Fleet Owners Insurance Fund: PLAN A

Coverage Period: Calendar Year 2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Essential Health Benefits | **Plan Type:** Plan A

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.fleetownersinsurance.org or by calling 1-877-301-0874

Important Questions	Answers		Why this Matters:
	In-Network	**Out-of-Network**	Terms in this summary are defined in the Plan Booklet and at www.healthcare.gov/glossary.
What is the overall deductible?	**Single/Family** $200/$400	**Single/Family** $400/$800	You must pay all costs up to the **deductible** amount before this plan begins to pay for covered services you use. Starts each year on January 1st. Chart on Page 2 shows how much you pay for covered services after you meet the **deductible**. Doesn't apply to coinsurance or co-pays.
Are there other deductibles for specific services?	No		You don't have to meet **deductibles** for specific services, but see page 2 for other costs for services this plan covers. Once the overall **deductible** is paid, you are subject to the coinsurance provisions for covered benefits.
Is there an out–of–pocket limit on my expenses?	**Single/Family** $500/$1,000	**Single/Family** $1000/$2,000	Your Fund is a multiple employer welfare arrangement not subject to State insurance regulation under Section 514 of ERISA.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, co-pays and health care this Plan does not cover		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	No	Plan pays most claims subject to specific deductibles, co-pays, coinsurance and out-of-pockets explained in this summary.
Does this plan use a network of providers?	Yes, visit MedMutual.com or call (877) 301-0874 to get a provider booklet.		If you use an in-network doctor or other healthcare **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 types of **providers**.
Do I need a referral to see a specialist?	No. You do not need a referral to see a specialist.		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 summary plan description for information about **excluded services**.

Questions: Call 1-877-301-0874 or visit us at www.fleetownersinsurance.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.fleetownersinsurance.org or call 1-877-301-0874 to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Corrected on January 1, 2015.

- **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.
- All benefits are subject to usual, customary and reasonable charges and are subject to the annual dollar maximum.

Common Medical Event	Services 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	$10 co-pay/visit	50% after deductible	
	Preventative Care	No charge	50% after deductible	1 per benefit period. Participant and Spouse.
	Well Child Care Exam and Immunization	$10 co-pay/visit	50% after deductible	To age nine
	Other practitioner office Visit (Chiropractic)	20% after deductible	50% after deductible	12 visits per benefit period.
	Specialist visit	$10 co-pay/visit	50% after deductible	
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible	50% after deductible	
	Imaging (CT/PET scans, MRIs)	No charge after deductible	50% after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.fleetownersinsurance.org.	Generic drugs	10% co-pay	10% co-pay	
	Preferred brand drugs	20% co-pay	20% co-pay	
	Non-preferred brand drugs	50% co-pay	50% co-pay	
	Specialty Drugs	50% co-pay	50% co-pay	

Common Medical Event	Services 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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	50% after deductible	
	Physician/surgeon fees	No charge after deductible	50% after deductible	No Coverage for occupational caused injuries or due to a prior operation. Charges must not exceed usual customary and reasonable charges.
If you need immediate medical attention	Emergency room services	No charge (deductible does not apply)		The injury or illness must be serious and endanger health. If the need is non-emergency, $200 co-pay then 20% for in-network or $200 co-pay then 50% for non-network.
	Emergency medical transportation	20% after deductible	50% after deductible	
	Urgent care	$10 co-pay/visit	50% after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	50% after deductible	Semi-private room. 365 days
	Physician/surgeon fee (inpatient)	20% after deductible	50% after deductible	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Benefits paid based on corresponding medical benefits	Benefits paid based on corresponding medical benefits	
	Mental/Behavioral health inpatient services	Benefits paid based on corresponding medical benefits	Benefits paid based on corresponding medical benefits	
	Substance use disorder outpatient services	Benefits paid based on corresponding medical benefits	Benefits paid based on corresponding medical benefits	30 visits per benefit period
	Substance use disorder inpatient services	Benefits paid based on corresponding medical benefits	Benefits paid based on corresponding medical benefits	30 days per benefit period
If you are pregnant	Prenatal and postnatal care	No charge after deductible	50% after deductible	
	Delivery and all inpatient services	No charge after deductible	50% after deductible	

Common Medical Event	Services 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 need help recovering or have other special health needs	Home health care	40% after deductible	50% after deductible	30 days per benefit period.
	Rehabilitation services (Physical Therapy) Facility Professional	No charge after deductible 20% after deductible	50% after deductible 50% after deductible	
	Habilitation services (Speech Therapy) Facility Professional	No charge after deductible 20% after deductible	50% after deductible 50% after deductible	
	Habilitation services (Occupational Therapy) Facility Professional	No charge after deductible 20% after deductible	50% after deductible 50% after deductible	
	Skilled nursing care	40% after deductible	50% after deductible	30 days per benefit period.
	Durable medical equipment	20% after deductible	50% after deductible	
	Hospice service	20% after deductible	50% after deductible	
If your child needs dental or eye care	Eye exam	No charge up to $75.00		You will be responsible for anything over $75.00. One per benefit period.
	Glasses Frames Lenses	No charge per frame up to $125.00 No charge per pair up to $125.00		You will be responsible for anything over $125.00 per frame and anything over $125.00 per pair for lenses.
	Dental check-up (exam)	No charge		Two exams per benefit period. Subject to UCR.

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.)

- Cosmetic Surgery
- Acupuncture
- Infertility

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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.)

- Hearing
- Vision (Adult)
- Extended Surgical Benefits is totally disabled after coverage termination.
- Voluntary Second Surgical Opinion
- Routine Mammogram
- PAP Test
- Allergy Testing and Treatments
- Routine PSA
- Dental (Adult)

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 may also apply. For more information on your rights to continue coverage, contact the plan at 1-877-301-0874. You may also contact, 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 ext.61565.

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: Fleet Owners Insurance Fund at 1-877-301-0874.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage as it is a grandfathered plan.**

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 does meet the minimum value standard for the benefits it provides.**

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** $7,340
- **Patient pays** $200

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	$200
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$200**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,225
- **Patient pays** $1,175

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	$100
Copays	$60
Coinsurance	$0
Limits or exclusions	$725
Total	**$1,175**

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.