LOCAL 99 Health & Welfare Fund

Notice of Grandfathered Status of Fund

Because the Fund is a "grandfathered health plan," we are required by law to provide this notice to you. The Fund believes it is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that the Fund may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund's Contract Administrator, 703 McCarter Highway, Suite 101, Newark, NJ 07102; Phone: 973-735-6464, Fax: 973-735-6465. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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, call 973-735-6464 or refer to www.local99healthandwelfarefund.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 973-735-6464 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 In-Network	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call 1-800-810-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 copay/office visit	Not Covered	No coverage for hospital based/owned clinics.
	Specialist visit	$20 copay/visit	Not Covered	No coverage for hospital based/owned clinics.
	Preventive care/screening/ immunization	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not Covered	Must be performed in free-standing facility, unless hospital location is medically necessary. Preauthorization is required for CT/PETS,MRIs. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.benecard.com	Generic drugs	$3 copay (retail) $10 copay (mail order)	Not Covered	Non-prescription OTC drugs not covered. Non-preferred brand name drugs are covered, if medically necessary (retail and mail order) **Retail:** 14-day supply, limited to 2X per drug every six months. Mandatory Generic if available. **Mail Order:** 90-day supply **Specialty Drugs:** Preauthorization is required. Not covered at retail. No copay if enrolled in the diabetic disease management program.
	Preferred brand drugs	$10 copay (retail) $15 copay (mail order)	Not Covered	
	Non-preferred brand drugs	$15 copay (retail &mail order)	Not Covered	
	Specialty drugs	$10 copay (mail order)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not Covered	No coverage for out of network hospitals. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	Physician/surgeon fees	10% coinsurance	Not Covered	Be aware, your network provider might use an out-of-network provider for some services (such as anesthesia). Check with your provider before you get services. Preauthorization is required.

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 need immediate medical attention	Emergency room care	$50 copay/visit	20% coinsurance	Emergency copay is waived if admitted but inpatient copay of $100 applies. Emergency medical transportation: $750 limit per occurrence.
	Emergency medical transportation	No charge	No charge	
	Urgent care	$20 copay/visit	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay	Not Covered	120 days limit per occurrence. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	Physician/surgeon fees	10% coinsurance	Not Covered	Be aware, your network provider might use an out-of-network provider for some services (such as anesthesia). Check with your provider before you get service.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/visit	Not Covered	**Outpatient services:** 30 visits limit per year. **Inpatient services**: 120 days limit per occurrence. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	Inpatient services	$100 copay	Not Covered	
If you are pregnant	Office visits	$20 copay – initial visit only	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound), Normal delivery covered up to 48 hours, Cesarean section covered up to 96 hours. Preauthorization is required if stay is beyond 48/96 hours. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	Childbirth/delivery professional services	10% coinsurance	Not Covered	
	Childbirth/delivery facility services	$100 copay	Not Covered	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not Covered	90 visits limit per year. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.

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)	
	Rehabilitation services	Inpatient / No charge Out-Patient / $10 copay/ visit	Not Covered	**Inpatient services**: 30 days limit per year. Includes physical therapy, speech therapy, occupational therapy and cardiac rehabilitation. **Outpatient services:** 30 visits limit per year. Includes physical therapy, speech therapy, occupational therapy and cardiac rehabilitation. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered. **Habilitation services:** None
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	No charge	Not Covered	30 visits limit per year. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	Durable medical equipment	10% coinsurance	Not Covered	Preauthorization is required in excess of $1,000 or for any rentals. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	Hospice services	No charge	Not Covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	One exam per year.
	Children's glasses	Charges in excess of $225	Charges in excess of $225	One pair of glasses ever two years up to $225.
	Children's dental check-up	Not covered	Not covered	None

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
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery, Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.
- Chiropractic Care, 30 visits per year, in-network only. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.
- Routine eye care (Adult), one exam limit per year. Eye Glasses limited to $225 every two years.
- Routine Foot Care covered for diabetics only.
- Weight Loss Programs as described in the Federal Preventive Guidelines.
- Kidney Dialysis covered at a maximum of $1500 per day, In-Network Only.

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: U.S Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. You may also contact your Plan Administrator at 973-735-6464. 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 Plan Administrator at 973-735-6464 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 premium tax credit.

Does this plan meet 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 973-735-6464

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

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	$0
Specialist copayment	$20
Hospital (facility) coinsurance	$0
Other coinsurance	$0

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	**$12,686**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$110
Coinsurance	$490
What isn't covered	
Limits or exclusions	$660
The total Peg would pay is	**$1,260**

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	$0
Other coinsurance	$0

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	**$5,601**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$360
Coinsurance	$60
What isn't covered	
Limits or exclusions	$260
The total Joe would pay is	**$680**

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	$0
Other coinsurance	$0

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$120
Coinsurance	$30
What isn't covered	
Limits or exclusions	$190
The total Mia would pay is	**$340**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. Additional information regarding the wellness program can be found at **begin.livongo.com/LOCAL99.**

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