MCASF Local 725 Health & Welfare Fund

Coverage Period: 01/01/2024 - 12/31/2024

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Individual and/or 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 at www.725benefits.org. 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 view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-664-5295 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$500** Per Person/**$1,500** Family. Out-of-Network: **Combined with In-Network.**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$300** Out-of-Network Per Hospital Admission Deductible. **$300** In-Network/ **$300** Out-of-Network per ER Visit. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$4,500** Per Person/**$9,000** Family. Out-Of-Network: Not Applicable	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan does not cover.	Even though you 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 https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-664-5295 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	Primary Care Visits: $45 Copay per Visit/ Virtual Visits (Telemedicine) $45 Copay per Visit	Primary Care Visits: Deductible + 40% Coinsurance/ Virtual Visits: (Telemedicine) Not Covered	Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Specialist: Deductible + 20% Coinsurance/ Virtual Visits: (Telemedicine) Deductible + 20% Coinsurance	Specialist: Deductible + 40% Coinsurance/ Virtual Visits: (Telemedicine) Not Covered	Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge	40% Coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Independent Clinical Lab: 20% Coinsurance/ Independent Diagnostic Testing Center: Deductible + 20% Coinsurance	Independent Clinical Lab: 40% Coinsurance/ Independent Diagnostic Testing Center: Deductible + 40% Coinsurance	Prior authorization may be required for certain procedures. Failure to obtain prior coverage authorization may result in denial of coverage for such Services.
	Imaging (CT/PET scans, MRIs)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.floridablue.com/members/tools-resources/pharmacy/medication-guide	Generic drugs	$15 Copay per Prescription at retail, $30 Copay per Prescription by mail	50% Coinsurance	Up to 30-day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. Failure to obtain prior coverage authorization may result in denial of coverage for such Services. See Medication guide for more information.
	Preferred brand drugs	$35 Copay per Prescription at retail, $70 Copay per Prescription by mail	50% Coinsurance	
	Non-preferred brand drugs	$65 Copay per Prescription at retail, $130 Copay per Prescription by mail	50% Coinsurance	
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30-day supply for retail. Responsible Rx programs such as Prior Authorization may apply. Failure to obtain prior coverage authorization may result in denial of coverage for such Services. See Medication guide for more information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	————none————
	Physician/surgeon fees	Deductible + 20% Coinsurance	Ambulatory Surgical Center: Deductible + 40% Coinsurance/ Hospital: Deductible + 20% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Per Visit Deductible + 20% Coinsurance	Per Visit Deductible + 20% Coinsurance	————none————
	Emergency medical transportation	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	————none————
	Urgent care	$45 Copay per Visit	Deductible + 40% Coinsurance	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 20% Coinsurance	Per Admission Deductible + Deductible + 40% Coinsurance	Prior Authorization may be required. Failure to obtain prior coverage authorization may result in denial of coverage for such Services.
	Physician/surgeon fees	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	————none————

For more information about limitations and exceptions, see the plan or policy document at www.725benefits.org

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 mental health, behavioral health, or substance abuse services	Outpatient Services	Not Covered	Not Covered	————none————
	Inpatient Services	Not Covered	Not Covered	————none————
If you are pregnant	Office visits	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	————none————
	Childbirth/delivery facility services	Deductible + 20% Coinsurance	Per Admission Deductible + Deductible + 40% Coinsurance	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	————none————
	Rehabilitation services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Occupational Therapy is Not Covered
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	0% Coinsurance plus amounts over allowed charges	Coverage is through Florida Combined Life and is limited to 2 visits and $2,500 in any Contract Year

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 • Bariatric surgery • Cosmetic surgery • Habilitation services	• Hearing aids • Infertility treatment • Long-term care • Mental health/behavioral health and substance abuse • Pediatric eye exam	• Pediatric glasses • Private-duty nursing • Routine eye care (Adult) • Routine foot care unless for treatment of diabetes • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care • Dental care (Adult/Child) through Florida Combined Life	• For any questions regarding dental benefits, or if you desire to appeal a denial of coverage of any dental claim, please contact Florida Combined Life at 1-888-223-4892 or visit its website at www.floridabluedental.com.	• Most coverage provided outside the United States. See www.floridablue.com • Non-emergency care when traveling outside the U.S.

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: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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 insurer at 1-800-664-5295. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) 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 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.

***No Surprises Act:** Effective January 1, 2022, the "No Surprises Act" enacted by Congress will cap your cost-sharing obligation for out-of-network (OON) claims to the applicable in-network cost-sharing level for the following services: (1) emergency services performed by an OON provider or facility and post-stabilization care if you cannot be moved to an in-network facility; (2) non-emergency services provided by an OON provider at in-network facilities, including hospital and ambulatory surgical centers (such services may include off-site lab, imaging, or other services associated with the visit to the in-network facility); and (3) air ambulance services provided by OON providers. These caps are intended to protect you from balance-billing or "surprise billing" by OON providers

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

For more information about limitations and exceptions, see the plan or policy document at www.725benefits.org

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 Coinsurance	20%
Hospital (facility) Coinsurance	20%
Other Coinsurance	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	$40
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,020**

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 Coinsurance	20%
Hospital (facility) Coinsurance	20%
Other Coinsurance	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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$1,900
Coinsurance	$50
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,510**

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

The plan's overall deductible	$500
The plan's per visit ER deductible	$300
Specialist Coinsurance	20%
Hospital (facility) Coinsurance	20%
Other Coinsurance	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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles (includes per visit deductible)	$800
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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

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