	Retail: $10 copay (21 day supply); Mail Order: $40 copay (90 day supply);	Not Covered	Medication needed on an on-going basis must be filled through the Mail Order Program. If brand name purchased when generic is available you are responsible for any difference between brand and generic cost. Out-of-Network not covered. One direct reimbursement available per lifetime; reimbursement made at the in-network cost.
	Brand Name drugs	Retail: $30 copay (21 day supply); Mail Order: $40 copay (90 day supply)	Not Covered	
	Specialty drugs	Retail : $10 copay (21 day supply) ; Mail Order: $40 (30 day supply)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fees	No Charge	Not Covered	——————none——————
If you need immediate medical attention	Emergency room services	$100/visit	Not Covered	Initial visit per occurrence. Copay waived if admitted.
	Emergency medical transportation	No Charge	Not Covered	Local transport to nearest hospital.
	Urgent care	$20/visit	Not Covered	There is no unique benefit for Urgent Care. It will be billed as either an office or ER visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fee	No Charge	Not Covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20/visit	Not Covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Mental/Behavioral health inpatient services	No Charge	Not Covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Substance use disorder outpatient services	$20 /visit	Not Covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Substance use disorder inpatient services	No Charge	Not Covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.

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 are pregnant	Prenatal and postnatal care	No Charge	Not Covered	——————none——————
	Delivery and all inpatient services	No Charge	Not Covered	——————none——————
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage. Limited to 200 visits per calendar year.
	Rehabilitation services	$20/visit	Not Covered	Limited to 60 visits per calendar year combined in home, office or outpatient facility.
	Habilitation services	No Charge	Not Covered	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	No Charge	Not Covered	Limited to 120 days per calendar year. Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Durable medical equipment	No Charge	Not Covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Hospice service	No Charge	Not Covered	Limited to 210 days per lifetime. Failure to obtain preauthorization may result in non-coverage or reduced coverage .
If your child needs dental or eye care	Eye exam	Charges over $300	Charges over $300	Limited to $300 per person per calendar year for eye exam, frames, and/or lenses, including contact lenses. Non-prescription sunglasses not covered.
	Glasses	Charges over $300	Charges over $300	
	Dental check-up	No Charge	20% coinsurance after dental deductible	Limited to two oral exams per year.

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
- Private-duty nursing
- Infertility treatment
- Long-term care
- 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.)

- Bariatric surgery
- Dental care (Adult)(Up to $3,000 per year)
- Non-emergency care when traveling outside the U.S. (coverage provided outside the United States). See **www.BCBS.com/bluecardworldwide**
- Routine Eye Care (Adult) (Limited to $300 per person per calendar year for eye exam, frames, and/or lenses, including contact lenses.)

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 212-465-8888. 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 Fund Office at: Metal Trades Branch Local 638 Welfare Fund, 5 Penn Plaza, New York, NY 10001-1887 or 1-212-465-8888. You may also contact: Empire Blue Cross and Blue Shield, P.O. Box 11825, Appeals Department Mail Drop 6/0, Albany, NY 12211.

You may also contact: Department of Labor's Employee Benefits Security Administration, 1-866-444-EBSA (3272) or go to **www.dol.gov/ebsa/healthreform** Additionally, a consumer assistance program can help you file your appeal. Contact: Community Service Society of New York, Community Health Advocates, 105 East 22nd Street, 8th floor, New York, NY 10010, (888) 614-5400 or go to **www.communityhealthadvocates.org**.

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:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

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** $7,370
- **Patient pays** $170

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	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

You may be eligible for Healthcare Reimbursement Benefits which can be used to help with out-of-pocket costs. Because these benefits vary depending on, among other things, your account balance, this benefit is not factored into the above example.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,620
- **Patient pays** $780

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	$0
Copays	$700
Coinsurance	$0
Limits or exclusions	$80
Total	**$780**

You may be eligible for Healthcare Reimbursement Benefits which can be used to help with out-of-pocket costs. Because these benefits vary depending on, among other things, your account balance, this benefit is not factored into the above example.

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.