
 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 1-212-245-4802. 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.local802afm.org/about/benefits-services/health-benefits or call 1-212-245-4802 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>In-Network</u> : \$0 <u>Out-of-Network</u> : \$1,500 Individual / \$3,750 Family	<u>In-Network</u> : See the Common Medical Events chart below for your costs for services this plan covers. <u>Out-of-Network</u> : Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	<u>In-Network</u> : Not applicable. <u>Out-of-Network</u> : Yes. <u>Preventive care</u> , optical and <u>prescription drugs</u> are covered before you meet your deductible.	<u>In-Network</u> : This plan does not have a <u>deductible</u> . <u>Out-of-Network</u> : This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Yes. For <u>in-network providers</u> : Medical and Hospital: \$5,050 Individual / \$10,100 Family; <u>Prescription Drug</u> : \$1,300 Individual / \$2,600 Family For <u>out-of-network providers</u> : Not Applicable.	<u>In-Network</u> : The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. <u>Out-of-Network</u> : This plan does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.aetna.com or call 1-800-370-4526 for a list of <u>network providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your plan pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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	\$25 <u>copay</u> /visit	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	No charge; <u>deductible</u> does not apply	Subject to age and frequency limits. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Office and free-standing facility: x-ray: 20% <u>coinsurance</u> ; blood work: \$25 <u>copay</u> /test; Hospital outpatient: x-ray and blood work: No charge	Office and free-standing facility: 30% <u>coinsurance</u> after <u>deductible</u> ; Hospital outpatient: 20% <u>coinsurance</u>	Coinsurance waived if used with OneCall, contact Fund Office for more information.
	Imaging (CT/PET scans, MRIs)	Office and free-standing facility: 20% <u>coinsurance</u> ; Hospital outpatient: No charge	Office and free-standing facility: 30% <u>coinsurance</u> ; Hospital outpatient: 20% <u>coinsurance</u>	Coinsurance waived if used with OneCall, contact Fund Office for more information.

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)	
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.expressscripts.com</p>	Generic drugs	Retail: \$20 <u>copay</u> /prescription Mail Order: \$40 <u>copay</u> /prescription	Retail: \$20 <u>copay</u> /prescription Mail Order: Not covered	<p><u>Out-of-network deductible</u> does not apply. <u>Prescription drug</u> benefit covers up to a 30-day supply for retail prescriptions and up to a 90-day supply for mail order prescriptions. Maintenance prescription drugs are limited to two retail fills and then must be filled through the mail order pharmacy. No charge for FDA-approved generic preventive medication and contraceptives (or brand name contraceptives if a generic is medically inappropriate). Generic drugs are mandatory when available. If you fill a brand name drug when a generic equivalent is available, you will pay an additional amount equal to the difference between the <u>allowed amount</u> for the brand name and the generic medication. Mail order not covered <u>out-of-network</u>. If you fill a prescription at an out-of-network pharmacy, you will pay an additional amount equal to the difference between the pharmacy's charges and the allowed amount for the medication. Certain drugs subject to prior authorization and/or quantity limitations or exclusions. *See the Prescription Drug section of the Summary Plan Description. Drugs administered in a doctor's office or compounded for IV infusion are not available by mail order. <u>Specialty drugs</u> must be ordered from Accredo mail order pharmacy.</p>
	Preferred brand drugs	Retail: \$35 <u>copay</u> /prescription Mail Order: \$70 <u>copay</u> /prescription	Retail: \$35 <u>copay</u> /prescription Mail Order: Not covered	
	Non-preferred brand drugs	Retail: 40% <u>coinsurance</u> (\$50 minimum/prescription, \$75 maximum/prescription) Mail Order: 40% <u>coinsurance</u> (\$100 minimum/prescription, \$150 maximum/prescription)	Retail: 40% <u>coinsurance</u> (\$50 minimum/prescription, \$75 maximum/prescription) Mail Order: Not covered	
	<u>Specialty drugs</u>	Retail: Not covered Mail Order: 40% <u>coinsurance</u> (\$300 maximum/prescription)	Not covered.	

*For more information about limitations and exceptions, see the Summary Plan Description at www.local802afm.org/about/benefits-services/health-benefits/.

Common Medical Event	Services You May Need	What You Will Pay		What You Will Pay
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the least)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> is required at least 14 days in advance. Failure to preauthorize may result in benefit reduction.
	Physician/surgeon fees	\$25 <u>copay</u> /visit	30% <u>coinsurance</u>	None.
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit	<u>Copay</u> waived if admitted to the hospital. Professional/physician charges may be billed separately.
	<u>Emergency medical transportation</u>	No charge	30% <u>coinsurance</u>	None.
	<u>Urgent care</u>	\$25 <u>copay</u> /visit	30% <u>coinsurance</u>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> is required for elective admissions at least 14 days in advance. Admission notification is required within 2 days or when reasonable following emergency admission. Failure to preauthorize may result in benefit reduction.
	Physician/surgeon fees	\$25 <u>copay</u> /visit	30% <u>coinsurance</u>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: \$25 <u>copay</u> /visit; Other outpatient (partial hospitalization/intensive outpatient): 20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required for partial <u>hospitalization</u> and intensive outpatient programs as soon as reasonably possible. Failure to preauthorize may result in benefit reduction
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> is required for elective admissions at least 14 days in advance. Admission notification is required within 2 days or when reasonable following emergency admission. Failure to preauthorize may result in benefit reduction.

