Local 802 Musicians Health Fund: Plan A+

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

Coverage Period: 10/01/2016 - 9/30/2017

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 medical plan document at **www.local802afm.org/about/benefits-services/health-benefits** or by calling the Fund Office at **1-(212)-245-4802** or the hospital policy at **www.empireblue.com** or by calling Empire at **1-800-553-9603**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$0**; Out-of-Network: **$500** Individual/ **$1,000** Family Doesn't apply to **preventive services** or **prescription drugs**. **Balance billed charges** and excluded services also 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 on page 2 for other costs for services this plan covers.
Is there an out–of– pocket limit on my expenses?	Yes. In-Network Medical: **$2,200** Individual/**$4,400** Family; In-Network Hospital: **$2,850** Individual/**$5,700** Family; Prescription Drug: **$1,300** Individual/**$2,600** Family; Out-of-Network: None	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**, 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. For a list of in-network hospital **providers**, see **www.empireblue.com** or call **1-800-553-9603**. For a list of in-network medical **providers**, see **www.magnacare.com** or call **1-800-352-6465**.	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: Medical: Call the Fund Office at **1-(212)-245-4802** or visit us at **www.local802afm.org/about/benefits-services/health-benefits**; Hospital: Call Empire at **1-800-553-9603** or visit Empire at **www.empireblue.com**.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or call the Fund Office at **1-(212)-245-4802** to request a copy.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	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 6. 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 copay/visit	30% coinsurance	-- None --
	Specialist visit	$20 copay/visit	30% coinsurance	-- None --
	Other practitioner office visit	Acupuncture and chiropractic care: $20 copay/visit	Acupuncture and chiropractic care: 30% coinsurance	-- None --
	Preventive care/ screening/ immunization	Physician Office: No charge	Physician Office: No charge	Subject to age and frequency limits. Well Woman care also covered in outpatient department of hospital at no charge In-Network and 20% coinsurance Out-of-Network.
If you have a test	Diagnostic test (x-ray, blood work)	Office and free-standing facility: x-ray: 20% coinsurance; blood work: $20 copay/test; Hospital outpatient: x-ray and blood work: No charge	Office and free-standing facility: 30% coinsurance; Hospital outpatient: 20% coinsurance	Failure to obtain precertification may result in non coverage or reduced benefits.
	Imaging (CT/PET scans, MRIs)	Office and free-standing facility: 20% coinsurance; Hospital outpatient: No charge	Office and free-standing facility: 30% coinsurance; Hospital outpatient: 20% coinsurance	

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: $20 copay/prescription Mail Order: $40 copay/prescription	Retail: $20 copay/prescription Mail Order: $40 copay/prescription	Retail: 30-day supply Mail Order: 90-day supply FDA-approved women's contraceptives and other preventive medications under the ACA available at no charge with a prescription. Generic drugs are mandatory when available. If you fill a brand name drug when a generic equivalent is available, you will pay an additional amount equal to the difference between the allowed amount for the brand-name and the generic medication. If you fill a prescription at an Out-of-Network pharmacy, you will pay an additional amount equal to the difference between the pharmacy's charges and the allowed amount for the medication. Certain drugs subject to prior authorization and/or quantity limitations or exclusions. Maintenance prescription drugs limited to two retail fills must be filled by the Mail Order. Dugs administered in a doctor's office or compounded for IV infusion are not available by Mail Order.
	Preferred Brand drugs	Retail: $35 copay/prescription Mail Order: $70 copay/prescription	Retail: $35 copay/prescription Mail Order: $70 copay/prescription	
	Non-Preferred Brand drugs	Retail: 40% coinsurance ($50 minimum, $75 maximum/prescription) Mail Order: 40% coinsurance ($100 minimum, $150 maximum/prescription)	Retail: 40% coinsurance ($50 minimum, $75 maximum/prescription) Mail Order: 40% coinsurance ($100 minimum, $150 maximum/prescription)	
	Specialty drugs	Applicable cost-sharing amount above	Applicable cost-sharing amount above	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	Failure to obtain precertification for certain procedures may result in non coverage or reduced benefits.
	Physician/surgeon fees	$20 copay/visit	30% coinsurance	-- None --

