Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services Coverage Period: 01/01/2021 – 12/31/2021

KALAMAZOO PLUMBERS, STEAMFITTERS & PIPEFITTERS

LOCAL 357 HEALTH & WELFARE INSURANCE FUND - ACTIVE PLAN Coverage for: Individual/Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please go to: www.umr.com (for medical/surgical services) and www.optumrx.com (for prescription drugs) or call the phone numbers on the back of your UMR ID card. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can call the Fund Office at (248) 645-6550 or toll free at (888) 281-3461 to request a copy.

Important Questions	Answers		Why This Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$500 person $1,000 family Does not apply to prescription drugs or preventive care.	$1,000 person $2,000 family Does not apply to prescription drugs or preventive care.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your 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 services covered before you meet your deductible?	Yes. In-network preventive care, office visits and prescription drugs are covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	There are no other specific deductibles.		You don't have to meet specific deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	$5,000 person $10,000 family	No maximum limit for individuals or families.	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, self-payments, balance billed charges, dental, vision and health care this plan does not cover.		Even though you may be required to pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.umr.com and www.optumrx.com or call the phone numbers on the back of your UMR ID card for a list of participating 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 chart starting on page 2 for how this plan pays different kinds of providers.
Do you 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.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay	40% co-insurance after deductible	Online visits with your medical provider in-network will be covered 100% if provided through Teledoc.
	Specialist visit	$20 co-pay	40% co-insurance after deductible	Online visits with your medical provider in-network will be billed at the $20 copay rate. Chiropractic care is limited to 24 visits per year.
	Preventive care/screening/ immunization	No charge	Not Covered	Benefits covered at 100% in-network. Limitations may apply on number of visits.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	---none---
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.umr.com and www.optumrx.com or by calling the numbers on the back of your UMR ID card.	Generic drugs	$4 co-pay for retail 30-day supply, $10 co-pay for mail order 90-day supply.	$4 co-pay plus an additional 25% of the approved amount for retail 30-day supply.	For information on contraceptive coverage, contact your plan administrator. 90-day supply not covered out-of-network.
	Preferred brand drugs	$40 co-pay for retail 30-day supply, $100 co-pay for mail order 90-day supply.	$40 co-pay plus an additional 25% of the approved amount for retail 30-day supply.	90-day supply not covered out-of-network.
	Non-preferred brand drugs	$80 co-pay for retail 30-day supply, $200 co-pay for mail order 90-day supply.	$80 co-pay plus an additional 25% of the approved amount for retail 30-day supply.	90-day supply not covered out-of-network.
	Generic and preferred brand specialty drugs	25% coinsurance of the approved amount, up to a maximum of $200 for retail 30-supply.	In-network coinsurance plus 25% of the approved amount for retail 30-day supply.	All specialty drugs require step therapy and prior authorization. 90-day supply not covered in-network or out-of-network.
	Non-preferred brand specialty drugs	40% coinsurance of the approved amount, up to a maximum of $300 for retail 30-day supply.	In-network coinsurance plus 25% of the approved amount for retail 30-day supply.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible.	40% co-insurance after deductible.	---none---
	Physician/surgeon fees	20% co-insurance after deductible.	40% co-insurance after deductible.	---none---
If you need immediate medical attention	Emergency room care	$100 co-pay	$100 co-pay	Co-pay waived if admitted or for an accidental injury.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	20% co-insurance after deductible	20% co-insurance after deductible	---none---
	Urgent care	$20 co-pay	40% co-insurance after deductible	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible	40% co-insurance after deductible	---none---
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	Your cost share may be different for services performed in an office setting.
	Inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	---none---
If you are pregnant	Office visits	20% co-insurance after deductible (PPACA preventive services provided at no charge)	40% co-insurance after deductible	Prenatal and postnatal preventive services are provided in-network at no charge to the extent required by federal law. Please contact the Fund office for more information.
	Childbirth/delivery professional services	20% co-insurance after deductible	40% co-insurance after deductible	---none---
	Childbirth/delivery facility services	20% co-insurance after deductible	40% co-insurance after deductible	---none---
If you need help recovering or have other special health needs	Home health care	20% co-insurance after deductible	Not covered	---none---
	Rehabilitation services	20% co-insurance after deductible	40% co-insurance after deductible	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	Not covered	Not covered	---none---
	Skilled nursing care	20% co-insurance after deductible	Not covered	Limited to a maximum of 120 days per member per calendar year.
	Durable medical equipment	20% co-insurance after deductible	40% co-insurance after deductible	---none---
	Hospice services	No Charge	No Charge	Bereavement counseling covered, provided care is obtain within six (6) months of death.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Elective benefit covered through VSP.
	Children's glasses	Not Covered	Not Covered	Elective benefit covered through VSP.
	Children's dental check-up	Not Covered	Not Covered	Elective benefit covered through Delta Dental.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic Surgery	• Infertility Treatment • Long-Term Care • Private Rooms	• Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Autism Screening • Chiropractic Services • Coverage provided outside the United States. See www.umr.com and www.optumrx.com • Dental Care – covered under a separate plan. Please contact the Plan Office at (248) 645-6550. • Hearing Aids • Human Organ Transplant	• Non-Emergency care when traveling outside the U.S. • Oral surgery • Orthotics and Prosthetics • Routine eye care – covered under a separate plan. Please contact the Plan Office at (248) 645-6550. • Telemedicine Services (includes dermatology)	• Private Duty Nursing • Respite Care • If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, co-payments, or co-insurance, or benefits not otherwise covered.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Fund Office at (248) 645-6550 or toll free at (888) 281-3461.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.
Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al (248) 645-6550.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (248) 645-6550.]
[Chinese (**中文**): **如果需要中文的帮助**, 请拨打这个号码 (248) 645-6550.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (248) 645-6550.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$20
Coinsurance	$2,420
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,000

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$830
Coinsurance	$270
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,700

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$160
Coinsurance	$170
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$800

The plan would be responsible for the other costs of these EXAMPLE covered services.