
 **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?	<p><u>In-Network</u>: \$625 Individual / \$1,250 Family <u>Out-of-Network</u>: \$4,150 Individual / \$10,400 Family <u>Deductible</u> is pro-rate for 10 month coverage period.</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, 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>.</p>
Are there services covered before you meet your deductible?	<p>Yes. <u>Preventive care</u>, optical and <u>prescription drugs</u> are covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> 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 <u>plan</u> 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/</p>
Are there other deductibles for specific services?	<p>Yes. \$43 Individual / \$83 Family for <u>prescription drugs</u>. <u>Deductible</u> is pro-rate for 10 month coverage period. There are no other specific <u>deductibles</u>.</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.</p>
What is the out-of-pocket limit for this plan?	<p>Yes. For <u>In-Network</u> medical <u>providers</u>: Medical and Hospital: \$4,450 Individual / \$8,900 Family; <u>out-of-pocket limit</u> is pro-rate for 10 month coverage period. <u>In-Network</u> Prescription Drugs: \$1,300 Individual / \$2,600 Family; applies for 15-month period 10/1/2020 – 12/31/2021; For <u>out-of-network</u> providers: Not Applicable.</p>	<p><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 <u>plan</u>, 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 <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.</p>
What is not included in the out-of-pocket limit?	<p><u>Premiums</u>, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
Will you pay less if you use a network provider?	<p>Yes. See www.aetna.com or call 1-800-370-4526 for a list of <u>network providers</u>.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's 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</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-</u></p>

		<u>network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	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	\$30 <u>copay</u> /visit	50% <u>coinsurance</u>	None.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit	50% <u>coinsurance</u>	None.
	<u>Preventive care/ screening/immunization</u>	No charge; <u>deductible</u> does not apply	No charge; <u>deductible</u> does not apply	Subject to age and frequency limits. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. *See "Your Hospital and Medical Benefits" section of the SPD and subsequent SMMs.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Office and free-standing facility: 30% <u>coinsurance</u> ; Hospital outpatient: No charge	Office, free-standing facility and hospital outpatient: 50% <u>coinsurance</u>	<u>Coinsurance</u> waived if used with OneCall, contact Fund Office for more information.
	Imaging (CT/PET scans, MRIs)	Office and free-standing facility: 30% <u>coinsurance</u> ; Hospital outpatient: No charge	Office, free-standing facility and hospital outpatient: 50% <u>coinsurance</u>	<u>Coinsurance</u> waived if used with OneCall, contact Fund Office for more information.

*For more information about limitations and exceptions, see the Summary Plan Description (SPD) and Summaries of Material Modifications (SMM) 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)	
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.expresscripts.com</p>	Generic drugs	Retail: \$20 <u>copay</u> /prescription Mail Order: \$40 <u>copay</u> /prescription	Retail: \$20 <u>copay</u> /prescription plus difference in cost between <u>out-of-network</u> pharmacy charges and <u>allowed amount</u> ; Mail Order: Not covered	<p>Medical <u>deductibles</u> do not apply; separate <u>prescription drug deductible</u> applies.</p> <p><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 <u>prescription drugs</u> are limited to two retail fills and then must be filled through the mail order pharmacy.</p>
	Formulary brand drugs	Retail: \$35 <u>copay</u> /prescription Mail Order: \$70 <u>copay</u> /prescription	Retail: \$35 <u>copay</u> /prescription plus difference in cost between <u>out-of-network</u> pharmacy charges and <u>allowed amount</u> Mail Order: Not covered	<p>No charge for FDA-approved generic preventive medications and contraceptives (or brand name if a generic is medically inappropriate).</p> <p>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.</p>
	Non-formulary brand drugs	Not covered	Not covered	<p>If you fill a prescription at an <u>out-of-network</u> pharmacy, you will pay an additional amount equal to the difference between the pharmacy's charges and the <u>allowed amount</u> for the medication. Mail order not covered <u>out-of-network</u>.</p>
	<u>Specialty drugs</u>	Retail: Not covered Mail Order: 40% <u>coinsurance</u> (\$300 maximum/prescription)	Not covered.	<p>Certain drugs subject to <u>preauthorization</u> in order to be covered and/or there may be quantity limitations or exclusions. Non-formulary brand drugs are not covered and you must pay 100% of this service, even <u>in-network</u>. *See the <u>Prescription Drug</u> section of the SPD and subsequent SMMs.</p> <p>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>