Common Medical Event	Services You May Need	What You Will Pay		What You Will Pay
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the least)	
If you are pregnant	Office visits	No charge	30% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive services</u> . Depending on the type of services and/or <u>provider</u> , a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Notification is required for <u>out-of-network</u> admissions that exceed 48-hours for delivery (or 96-hours for C-sections).
If you need help recovering or have other special health needs	<u>Home health care</u>	\$25 <u>copay</u> /visit	30% <u>coinsurance</u>	Coverage is limited to 40 visits/calendar year (combined <u>in/out-of-network</u>).
	<u>Rehabilitation services</u>	Inpatient: 20% <u>coinsurance</u> ; Outpatient: \$25 <u>copay</u> /visit	Inpatient: 20% <u>coinsurance</u> ; Outpatient: 30% <u>coinsurance</u>	<u>Preauthorization</u> is required for elective admissions at least 14 days in advance or as soon as reasonably possible. Failure to preauthorize may result in benefit reduction.
	<u>Habilitation services</u>	Inpatient: 20% <u>coinsurance</u> ; Outpatient: \$25 <u>copay</u> /visit	Inpatient: 20% <u>coinsurance</u> ; Outpatient: 30% <u>coinsurance</u>	Outpatient maintenance speech and hearing therapy not covered.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Coverage is limited to 60 inpatient skilled nursing care facility bed days/calendar year (combined <u>in/out-of-network</u>). <u>Preauthorization</u> is required for elective admissions at least 14 days in advance or as soon as reasonably possible.
	<u>Durable medical equipment</u>	\$25 <u>copay</u> /durable medical <u>equipment</u>	30% <u>coinsurance</u>	None.
	<u>Hospice services</u>	Inpatient: 20% <u>coinsurance</u> ; Outpatient: \$25 <u>copay</u> /visit	Inpatient: 20% <u>coinsurance</u> ; Outpatient: 30% <u>coinsurance</u>	Inpatient hospice limited to 210 days per lifetime.

Common Medical Event	Services You May Need	What You Will Pay		What You Will Pay
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the least)	
If your child needs dental or eye care	Children's eye exam	Amount over \$15 <u>plan allowance</u>	Amount over \$15 <u>plan allowance</u>	Vision benefits separately administered by the Fund Office. Limited to one eye exam/calendar year and one complete pair of glasses/calendar year. You are responsible for amounts over <u>plan allowances</u> .
	Children's glasses	Frames: Amount over \$11 <u>plan allowance</u> ; Single vision lenses: Amount over \$13 <u>plan allowance</u> ; Bifocals: Amount over \$19 <u>plan allowance</u> ; Trifocals: Amount over \$24 <u>plan allowance</u>	Frames: Amount over \$11 <u>plan allowance</u> ; Single vision lenses: Amount over \$13 <u>plan allowance</u> ; Bifocals: Amount over \$19 <u>plan allowance</u> ; Trifocals: Amount over \$24 <u>plan allowance</u>	
	Children's dental check-up	Not covered	Not covered	You must pay 100% of these expenses, even in-network.

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.)

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| <ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult & Child) | <ul style="list-style-type: none"> • Hearing aids • Long-term care • Non-emergency care when travelling outside the U.S. | <ul style="list-style-type: none"> • Private-duty nursing • Routine foot care • Weight loss programs (Except for morbid obesity and as required for <u>preventive services</u> under the ACA) |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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| <ul style="list-style-type: none"> • Acupuncture (Combined 50 visit limit/calendar year with chiropractic care and physical therapy) • Bariatric surgery • Chiropractic care (Combined 50 visit limit/calendar year with acupuncture and physical therapy) | <ul style="list-style-type: none"> • Infertility treatment (Limited to diagnosis and treatment of correctable medical conditions that result in infertility) | <ul style="list-style-type: none"> • Routine eye care (Adult) (Limited to one eye exam/calendar year and one pair of glasses/calendar year) |
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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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 Fund Office at 1-212-245-4802 or Aetna at 1-800-370-4526. 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 plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-212-245-4802.

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 <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copay</u>	\$40
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$90
Coinsurance	\$2,120
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Peg would pay is	\$2,220

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copay</u>	\$40
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,510
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,510

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copay</u>	\$40
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$240
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$240