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 516-365-3470 or Aetna at 1-800-370-4526. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: Individual: $1,500 / Family $3,750. Out-of-Network: Individual $3,000 / Family $7,500.	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: Yes. Office visits, preventive care, diagnostic testing (x-ray, blood work), urgent care, dental and optical benefits are covered before you meet your deductible. Out-of-Network: Yes. Preventive care, home health care, dental and optical benefits are covered before you meet your deductible.	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?	In-Network Medical: Individual $2,750 / Family $5,500 In-Network Prescription drugs: Individual $5,500 / Family $11,000 Out-of-Network Medical: Individual $20,000 / Family $50,000 Out-of-Network Prescription drugs: not covered	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?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain pre-authorization for services, dental and optical benefits.	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/docfind or call 1-800-370-4526 for a list of in-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 deductible doesn't apply	40% coinsurance	None
	Specialist visit	$50 copay/visit deductible doesn't apply	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	40% coinsurance, deductible doesn't apply; no charge for well child & immunizations up to age 19	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)	No charge deductible doesn't apply	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	Retail: $10 copay/prescription; Mail order: $10 copay/prescription	Not covered	Cost sharing does not count toward medical out-of-pocket limit; counts toward separate out-of-pocket limit for prescription drugs. Retail: 30-day supply. Mail order: 90-day supply. Must use mail order for maintenance drugs after one refill or responsible for full cost of drug. No copay for generic contraceptives for women and other ACA-required preventive prescriptions (or brand name if a generic is medically inappropriate). Over-the-counter drugs are excluded except for ACA-required preventive prescriptions. Over-the-counter ACA-required preventive drugs require a prescription to be covered.
	Preferred brand drugs	Retail: $25 copay/prescription; Mail order: $50 copay/prescription	Not covered	
	Non-preferred brand drugs	Retail: $40 copay/prescription; Mail order: $80 copay/prescription	Not covered	
	Specialty drugs	5% coinsurance (retail and mail order)	Not covered	Specialty: 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 copay	40% coinsurance	None

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)	
	Physician/surgeon fees	No charge	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$200 copay/visit	$200 copay/visit	No coverage when not an emergency medical condition. Professional/physician charges may be billed separately.
	Emergency medical transportation	No charge	No charge	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$50 copay/visit, deductible doesn't apply	40% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission	40% coinsurance	Penalty of $200 for failure to obtain preauthorization for out-of-network care.
	Physician/surgeon fees	No charge	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $25 copay/visit, deductible doesn't apply; other outpatient services: no charge	Office visits & other outpatient services: 40% coinsurance	None
	Inpatient services	$250 copay	40% coinsurance	Penalty of $200 for failure to obtain preauthorization for out-of-network care.
If you are pregnant	Office visits	No charge	40% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $200 for failure to obtain preauthorization for out-of-network care may apply.
	Childbirth/delivery professional services	No charge	40% coinsurance	
	Childbirth/delivery facility services	No charge	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	40% coinsurance,	200 visits/calendar year. Penalty of $200 for failure to obtain preauthorization for out-of-network care.
	Rehabilitation services	$50 copay/visit. Deductible does not apply	40% coinsurance	60 visits/calendar year for Physical, Occupational & Speech Therapy combined, including outpatient hospital services.

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)	
	Habilitation services	No charge	40% coinsurance	None
	Skilled nursing care	$250 copay/stay	40% coinsurance	120 days/calendar year. Penalty of $200 for failure to obtain preauthorization for out-of-network care.
	Durable medical equipment	No charge	40% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	No charge	40% coinsurance	Penalty of $200 for failure to obtain preauthorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	Balances over Plan allowance. Deductible does not apply.	Benefits are administered separately by Davis Vision. Cost sharing does not count toward out-of-pocket limits.
	Children's glasses	No charge. Deductible does not apply.	Balances over Plan allowance. Deductible does not apply.	Limited to one eye exam and pair of glasses or contact lenses (in lieu of glasses)
	Children's dental check-up	No charge. Deductible does not apply.	Balances over scheduled allowance. Deductible does not apply.	Benefits are provided separately from the medical program under a separate contract with Aetna. Cost sharing does not count toward out-of-pocket limits. Age and frequency limits apply.

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
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs - Except for required preventive services.

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

- Acupuncture – 12 visits/calendar year for disease, injury, & chronic pain
- Bariatric surgery
- Chiropractic care
- Dental care (Adult) (Maximum $4,000 per person per year. Benefits are provided separately from the medical program under a separate contract with Aetna.)
- Hearing Aids (Limited to $2,000 maximum/3 years)
- Infertility treatment (Limited to the diagnosis & treatment of underlying medical condition, artificial insemination & ovulation induction.)
- Private-duty nursing (Limited to 70 8-hour shifts/calendar year.)
- Routine eye care (Adult) (Limited to one eye exam and pair of glasses or contact lenses in lieu of glasses)

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: call the number(s) on your ID Card or contact the Fund Office at 516-365-3470. 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. Additionally, a consumer assistance program can help you file your appeal. Contact information is at http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

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 1-800-370-4526.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-370-4526.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-370-4526.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-370-4526.

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 plan's overall deductible	$0
Specialist copayment	$50
Hospital (facility) copayment	$0
Other copayment (diagnostic tests)	$0

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	$1,500
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,570**

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 copayment	$25
Hospital (facility) copayment	$0
Other copayment (diagnostic tests)	$0

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	$0
Copayments	$1,040
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,040**

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

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) copayment	$0
Other copayment (diagnostic tests)	$0

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	$1,500
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

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