Board of Trustees: Greater St. Louis Construction Laborers' Welfare Fund

Coverage Period: 7/1/2016-6/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Spouse, Family| **Plan Type:** HMO/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.stllaborers.com or by calling 1-800-489-0228.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Tier 1 Network: $400 individual/$800 family. Tier 2 Network: $400 individual/$800 family. Tier 3 Out-of-Network: $500 individual/$1,000 family. Does not apply to wellness care for Tier 1 and 2 Networks. Copayments, dental benefits, and prescription drug benefits 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?	Dental: $75 individual/$225 family. Weight loss programs: $100.	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?	Tiers 1 and 2: $4,000 individual/$5,000 family. Tier 3 Out-of-Network: no limit. Prescription Drugs Network: $2,600 individual/$8,200 family. Prescription Drugs Out-of-Network: no limit.	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-billed charges, healthcare this plan does not cover, dental and vision expenses and difference in cost between generic and multi-source prescription drug charges.	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.chcmo.com or call 1-800-775-3540 for a list of Tier 1 and Tier 2 Network providers.	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 8. 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 **Tier 1 or Tier 2 providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use a Tier 3 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	$15 co-pay, then deductible; Other services in office setting: 10% co-insurance after deductible	$15 co-pay, then deductible; Other services in office setting: 20% co-insurance after deductible	40% co-insurance after deductible; Other services in office setting: 40% coinsurance after deductible	---none---
	Specialist visit	$15 co-pay, then deductible; Other services in office setting: 10% co-insurance after deductible	$15 co-pay, then deductible; Other services in office setting: 20% co-insurance after deductible	40% co-insurance after deductible; Other services in office setting: 40% coinsurance after deductible	---none---
	Other practitioner office visit	Chiropractor: $15 co-pay, then deductible; Other services in office setting: 10% co-insurance after deductible	Chiropractor: $15 co-pay, then deductible; Other services in office setting: 20% co-insurance after deductible	Chiropractor: 40% co-insurance after deductible.	Maximum of 60 chiropractor visits/year, including 26 Out-of-Network. Out-of-Network chiropractor limited to spinal manipulation and manual medical intervention services.

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use a Tier 3 Out-of-Network Provider	Limitations & Exceptions
	Preventive care/screening/immunization	No charge	No charge	40% co-insurance after deductible	Preventive care as required by the Patient Protection and Affordable Care Act (PPACA). Includes two tobacco cessation attempts per calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance after deductible	20% co-insurance after deductible	40% co-insurance after deductible	---none---
	Imaging (CT/PET scans, MRIs)	10% co-insurance after deductible	20% co-insurance after deductible	40% co-insurance after deductible	Prior authorization required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mycatamaranrx.com	Generic drugs	$5 co-pay (retail); $12.50 co-pay (mail/90 day retail).	$5 co-pay (retail); $12.50 co-pay (mail/90 day retail).	Not covered	Limited to 30-day supply (retail) or a 90-day supply (mail order or Retail 90). No cost-sharing for PPACA preventive care drugs (may be limited to generic). NSAIDS, Celebrex, Antihyperlipidemics, and Peptic Ulcer Therapies require trial of generic. No coverage for compound bulk chemicals and medicines. Prior authorization required for compound drug prescriptions in excess of $250. Additional clinical
	Brand name drugs	$25 co-pay (retail); $62.50 co-pay (mail/90 day retail).	$25 co-pay (retail); $62.50 co-pay (mail/90 day retail).	Not covered	
	Multi-source brand name drugs	$5 co-pay + difference in cost between brand name and generic (retail); $12.50 co-pay + difference in cost between brand name and generic (mail/90 day retail).	$5 co-pay + difference in cost between brand name and generic (retail); $12.50 co-pay + difference in cost between brand name and generic (mail/90 day retail).	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use a Tier 3 Out-of-Network Provider	Limitations & Exceptions
	Specialty drugs	Covered under applicable physician or medical facility benefit or prescription drug category.	Covered under applicable physician or medical facility benefit or prescription drug category.	Covered under applicable physician or medical facility benefit. Not covered under prescription benefit.	guidelines may apply.
If you have outpatient surgery	Facility fee (e.g., hospital or ambulatory surgery center)	10% co-insurance after deductible	20% co-insurance after deductible	40% co-insurance for hospital after deductible	Ambulatory surgery center not covered for Tier 3 Out-of-Network. Prior authorization required.
	Physician/surgeon fees	10% co-insurance after deductible	20% co-insurance after deductible	40% co-insurance after deductible	---none---
If you need immediate medical attention	Emergency room services	$75 co-pay + 10% co-insurance after deductible	$75 co-pay + 20% co-insurance after deductible	$75 co-pay + 20% co-insurance after deductible	---none---
	Emergency medical transportation	10% co-insurance after deductible	20% co-insurance after deductible	Co-insurance after deductible, based on the facility to which the individual is transported (Tier 1: 10%; Tier 2: 20%; Tier 3 Out-of-Network: 40%)	---none---
	Urgent care	$15 co-pay + 10% co-insurance after deductible	$15 co-pay + 20% co-insurance after deductible	40% co-insurance after deductible	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 co-pay/day (maximum of $500) + 10% co-insurance after deductible	$100 co-pay/day (maximum of $500) + 20% co-insurance after deductible	40% co-insurance after deductible	Limited to semi-private room rate. Prior authorization required.

