# National Automatic Sprinkler Metal Trades
## Welfare Fund ● Pension Fund

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November 2014

## *To All Participants in the NAS Metal Trades Welfare Fund*

### *From the Board of Trustees*

In recent years, the National Automatic Sprinkler Metal Trades ("NASMT") Welfare Fund has been financially struggling. Before this year, expenses have been consistently exceeding income and the assets of the Fund have been dwindling. The combination of deep benefit cuts imposed effective January 1, 2013, along with a $0.50 per hour contribution rate increase effective September 1, 2013, finally brought the finances of the plan back in balance. Projections, however, showed deficits returning in 2015 if no additional changes (to the contribution rate or to the benefits) were made.

In response to the benefit cuts imposed as of January 1, 2013, the Board of Trustees has heard from participants, employers and local unions seeking improvements in the existing benefit levels. To address the benefit improvement request along with the prospect of returning financial deficits, the Trustees decided that, effective September 1, 2014, the contribution requirement for each level of coverage was to be increased by $0.60 per hour.

Because of the increased level of contribution income, the Board of Trustees are now able to announce the following benefit levels that are effective beginning January 1, 2015.

**Plan A In-Network Benefits**

| | |
|---|---|
| Annual Deductibles | |
| Individual | $ 750 |
| Family | $1,500 |
| Out-of-Pocket Maximums | |
| Individual | $6,100* |
| Family | $12,200* |
| Prescription Co-insurance | |
| Preferred Brands and generics | 70% |
| Non- Preferred Brands | 60% |
| Prescription Out-of-Pocket Maximums | |
| Individual | $ 500 |
| Family | $1,000 |

* (this amount includes the deductible)

**Plans B and C In-Network Benefits**

| | |
|---|---|
| Annual Deductibles | |
| Individual | $1,250 |
| Family | $2,500 |
| Out-of-Pocket Maximums | |
| Individual | $6,100* |
| Family | $12,200* |
| Prescription Co-insurance | |
| Preferred Brands and generics | 70% |
| Non- Preferred Brands | 60% |
| Prescription Out-of-Pocket Maximum | |
| Individual | $ 500 |
| Family | $1,000 |

* (this amount includes the deductible)

**Plan A** will continue to have medical co-insurance with the Plan paying 70% on covered expenses for In-Network providers and 55% on out-of-network providers.

**Plan B** will continue to have medical co-insurance with the Plan paying 70% on covered expenses for In-Network providers and 50% on out-of-network providers.

**Plan C** will continue to have medical co-insurance with the Plan paying 65% on covered expenses for In-Network providers and 50% on out-of-network providers.

## Flu shots and other Immunizations

Remember to get your seasonal flu shot from your Blue Cross Blue Shield participating physician or at your local pharmacy that participates with Express Scripts. Most immunizations, including flu shots are covered at 100% by the NASMT Welfare Fund when using an In-Network provider.

Many more people will die this year from influenza than from Ebola. We can do something about flu – be smart and **get the immunization**.

## REMINDERS

### Retiree Benefits and Medicare

Medicare is the primary coverage for retirees, dependents of retirees and beneficiaries. The NASMT Welfare Plan requires that individuals who are eligible for Medicare Part B benefits sign up for those benefits. Additionally, if an individual is not entitled to cost-free Medicare Part A, that individual must also purchase Part A coverage from Medicare when they become eligible to do so at age 65.

### Notification Requirement upon Divorce

Notice of your divorce must be provided to the Fund office within 60 days of your divorce.
If notice of your divorce is not provided to the Fund Office in this time frame, and as a result, benefits are paid to an ineligible dependent, the Fund can recover those benefits by treating such benefits as an advance to you, and deducting such amounts from benefits which become due to you until the entire amount of benefits erroneously paid is recovered.

### Annual Reminder regarding Women's Health and Cancer Rights Act of 1998

The NASMT Welfare Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call the Fund Office at 1-800-638-2603 for more information.

### Summary of Benefits and Coverage

The pages that follow this announcement are designed to meet requirements of the PPACA.

# NAS Metal Trades Welfare Fund: Plan A

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

**Coverage Period: 01/01/2015 - 12/31/2015**

**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 policy or plan document at **www.nasifund.org** or by calling **1-800-638-2603**.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network: **$750** person/**$1,500** family; Out-of-Network: **$2,500** person/**$5,000** family. Doesn't apply to prescription drugs or in-network preventive care. Balance billing & excluded services don't 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?** | Yes. A **$75** per person dental **deductible** may apply. | You don't have to meet **deductibles** for specific services, 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?** | Yes. In-Network: **$6,100** person/**$12,200** family; Out-of-Network: **$7,150** person/no family **out-of-pocket limit**. Separate **$500** per person limit for prescription drugs, both In and Out-of Network combined. | 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?** | Balance billing, health care this plan does not cover, and the out-of-network **deductible**. | 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. |

**Questions:** Call **1-800-638-2603** or visit us at **www.nasifund.org**.
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 **1-800-638-2603** to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **Does this plan use a network of providers?** | Yes. For a list of in-network **providers**, see **www.nasifund.org, call 1-800-810-BLUE**. | 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**. |
| **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**. |

