



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 1-914-769-2440. 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.dol.gov/ebsa/healthreform or call 1-914-769-2440 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For participating providers : \$0 person/\$0 family	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 ?	Yes. For participating providers : All services 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.
Are there other deductibles for specific services?	\$50/person for Dental. This deductible does not apply to preventive services . There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	For participating providers : Hospital and Medical: \$1,500 person/\$3,000 family Prescription: \$5,000 person/\$10,000 family	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 ?	For all providers : preauthorization penalty amounts, and health care this plan doesn't cover. . For non-participating providers : Premiums , copays , deductibles , and balance billing charges	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. Hospital and Medical: www.aetna.com/docfind/custom/mymeritain or call 1-800-343-3140 for a list of network providers .	This plan is an in-network only plan . 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.

Important Questions	Answers	Why This Matters:
	Prescription drugs: www.express-scripts.com or call 1-844-520-2679.	
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	\$10 copay /visit	Not Covered	Copay applies per visit regardless of what services are rendered.
	Specialist visit	\$25 copay /visit	Not Covered	Copay applies per visit regardless of what services are rendered. \$1,250 annual maximum for chiropractic & podiatry services
	Preventive care / screening /Immunization	\$0 copay /visit	Not Covered	Plan allows one well visit/calendar year. Immunizations, except for ACIP vaccine, are not covered for individuals 26 years of age or older.
If you have a test	Diagnostic test (x-ray, blood work)	\$100 copay /visit (outpatient hospital)/ \$50 (all other outpatient facilities)	Not Covered	-----none-----
	Imaging (CT/PET scans, MRIs)	\$100 copay /visit	Not Covered	Preauthorization required for PET scans and non-orthopedic CT/MRI's. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service.

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 call Express Scripts at 1-844-520-2679 or visit the website www.express-scripts.com	Generic (Preferred)	\$10 <u>copay</u> per 30 days (retail) \$20 Mail Order 90 day	Not Covered	Non-covered prescriptions are weight loss, IVF therapy, and cell and gene therapy.
	Generic (Non-Preferred)	\$20 <u>copay per 30 days</u> (retail) \$40 Mail Order 90 day	Not Covered	
	Brand (Preferred)	\$30 <u>copay</u> per 30 days (retail) \$60 Mail Order 90 day	Not Covered	
	Brand (Non-Preferred)	\$100 <u>copay per 30 days</u> (retail) \$200 Mail Order 90 day	Not Covered	
	Specialty drugs	20% coinsurance to a max of \$500 for each RX fill	Not Covered	

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)	\$100 <u>copay</u> /occurrence	Not Covered	<u>Preauthorization</u> required for certain surgeries. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service. See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	No charge	Not Covered	
If you need immediate medical attention	Emergency room care	\$150 <u>copay</u> /visit (<u>emergency services</u>) \$150 <u>copay</u> /visit (non- <u>emergency services</u>)	\$150 copay/visit (emergency services) Not Covered – (non-emergency services)	<u>Copay</u> is waived if admitted to the hospital.
	Emergency medical transportation	No Charge (<u>emergency services</u>)(ground and air)/ Not Covered (non- <u>emergency services</u>) (ground and air)	Not Covered	
	Urgent care	\$30 <u>copay</u>	Not Covered	<u>Copay</u> applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 <u>copay</u> /admission, then no charge	Not Covered	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	No charge	Not Covered	

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	\$10 <u>copay</u> /visit (office visit)/\$100 <u>copay</u> (all other outpatient)	Not Covered	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
	Inpatient services	\$200 <u>copay</u> /admission	Not Covered	
If you are pregnant	Office visits	\$10 <u>copay</u> /visit	Not Covered	<u>Preauthorization</u> required for inpatient hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (c-section). If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby does not count toward the mother's expense; therefore, the family <u>deductible</u> amount may apply.
	Childbirth/delivery professional services	No additional charge	Not Covered	
	Childbirth/delivery facility services	\$200 <u>copay</u> /admission (hospital) \$100 copay – birthing center	Not Covered	
If you need help recovering or have other special health needs	Home health care	\$50 <u>copay</u> /visit	Not Covered	Pre-certification required. Failure to pre-certify may result in reduction of benefit or denial of claim. Maximum 200 visits/year, 4 hours equals one visit.
	Rehabilitation services	\$50 <u>copay</u> /visit (outpatient rehab) \$100 copay/admission (inpatient rehab)	Not Covered	Pre-certification required. Failure to pre-certify may result in reduction of benefit or denial of claim. Outpatient Maximum 26 visits combined per calendar year Inpatient Maximum 30 days inpatient per 36 months.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	Not covered	Not covered	Not covered
	Durable medical equipment	First \$1,500 in allowed	Not Covered	Pre-certification & medical necessity

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)	
		charges paid by Plan, between \$1,500 & \$11,500 is 100% participant <u>coinsurance</u> . DME charges over \$11,500 are 80% participant <u>coinsurance</u> .		required.
	Hospice services	Not covered	Not covered	Bereavement counseling is not covered.
If your child needs dental or eye care	Children's eye exam	Charges over \$50	Charges over \$50	<u>Plan</u> allows one exam/yr. up to \$50.00 <u>Plan</u> allows one pair of glasses/contacts per year up to \$100.00
	Children's glasses	Charges over \$100	Charges over \$100	<u>Plan</u> allows one exam/yr. up to \$50.00 <u>Plan</u> allows one pair of glasses/contacts per year up to \$100.00
	Children's dental check-up	Amount over <u>plan's</u> schedule allowance	Amount over <u>plan's</u> schedule allowance	Annual dental max \$1,800/person \$50/person annual <u>deductible</u> applies to non-preventive covered dental services www.aetna.com

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.)

- Acupuncture
- Bariatric surgery (unless medically necessary)
- Cosmetic surgery
- Habilitation services
- Immunizations age 26 years and older, except for a ACIP vaccine-specific recommendations
- Hospice services
- Infertility treatments
- Long-term care services
- Non-emergency care when traveling outside the USA
- Clinic visits through a hospital
- Private-duty nursing
- Skilled nursing care
- Weight loss programs
- Genetic testing and cell and gene therapy

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

- Chiropractic care (\$25 copay; 2 x-rays & \$1,250/person annual individual maximum)
- Hearing aids (up to \$850/member & \$350/dependent, every 24 months).
- Physical, speech, and occupational therapy
- Routine eye care (Adult) (\$50/exam & \$100 for lenses/frames/contacts per calendar year).
- Routine foot care (Podiatry services: \$1,250 annual

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

individual maximum) www.aetna.com	(26 combined visits/person per year. Precertification required.)	maximum/person/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 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 1-914-769-2440. 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 1-914-769-2440.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-378-1179.

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 copay	\$25
■ Hospital (facility) copay	\$200
■ Other copay	\$100

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:

Cost Sharing	
Deductibles	\$0
Copayments	\$905
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$965

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	\$25
■ Hospital (facility) copay	\$200
■ Other copay	\$100

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:

Cost Sharing	
Deductibles	\$0
Copayments	\$675
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$420
The total Joe would pay is	\$1,095

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copay	\$25
■ Hospital (facility) copay	\$200
■ Other copay	\$100

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:

Cost Sharing	
Deductibles	\$0
Copayments	\$325
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$325

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.