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use a Tier 3 Out-of-Network Provider	Limitations & Exceptions
	Physician/surgeon fee	10% co-insurance after deductible	20% co-insurance after deductible	40% co-insurance after deductible	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visit: $15 co-pay, then deductible Other outpatient services: 10% co-insurance after deductible	Office Visit: $15 co-pay, then deductible Other outpatient services: 20% co-insurance after deductible	Office Visit: 40% co-insurance after deductible Other outpatient services: 40% co-insurance after deductible	---none---
	Mental/Behavioral health inpatient services	$100 co-pay/day (maximum of $500) + 10% co-insurance after deductible	$100 co-pay/day (maximum of $500) + 20% co-insurance after deductible	40% co-insurance after deductible	Prior authorization required.
	Substance use disorder outpatient services	Office Visit: $15 co-pay, then deductible Other outpatient services: 10% co-insurance after deductible	Office Visit: $15 co-pay, then deductible Other outpatient services: 20% co-insurance after deductible	Office Visit: 40% co-insurance after deductible Other outpatient services: 40% co-insurance after deductible	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use a Tier 3 Out-of-Network Provider	Limitations & Exceptions
	Substance use disorder inpatient services	$100 co-pay/day (maximum of $500) + 10% co-insurance after deductible	$100 co-pay/day (maximum of $500) + 20% co-insurance after deductible	40% co-insurance after deductible	Prior authorization required.
If you are pregnant	Prenatal and postnatal care	No charge for prenatal preventive care. $15 co-pay + 10% co-insurance after deductible for postnatal care.	No charge for prenatal preventive care. $15 co-pay + 20% co-insurance after deductible for postnatal care.	40% co-insurance after deductible	No coverage for delivery or postnatal care of dependent child's newborn, unless part of the customary global physician package for pre-natal care. No out-of-network coverage for dependent child's pregnancy. No coverage for non-routine prenatal care of dependent child. No coverage for dependent pregnancy complications.
	Delivery and all inpatient services	No charge for delivery related physician care. $100 co-pay/day (maximum of $500) + 10% co-insurance after deductible for other services and hospital facility charges.	No charge for delivery related physician care. $100 co-pay/day (maximum of $500) + 20% co-insurance after deductible for other services and hospital facility charges.	40% co-insurance after deductible	Prior authorization required. No coverage of hospital facility charges for your dependent child's pregnancy. No coverage for postnatal care of dependent or dependent child's newborn.

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use a Tier 3 Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% co-insurance after deductible	20% co-insurance after deductible	40% co-insurance after deductible	Maximum of 100 visits/ year. Prior authorization required. Maximum of 15 bereavement counseling visits per calendar year.
	Rehabilitation services	10% co-insurance after deductible	20% co-insurance after deductible	40% co-insurance after deductible	Tier 3 Out-of-Network limited to 30 visits/year. Prior authorization required.
	Habilitation services	10% co-insurance after deductible	20% co-insurance after deductible	40% co-insurance after deductible	Prior authorization required.
	Skilled nursing care	10% co-insurance after deductible	20% co-insurance after deductible	40% co-insurance after deductible	Maximum of 90 days/year. Prior authorization required.
	Durable medical equipment	10% co-insurance after deductible	20% co-insurance after deductible	40% co-insurance after deductible	Prior authorization required for purchase over $250 and rental equipment (oxygen and TENS units not included). Co-payment, Deductible and Co-insurance do not apply to items provided by a Tier 1 or Tier 2 provider and determined to be preventive care as required by the PPACA.
	Hospice service	10% co-insurance after deductible	20% co-insurance after deductible	40% co-insurance after deductible	---none---
If your child needs dental or eye care	Eye exam	$10 co-pay		100% co-insurance after the first $38	One vision network. Maximum of 1 exam/year.

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use a Tier 3 Out-of-Network Provider	Limitations & Exceptions
	Glasses	$20 co-pay for lenses. 100% after the first $180 for frames.		100% co-insurance after the first $50 (single vision), $65 (bifocal), $100 (trifocal), $110 (lenticular). 100% after the first $50 (frames).	One vision network. Maximum of 1 pair/year.
	Dental check-up	No charge		No charge if the charge is equal to or greater than the maximum contractual charge for a network dentist.	Maximum of 2 check-ups/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.)

- Bariatric surgery
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S

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, by a licensed acupuncturist or licensed chiropractor
- Chiropractic care, maximum of 60 visits per calendar year for Network and Out-of-Network benefits combined; only 26 of those visits can be Out-of-Network.
- Dental care (Adult)
- Habilitation services
- Hearing aids, subject to $25 co-pay/device. Maximum benefit of $1,500 per hearing aid and one hearing aid per ear in a 48 month period. Hearing aids for newborns exempt from 48 month limit.
- Infertility testing, prior authorization required
- Private duty nursing by an RN or LPN if patient is confined as a bed patient in a Hospital
- Routine eye care (adult)
- Routine foot care
- Tobacco Cessation (see SPD for limitations)
- Weight loss programs, if medically necessary and under medical supervision, maximum lifetime benefit of $1,500. Obesity screening provided with no charge to participant for Tier 1 or Tier 2 providers

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 1-800-489-0228. 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: Greater St. Louis Construction Laborers' Welfare Fund, 2357 59th Street, St. Louis, MO 63110, 1-800-489-0228, or the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272).

Additionally, a consumer assistance program can help you file your appeal. Contact the Missouri Department of Insurance, 301 W. High Street, Room 830, Harry S. Truman State Office Building, Jefferson City, MO 65101, 1-800-726-7390, or visit the website at www.insurance.mo.gov, or email consumeraffairs@insurance.mo.gov.

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.**

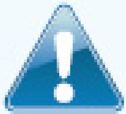
Does this Coverage Meet the Minimum Value Standard?

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

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	$800
Copays	$400
Coinsurance	$400
Limits or exclusions	$0
Total	**$1,600**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,440
- **Patient pays** $1000

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	$400
Coinsurance	$200
Limits or exclusions	$0
Total	**$1,000**

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.