UnitedHealthcare

Teamsters Local 251 Health Services and Insurance Plan
RIH / RIH EBL

Coverage Period: 01/01/2017-12/31/2017

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

Coverage for: Employee + 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 policy or plan document at www.teamsters251hsip.org or by calling **1-401-467-3323.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $100 Individual / $200 Family / Per calendar year; No network deductible under Enhanced Benefit Level (EBL). Non-Network: $375 Individual / $750 Family / Per calendar year. Does not apply to copays, pharmacy drugs, and services listed below as "No Charge".	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, there are no other **deductibles**.	You don't have to meet **deductibles** for specific service, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Medical- Network: $2,000 Individual / $4,000 Family Non-Network: $4,000 Individual / $8,000 Family	The **out-of-pocket limit** is the most you could pay during a calendar 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**, balanced-billed charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services and pharmacy, which has its own separate out-of-pocket limits (see page 3).	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?	This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes, this plan uses **network providers**. If you use a **non-network provider** your cost may be more. For a list of **network providers**, see www.myuhc.com or call 1-866-527-9596.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network **provider** for some services. Plans use the term 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**.

UnitedHealthcare

Teamsters Local 251 Health Services and Insurance Plan
RIH / RIH EBL

Coverage Period: 01/01/2017-12/31/2017

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

Coverage for: Employee + Family | **Plan Type:** PPO

- **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 network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-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 Copay per visit; $10 Copay per visit under Enhanced Benefit Level (EBL)	20% Coinsurance After Deductible	Christian Science Practitioners are not covered. Virtual visit - In network $5 copay per visit by a Designated Virtual Network Provider. No virtual visit coverage for out of network. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$25 Copay per visit	20% Coinsurance After Deductible	Christian Science Practitioners are not covered. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$15 Copay per visit	20% Coinsurance After Deductible	Cost Share applies for only Manipulative (Chiropractic) Care. Limited to 12 visits per calendar year.
	Preventive care/screening/immunization	No Charge	20% Coinsurance After Deductible	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% Coinsurance After Deductible	Advance Notification required for non-network sleep studies.
	Imaging (CT/PET scans, MRIs)	No Charge	20% Coinsurance After Deductible	Advance Notification required.