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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)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required at least 14 days in advance. Failure to preauthorize may result in benefit reduction. *See “Your Hospital and Medical Benefits” section of the SPD and subsequent SMMs.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None.
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay/visit</u>	\$200 <u>copay/visit</u>	<u>Copay</u> waived if admitted to the hospital. Professional/physician charges may be billed separately.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Non-emergent <u>out-of-network</u> ambulance services covered at 50% <u>coinsurance</u> .
	<u>Urgent care</u>	\$50 <u>copay/visit</u>	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay/visit</u>	50% <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. *See “Your Hospital and Medical Benefits” section of the SPD and subsequent SMMs.
	Physician/surgeon fees	Primary care physician: \$30 <u>copay/visit</u> ; Specialist: \$50 <u>copay/visit</u> ; Surgeon: 30% <u>coinsurance</u>	50% <u>coinsurance</u>	None.

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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	Office visits: \$30 <u>copay</u> /visit; Other outpatient (partial hospitalization/intensive outpatient): 30% <u>coinsurance</u>	50% <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. *See “Your Hospital and Medical Benefits” section of the SPD and subsequent SMMs.
	Inpatient services	\$500 <u>copay</u> /visit	50% <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. *See “Your Hospital and Medical Benefits” section of the SPD and subsequent SMMs.
If you are pregnant	Office visits	No charge	50% <u>coinsurance</u>	Cost sharing does not apply for <u>in-network 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). *See “Your Hospital and Medical Benefits” section of the SPD and subsequent SMMs.
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <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).
	Childbirth/delivery facility services	\$500 <u>copay</u>	50% <u>coinsurance</u>	

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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 help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to 40 visits/calendar year (combined <u>in/out-of-network</u>).
	<u>Rehabilitation services</u>	Inpatient and outpatient: 30% <u>coinsurance</u>	Inpatient and outpatient: 50% <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. *See “Your Hospital and Medical Benefits” section of the SPD and subsequent SMMs.
	<u>Habilitation services</u>	Inpatient and outpatient: 30% <u>coinsurance</u>	Inpatient and outpatient: 50% <u>coinsurance</u>	Outpatient maintenance speech and hearing therapy not covered.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to 60 <u>skilled nursing care</u> 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. *See “Your Hospital and Medical Benefits” section of the SPD and subsequent SMMs.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None.
	<u>Hospice services</u>	Inpatient and outpatient: 30% <u>coinsurance</u>	Inpatient and outpatient: 50% <u>coinsurance</u>	Inpatient hospice coverage is limited to 210 days/lifetime.
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 EyeMed. 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 <u>in-network</u> .

*For more information about limitations and exceptions, see the Summary Plan Description (SPD) and Summaries of Material Modifications (SMM) 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.
- Non-formulary prescription drugs
- 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 (SPD) and Summaries of Material Modifications (SMM) 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 <u>plan's</u> overall <u>deductible</u>	\$750
■ <u>Specialist copay</u>	\$50
■ Hospital (facility) <u>copay</u>	\$500
■ Other <u>coinsurance</u>	30%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles*	\$800
Copayments	\$1,510
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Peg would pay is	\$2,330

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>	\$750
■ <u>Specialist copay</u>	\$50
■ Hospital (facility) <u>copay</u>	\$500
■ Other <u>coinsurance</u>	30%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$800
Copayments	\$650
Coinsurance	\$170
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,620

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$750
■ <u>Specialist copay</u>	\$50
■ Hospital (facility) <u>copay</u>	\$500
■ Other <u>coinsurance</u>	30%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$760
Copayments	\$390
Coinsurance	\$170
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,320

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

*NOTE: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.