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 the Fund Office at 1-212-245-4802 or visit www.local802afm.org/healthcare/. 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 1-212-245-4802 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $0 Out-of-Network: $1,500 Individual / $3,750 Family	In-Network: See the Common Medical Events chart below for your costs for services this plan covers. Out-of-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?	In-Network: Not applicable. Out-of-Network: Yes. Preventive care, optical and prescription drugs are covered before you meet your deductible.	In-Network: This plan does not have a deductible. Out-of-Network: 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 https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. For in-network providers: Medical and Hospital: $5,050 Individual / $10,100 Family; Prescription Drug: $1,300 Individual / $2,600 Family For out-of-network providers: Not Applicable.	In-Network: 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. Out-of-Network: This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't 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 www.aetna.com or call 1-800-370-4526 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	$25 copay/visit	30% coinsurance	None
	Specialist visit	$40 copay/visit	30% coinsurance	None
	Preventive care/ screening/immunization	No charge	No charge; deductible does not apply	Subject to age and frequency limits. 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)	Office and free-standing facility: x-ray: 20% coinsurance; blood work: $25 copay/test; Hospital outpatient: x-ray and blood work: No charge	Office and free-standing facility: 30% coinsurance after deductible; Hospital outpatient: 20% coinsurance	Coinsurance waived if used with OneCall, contact Fund Office for more information.
	Imaging (CT/PET scans, MRIs)	Office and free-standing facility: 20% coinsurance; Hospital outpatient: No charge	Office and free-standing facility: 30% coinsurance; Hospital outpatient: 20% coinsurance	Coinsurance waived if used with OneCall, contact Fund Office for more information.

*For more information about limitations and exceptions, see the Summary Plan Description and Summaries of Material Modifications at www.local802afm.org/healthcare/.

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 www.expressscripts.com	Generic drugs	Retail: $20 copay/prescription Mail Order: $40 copay/prescription	Retail: $20 copay/prescription Mail Order: Not covered	Out-of-network deductible does not apply. Prescription drug 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 allowed amount for the brand name and the generic medication. Mail order not covered out-of-network. 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 preauthorization 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. Specialty drugs must be ordered from Accredo mail order pharmacy.
	Preferred brand drugs	Retail: $35 copay/prescription Mail Order: $70 copay/prescription	Retail: $35 copay/prescription Mail Order: Not covered	
	Non-preferred brand drugs	Retail: 40% coinsurance ($50 minimum/prescription, $75 maximum/prescription) Mail Order: 40% coinsurance ($100 minimum/prescription, $150 maximum/prescription)	Retail: 40% coinsurance ($50 minimum/prescription, $75 maximum/prescription) Mail Order: Not covered	
	Specialty drugs	Retail: Not covered Mail Order: 40% coinsurance ($300 maximum/prescription)	Not covered.	

*For more information about limitations and exceptions, see the Summary Plan Description and Summaries of Material Modifications at www.local802afm.org/healthcare/.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	Preauthorization is required at least 14 days in advance. Failure to preauthorize may result in benefit reduction.
	Physician/surgeon fees	$25 copay/visit	30% coinsurance	None.
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Copay waived if admitted to the hospital. Professional/physician charges may be billed separately.
	Emergency medical transportation	No charge	30% coinsurance	None.
	Urgent care	$25 copay/visit	30% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	Preauthorization 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	20% coinsurance	30% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $40 copay/visit; Other outpatient (partial hospitalization/intensive outpatient): 20% coinsurance	30% coinsurance	Preauthorization is required for partial hospitalization and intensive outpatient programs as soon as reasonably possible. Failure to preauthorize may result in benefit reduction
	Inpatient services	20% coinsurance	20% coinsurance	Preauthorization 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.

*For more information about limitations and exceptions, see the Summary Plan Description and Summaries of Material Modifications at www.local802afm.org/healthcare/.

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

*For more information about limitations and exceptions, see the Summary Plan Description and Summaries of Material Modifications at www.local802afm.org/healthcare/.

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 your child needs dental or eye care	Children's eye exam	Amount over $15 plan allowance	Amount over $15 plan allowance	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 plan allowances.
	Children's glasses	Frames: Amount over $11 plan allowance; Single vision lenses: Amount over $13 plan allowance; Bifocals: Amount over $19 plan allowance; Trifocals: Amount over $24 plan allowance	Frames: Amount over $11 plan allowance; Single vision lenses: Amount over $13 plan allowance; Bifocals: Amount over $19 plan allowance; Trifocals: Amount over $24 plan allowance	
	Children's dental check-up	Not covered	Not covered	You must pay 100% of these expenses, even in-network.

*For more information about limitations and exceptions, see the Summary Plan Description and Summaries of Material Modifications at www.local802afm.org/healthcare/.

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.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when travelling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs (Except for morbid obesity and as required for preventive services under the ACA)

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

- 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)
- Infertility treatment (Limited to diagnosis and treatment of correctable medical conditions that result in infertility)
- Routine eye care (Adult) (Limited to one eye exam/calendar year and one pair of glasses/calendar year)

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 on how 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**

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.

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.

*For more information about limitations and exceptions, see the Summary Plan Description and Summaries of Material Modifications at www.local802afm.org/healthcare/.

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 copay	$40
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$90
Coinsurance	$2,120
What isn't covered	
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 plan's overall deductible	$0
Specialist copay	$40
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,510
Coinsurance	$0
What isn't covered	
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 plan's overall deductible	$0
Specialist copay	$40
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$240
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$240**

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