Teamsters Local 251 Health Services and Insurance Plan
RIH / RIH EBL

Coverage Period: **01/01/2017-12/31/2017**

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

Coverage for: Employee + Family | **Plan Type:** PPO

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Tier 1 - Your Lowest-Cost Option	Retail: 20% coinsurance; 5% coinsurance under Enhanced Benefit Level (EBL) Mail Order: 20%; 5% coinsurance under EBL	Retail: 20% of the maximum allowance for all drugs	Your prescription drug plan requires the use of mail order services or CVS/pharmacy for all maintenance medications, however, you may receive two (2) fills (one original fill plus one refill) at your retail pharmacy prior to being required to use mail service or CVS/pharmacy. Maximum $50 per prescription for a 30-day supply at the retail pharmacy. By using mail service or CVS/pharmacy you will be able to obtain a 90-day supply for equivalent of two (2) retail copayments. A three month prescription (90 day) supply for the price of two months. $100 maximum copayments on a (90 day) supply. Out of Pocket limit: $4,350 Individual / $8,700 Family. Only prescription drug expenses apply to the Rx Out of Pocket limit.
	Tier 2 - Your Midrange-Cost Option	Retail: 25% coinsurance Mail Order: 25%	Retail: 20% of the maximum allowance for all drugs	
	Tier 3 - Your Highest-Cost Option	Retail: 35% coinsurance Mail Order: 35%	Retail: 20% of the maximum allowance for all drugs	
	Tier 4 - Additional High-Cost Option	Available through CVS Caremark Specialty Pharmacy	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% Coinsurance After Deductible; No charge under EBL	20% Coinsurance After Deductible	None
	Physician/surgeon fees	0% Coinsurance After Deductible; No charge under EBL	20% Coinsurance After Deductible	None
If you need immediate medical attention	Emergency room services	$100 Copay per visit	$100 Copay per visit	$100 copay regardless of location for all emergency services.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	No deductible and member responsibility is 20% of the expense. Air and water up to $3,000 maximum per occurrence.
	Urgent care	$50 Copay per visit	20% Coinsurance After Deductible	$50 copay for Urgent Care services in a Network location. Non-Network is subject to $375 deductible and 20% coinsurance.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	0% Coinsurance After Deductible; No charge under Enhanced Benefit Level (EBL)	20% Coinsurance After Deductible	Advance Notification required for non-network stay.
	Physician/surgeon fee	0% Coinsurance After Deductible; No charge under EBL	20% Coinsurance After Deductible	Christian Science Practitioners not covered.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 Copay per visit; $10 Copay per visit under EBL	20% Coinsurance After Deductible	None
	Mental/Behavioral health inpatient services	0% Coinsurance After Deductible; No charge under EBL	20% Coinsurance After Deductible	Advance Notification required for non-network services. Advance Notification is also required for non-network Benefits provided for Applied Behavioral Analysis (ABA).
	Substance use disorder outpatient services	$15 Copay per visit; $10 Copay per visit under EBL	20% Coinsurance After Deductible	None
	Substance use disorder inpatient services	0% Coinsurance After Deductible; No charge under EBL	20% Coinsurance After Deductible	Advance Notification required for non-network services.
If you are pregnant	Prenatal and postnatal care	0% Coinsurance After Deductible; No charge under EBL	20% Coinsurance After Deductible	Your cost in this category includes physician delivery charges. Routine pre-natal care is covered at No Charge.
	Delivery and all inpatient services	0% Coinsurance After Deductible; No charge under EBL	20% Coinsurance After Deductible	Your cost for inpatient services only. For physician delivery charges, see pre-postnatal care. Advance Notification required for non-network services when exceeding delivery time.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% Coinsurance After Deductible; No charge under Enhanced Benefit Level (EBL)	20% Coinsurance After Deductible	Advance Notification required for non-network home health care, PDN, nutrition.
	Rehabilitation services	Physical, occupational, speech and post-cochlear implant aural therapy: 0% Coinsurance After Deductible; No charge under EBL Cardiac rehab: 20% Coinsurance After Deductible; 20% Coinsurance under EBL Pulmonary rehab: No Charge	20% Coinsurance After Deductible	Review after 30 visits for OT, PT, ST. No limits for pulmonary rehab or post-cochlear implant aural therapy. Cardiac rehab limited to 36 visits per calendar year.
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitation services.
	Skilled nursing care	0% Coinsurance After Deductible; No charge under EBL	20% Coinsurance After Deductible	Advance Notification required for non-network skilled nursing, PDN, nutrition.
	Durable medical equipment	0% Coinsurance After Deductible; No charge under EBL	20% Coinsurance After Deductible	Advance Notification required for DME devices that cost more than $1000 per device.
	Hospice service	0% Coinsurance After Deductible; No charge under EBL	20% Coinsurance After Deductible	Advance Notification required for non-network inpatient stay.
If your child needs dental or eye care	Eye exam	No Charge at a Davis Vision Provider	Not Covered	Covered only at a Davis Vision Provider. One Eye Exam every 12 months (to the day).
	Glasses	No Charge 1st pair/$35 Copay 2 pairs per visit at a Davis Vision Provider	Not Covered	Covered only at a Davis Vision Provider. No Charge limited to one eye exam with one pair of glasses within 30 days of service, every 12 months. $35 copayment limited to one eye exam with two pairs of eye glasses, within 30 days of service, every 12 months.
	Dental check-up	No Charge at a Delta Dental Provider	Plan pays Network Provider's allowed amount	Network coverage at a Delta Dental Provider. One oral exam per calendar year; two oral exams per calendar year under Enhanced Benefit Level (EBL).

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
- Cosmetic Surgery
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S
- 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.)

- Adult routine vision exam (i.e. refraction) covered through Davis Vision
- Bariatric Surgery limitations may apply
- Chiropractic care limitations may apply
- Dental Care (Adult) covered through Delta Dental
- Glasses (Adult) covered through Davis Vision
- Hearing aids limitations may apply
- Infertility Treatment limitations may apply
- Private-duty nursing limitations may apply
- Routine foot care limitations may apply

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 1-401-467-3323. 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 us at 1-866-527-9596 or visit www.teamsters251hsip.org. Additionally, a consumer assistance program can help file your appeal. Contact: Rhode Island Consumer Assistance Program, Rhode Island Parent Information Network, Inc., 1210 Pontiac Avenue, Cranston, RI 02920. (Tel) 1-855- 747-3224, (website), http://www.rireach.org, or (email) rireach@ripin.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 <u>does</u> <u>meet</u> the minimum value standard for the benefits it provides.**

Language Access Services:

- Spanish (Español): Para obtener asistencia en Español, llame al 1-401-467-3323.
- Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-401-467-3323.
- Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-401-467-3323.
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-401-467-3323.

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 also will be different.

If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,390
- **Patient pays** $150

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	$0
Coinsurance	$0
Limits or exclusions	$150
Total	$150

These numbers assume the patient is covered under the Enhanced Benefit Level (EBL).

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

- **Amount owed to providers:** $5,400
- **Plan pays** $5,010
- **Patient pays** $390

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	$100
Coinsurance	$210
Limits or exclusions	$80
Total	$390

These numbers assume the patient is covered under the Enhanced Benefit Level (EBL).

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.