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 immediate medical attention	Emergency room services	No charge	No charge	-- None --
	Emergency medical transportation	No charge	30% coinsurance	Out-of-Network ambulance services limited to the following amounts per transport: $5 per mile and $300 for basic life support or $500 for advanced life support.
	Urgent care	$20 copay/visit	30% coinsurance	-- None --
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	Failure to obtain precertification may result in non coverage or reduced benefits.
	Physician/surgeon fee	$20 copay/visit	30% coinsurance	-- None --
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office visit: $20 copay/visit; Other outpatient services: No charge	Office visit: 30% coinsurance; other outpatient services: 20% coinsurance	Failure to obtain precertification for partial hospitalization and intensive outpatient programs may result in non coverage or reduced benefits.
	Mental/Behavioral health inpatient services	20% coinsurance	20% coinsurance	Failure to obtain precertification may result in non coverage or reduced benefits.
	Substance use disorder outpatient services	Office visit: $20 copay/visit; Other outpatient services: No charge	Office visit: 30% coinsurance; other outpatient services: 20% coinsurance	Failure to obtain precertification for partial hospitalization and intensive outpatient programs may result in non coverage or reduced benefits.
	Substance use disorder inpatient services	20% coinsurance	20% coinsurance	Failure to obtain precertification may result in non coverage or reduced benefits.
If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	Initial In-Network visit to confirm pregnancy subject to $20 copay/visit.
	Delivery and all inpatient services	20% coinsurance	20% coinsurance	-- None --

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 help recovering or have other special health needs	Home health care	Medical: $20 copay/visit; Hospital: 20% coinsurance	Medical: 30% coinsurance; Hospital: 20% coinsurance	Medical: Limited to 40 visits per calendar. Hospital: Limited to 200 visits per calendar year. 1 visit consists of up to 4 hours of care.
	Rehabilitation services	Inpatient: 20% coinsurance; Outpatient: $20 copay/visit	Inpatient: 20% coinsurance; Outpatient: 30% coinsurance	Inpatient physical occupational, speech and vision therapies limited to 30 days per calendar year. All habilitation services count toward rehabilitation limits. Failure to obtain precertification may result in non coverage or reduced benefits. Outpatient maintenance speech and hearing therapy not covered.
	Habilitation services	Inpatient: 20% coinsurance; Outpatient: $20 copay/visit	Inpatient: 20% coinsurance; Outpatient: 30% coinsurance	
	Skilled nursing care (facility)	20% coinsurance	20% coinsurance	Limited to 60 skilled nursing care facility bed days per calendar year. Failure to obtain precertification may result in non coverage or reduced benefits.
	Durable medical equipment	$20 copay/DME	30% coinsurance	Cost of rental limited to purchase price of the equipment.
	Hospice service	Inpatient: 20% coinsurance; Outpatient: $20 copay/visit	Inpatient: 20% coinsurance; Outpatient: 30% coinsurance	Inpatient hospice limited to 210 days per lifetime.
If your child needs dental or eye care	Eye exam	Amount over $15 Plan allowance	Amount over $15 Plan allowance	Vision benefits separately administered by the Fund Office. Limited to one eye exam and one complete pair of glasses every calendar year. You are responsible for amounts over Plan allowances.
	Glasses	Frames: Amount over $11 Plan allowance; Single vision lenses: Amount over $13 Plan allowance; Bifocals: Amount over $19 Plan allowance; Trifocals: Amount over $24 Plan allowance	Frames: Amount over $11 Plan allowance; Single vision lenses: Amount over $13 Plan allowance; Bifocals: Amount over $19 Plan allowance; Trifocals: Amount over $24 Plan allowance	
	Dental check-up	Not covered	Not covered	You must pay 100% of these expenses, even In-Network.

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
- Dental care (Adult)(Child)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs (Except for morbid obesity and as required for preventive services under the ACA)

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
- Chiropractic care
- Infertility treatment (Limited to diagnosis and treatment of correctable medical conditions that result in infertility)
- Non-emergency care when travelling outside the U.S.
- Routine eye care (Adult) (Limited to one eye exam and one pair of glasses every calendar year)

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 Fund Office for medical benefits at 1-(212)-245-4802 or Empire for hospital benefits at 1-800-553-9603. 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 for medical benefits at 1-(212)-245-4802 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact Empire for hospital benefits at 1-800-553-9603 or the New York State Department of Financial Services at 1-800-400-8882 or www.dfs.ny.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.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al Oficina del Fondo al 1-(212)-245-4802 o Empire al 1-800-553-9603.

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** $6,640
- **Patient pays** $900

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	$120
Coinsurance	$750
Limits or exclusions	$30
Total	**$900**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,980
- **Patient pays** $1,420

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	$1,340
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,420**

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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