- **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 | Service 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 | 30% coinsurance | 45% coinsurance | -- None -- |
| | Specialist visit | 30% coinsurance | 45% coinsurance | -- None -- |
| | Other practitioner office visit | 30% coinsurance for chiropractor | 45% coinsurance for chiropractor | Chiropractic coverage limited to 20 visits per year |
| | Preventive care/ screening/immunization | No charge | 45% coinsurance | Subject to age and frequency guidelines |

| Common Medical Event | Service 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 have a test** | Diagnostic test (x-ray, blood work) | 30% coinsurance | 45% coinsurance | -- None -- |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | 45% coinsurance | -- None -- |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.express-scripts.com. | Generic drugs | 30% coinsurance | 30% coinsurance | Covers up to a 30-day supply (retail) and up to a 90-day supply (mail order). Charges that exceed the Express-Scripts price for maintenance drugs are not covered. Brand coverage is limited to generic cost when generic is available, unless your physician requires a brand-name drug. Prescription drugs are subject to a separate $500 out-of-pocket maximum per person. For specialty drugs, you must use Express-Scripts' specialty pharmacy. |
| | Preferred brand drugs | 30% coinsurance | 30% coinsurance | |
| | Non-preferred brand drugs | 40% coinsurance | 40% coinsurance | |
| | Specialty drugs | 30% coinsurance | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | 45% coinsurance | -- None -- |
| | Physician/surgeon fees | 30% coinsurance | 45% coinsurance | -- None -- |
| **If you need immediate medical attention** | Emergency room services | 30% coinsurance | 30% coinsurance | -- None -- |
| | Emergency medical transportation | 30% coinsurance | 45% coinsurance | Limited to emergency transportation to or from the nearest hospital equipped to provide the required medical care |
| | Urgent care | 30% coinsurance | 45% coinsurance | -- None -- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance | 45% coinsurance | Precertification is required |
| | Physician/surgeon fee | 30% coinsurance | 45% coinsurance | -- None -- |

| Common Medical Event | Service 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 have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 30% coinsurance | 45% coinsurance | -- None -- |
| | Mental/Behavioral health inpatient services | 30% coinsurance | 45% coinsurance | Precertification is required |
| | Substance use disorder outpatient services | 30% coinsurance | 45% coinsurance | -- None -- |
| | Substance use disorder inpatient services | 30% coinsurance | 45% coinsurance | Precertification is required |
| **If you are pregnant** | Prenatal and postnatal care | No charge for prenatal routine office visits; Postnatal care: 30% co-insurance | 45% coinsurance | Prenatal care required by law will be covered without cost sharing. All other prenatal care services for non-spouse dependents are excluded. Postnatal care not covered for dependent children |
| | Delivery and all inpatient services | 30% coinsurance | 45% coinsurance | Delivery/inpatient services not covered for dependent children |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance | 45% coinsurance | Limited to hemodialysis, IV therapy and physician visits |
| | Rehabilitation services | 30% coinsurance | 45% coinsurance | -- None -- |
| | Habilitation services | Not covered | Not covered | You must pay 100% of these expenses, even in-network. |
| | Skilled nursing care | 30% coinsurance | 45% coinsurance | -- None -- |
| | Durable medical equipment | 30% coinsurance | 45% coinsurance | -- None -- |
| | Hospice service | 30% coinsurance | 45% coinsurance | Limited to a $150 daily maximum |
| **If your child needs dental or eye care** | Eye exam | Not covered | Not covered | You must pay 100% of these expenses, even in-network. |
| | Glasses | Not covered | Not covered | You must pay 100% of these expenses, even in-network. |
| | Dental check-up | 30% coinsurance up to UCR (maximum charge) after $75 dental deductible | 30% coinsurance up to UCR (maximum charge) after $75 dental deductible | Dental coverage available only at employer's discretion when additional hourly contribution is paid; limited to one cleaning per six-month period. |

## 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 (except to repair or alleviate damage resulting from or caused by injury, congenital defect or disfigurement related to disease)
- Eye exam (Child)
- Glasses (Child)
- Habilitation
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing (unless ordered by Physician as medically necessary)
- Routine eye care (Adult)
- Routine foot care
- 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.)

- Bariatric surgery
- Chiropractic care (limited to 20 visits per year)
- Dental Care (May be available)
- Non-emergency care when traveling outside the U.S.

## 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 1-800-638-2603. 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 plan at 1-800-638-2603. 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.

## 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 meet</u> the minimum value standard for the benefits it provides.**

## Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-638-2603.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-638-2603.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-638-2603.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-638-2603.

*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** $5,280
- **Patient pays** $2,260

**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 | $750 |
| Copays | $0 |
| Coinsurance | $1,360 |
| Limits or exclusions | $150 |
| **Total** | **$2,260** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,770
- **Patient pays** $1,630

**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 | $750 |
| Copays | $0 |
| Coinsurance | $800 |
| Limits or exclusions | $80 |
| **Total** | **$1,630** |

# 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.