

Plumbers & Steamfitters Local 267 Insurance Fund

Coverage Period: 01/01/2013-12/31/2013

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

Coverage for: Individual | 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 at www.MyPOMCO or by calling 1-800-967-5564. Includes amendments 2010-001 through -004.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$200 per person (only major medical services). Does not apply to basic services, prescription drugs paid through Express Scripts, and other services as specifically indicated and described in your plan document.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services. Check your plan document to see when the deductible starts over (usually, but not always, January 1 st). 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 do not 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?	\$1,000 individual; \$2,000 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 plan for health care expenses.
What is not included in the out-of-pocket limit ?	Deductible, copays, prescription drugs paid through Express Scripts, other services as specifically indicated and described in your plan document, premiums, balance-billed charges, and health care this plan does not cover.	Even though you pay these expenses, they do not 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 <i>specific</i> covered services, such as office visits.

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<p>Does this plan use a network of providers?</p>	<p>Yes. For a list of in-network providers, see www.MyPOMCO.com or call 1-800-967-5564.</p>	<p>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.</p>
<p>Do I need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without permission from this plan.</p>
<p>Are there services this plan doesn't cover?</p>	<p>Yes.</p>	<p>Some of the services this plan does not cover are listed on page 5. See your plan document for additional information about excluded services.</p>



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** payment of 20% would be \$200. 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**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay/visit	\$30 copay/visit then 30% coinsurance	-----none-----
	Specialist visit	\$20 copay/visit	\$30 copay/visit then 30% coinsurance	-----none-----
	Other practitioner office visit	\$20 copay/visit	\$30 copay/visit then 30% coinsurance	Chiropractic limited to 10 visits/ calendar year. Acupuncture not covered.

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		In-network Provider	Out-of-network Provider	
	Preventive care/screening/immunization	\$20 copay (well child)	\$30 copay then 30% coinsurance	Well adult not covered except specific tests as indicated in plan document.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	-----none-----
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	\$10 (retail), \$30 (mail order) copay/prescription	Not covered	Retail prescriptions limited to a 30 day supply. Mail order prescriptions limited to a 90 day supply.
	Preferred brand drugs	\$25 (retail), \$75 (mail order) copay/prescription	Not covered	
	Non-preferred brand drugs	\$40 (retail), \$120 (mail order) copay/prescription	Not covered	
	Specialty drugs	See above copay limits.	Not covered	Details see www.Express-Scripts.com .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	-----none-----
	Physician/surgeon fees	No charge	30% coinsurance	-----none-----
If you need immediate medical attention	Emergency room services	\$100 copay/visit	\$100 copay/visit then 30% coinsurance	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance		Different benefit for hospital owned ambulance. Deductible applies to professional ambulance.
	Urgent care	\$50 copay/visit	\$50 copay/visit then 30% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	Limit 365 days/calendar year.
	Physician/surgeon fee	No charge	30% coinsurance	-----none-----

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		In-network Provider	Out-of-network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Visits 1-7: 30% coinsurance Visits 8-20: 50% coinsurance		Limit 20 visits/calendar year; 60 visits/lifetime.
	Mental/Behavioral health inpatient services	No charge	30% coinsurance	Limit 365 days/calendar year.
	Substance use disorder outpatient services	30% coinsurance		Limit 20 visits/calendar year; 30 visits/lifetime.
	Substance use disorder inpatient services	No coverage		-----none-----
If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	Limit one pregnancy per dependent child.
	Delivery and all inpatient services	No charge	30% coinsurance	Limit 365 days/calendar year.
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Limit 40 visits/calendar year.
	Rehabilitation services	\$20 copay/visit	\$30 copay/visit then 30% coinsurance	Physical and occupational therapies limited to 12 visits/calendar year each. Speech therapy: 20% coinsurance after deductible.
	Habilitation services			
	Skilled nursing care	No charge	30% coinsurance	Limit 365 days/calendar year.
	Durable medical equipment	20% coinsurance after deductible		-----none-----
	Hospice service	No charge	30% coinsurance	Limit 6 months/lifetime.
If your child needs dental or eye care	Eye exam	No coverage		-----none-----
	Glasses	No coverage		-----none-----
	Dental check-up	30% coinsurance		Limit \$2,000/family/calendar year.

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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
- Hearing aids
- Routine eye care (adult and child)
- Cosmetic surgery
- Long-term care
- Routine foot care
- Substance use disorder inpatient care

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 (morbid obesity only)
- Infertility treatment (diagnostic only)
- Private-duty nursing
- Chiropractic care
- Non-emergency care when traveling outside the U.S. unless travel is for the sole purpose of obtaining medical services
- Weight loss programs (morbid obesity only)
- Dental care (adult and child)

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 1-800-967-5564. 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: POMCO, 2425 James St. Syracuse, NY 13206, Tel.1-800-967-5564. 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.

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

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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 \$7,330**
- **Patient pays \$210**

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	\$20
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$190
Total	\$210

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$4,180**
- **Patient pays \$1,220**

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	\$200
Co-pays	\$590
Co-insurance	\$210
Limits or exclusions	\$220
Total	\$1,220

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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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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