




**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 1-800-974-2873 or see [www.aetna.com](http://www.aetna.com). 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](http://www.dol.gov/ebsa/healthreform) or call 1-800-974-2873 to request a copy.

| Important Questions  | Answers   | Why This Matters:  |
|--|---|--|
| <b>What is the overall deductible?</b>                             | <p><u>In-Network providers</u>: \$750/individual or \$1,500/family</p> <p><u>Out-of-Network providers</u>: \$10,000/individual or \$20,000/family</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>   |
| <b>Are there services covered before you meet your deductible?</b> | <p>Yes. <u>In-Network preventive care</u>, office visits, <u>diagnostic tests</u>, imaging, <u>urgent care</u>, <u>home health care</u>, outpatient <u>hospice services</u>, outpatient <u>skilled nursing care</u> and <u>rehabilitation services</u>, and obesity treatment 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></p>   |
| <b>Are there other deductibles for specific services?</b>          | <p>Yes. \$50/individual or \$100/family for brand name <u>prescription drugs</u>. 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>  |
| <b>What is the out-of-pocket limit for this plan?</b>              | <p><u>In-Network providers</u>: \$5,350/individual or \$10,700/family</p> <p><u>Prescription drugs (In-Network)</u>: \$1,000/individual or \$2,000/family</p> <p><u>Out-of-Network providers</u>: No <u>out-of-pocket limit</u></p>   | <p>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.</p>  |
| <b>What is not included in the out-of-pocket limit?</b>            | <p><u>Premiums</u>, <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> for service and health care this <u>Plan</u> does not cover.</p>  | <p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>   |
| <b>Will you pay less if you use a network provider?</b>            | <p>Yes. See <a href="http://www.aetna.com">www.aetna.com</a> or call 1-800-370-4526 for a list of <u>In-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 charge</u> and what your <u>plan</u> 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.</p> |
| <b>Do you need a referral to see a specialist?</b>                 | <p>No.</p>  | <p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>   |

 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<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)    |  |
| <b>If you visit a health care provider's office or clinic</b>  | Primary care visit to treat an injury or illness | \$50 <u>copay</u> /visit. <u>Deductible</u> does not apply   | \$50 <u>copay</u> /visit, then 50% <u>coinsurance</u> | Acupuncture limited to 20 visits per calendar year.  |
|  | <u>Specialist</u> visit                          | \$50 <u>copay</u> /visit. <u>Deductible</u> does not apply   | \$65 <u>copay</u> /visit, then 50% <u>coinsurance</u> | None.  |
|  | <u>Preventive care/screening/immunization</u>    | No charge. <u>Deductible</u> does not apply.   | 50% <u>coinsurance</u>                                | Age and frequency limits apply. 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.  |
| <b>If you have a test</b>  | <u>Diagnostic test</u> (x-ray, blood work)       | No charge. <u>Deductible</u> does not apply.   | 50% <u>coinsurance</u>                                | None.  |
|  | Imaging (CT/PET scans, MRIs)                     | \$50 <u>copay</u> . <u>Deductible</u> does not apply.  | 50% <u>coinsurance</u>                                | None.  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> | Generic drugs                                    | Medical <u>deductible</u> does not apply<br>Retail (30 days): \$5 <u>copay</u> /script<br>Mail Order (90 days): \$10 <u>copay</u> /script  | Not covered   | No charge for generic ACA preventive medications, including certain over-the-counter drugs with a prescription and FDA-approved generic contraceptives (or brand name if a generic is medically inappropriate). Coverage for certain <u>prescription drugs</u> and related supplies requires your physician to obtain authorization prior to prescribing. <u>Preauthorization</u> may include, for example, a step therapy determination. Coverage for certain <u>specialty drugs</u> is available at no charge through <u>copay</u> assistance in the SaveonSP program; contact Fund Office to enroll.<br><br>*See the <u>Prescription drug</u> section of the SPD. |
|  | Formulary brand drugs                            | Medical <u>deductible</u> does not apply<br>Retail (30 days): \$45 <u>copay</u> /script after <u>prescription drug deductible</u><br>Mail Order (90 days): \$90 <u>copay</u> /script after <u>prescription drug deductible</u> | Not covered   |  |
|  | Non-Formulary brand drugs                        | Not covered  | Not covered   |  |
|  | <u>Specialty drugs</u>                           | Applicable <u>copay</u> above  | Not covered   |  |

\* For more information about limitations and exceptions, see the plan or policy document at [www.aetna.com](http://www.aetna.com) or call 1-800-974-2873.

| Common Medical Event                    | Services You May Need                          | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information  |
|---|--|--|--|---|
|   |  | Network Provider<br>(You will pay the least)                   | Out-of-Network Provider<br>(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>   | Failure to pre-certify <u>Out-of-Network</u> services will result in a 50% reduction of benefits.         |
|   | Physician/surgeon fees                         | 30% <u>coinsurance</u>   | 50% <u>coinsurance</u>   |   |
| If you need immediate medical attention | <u>Emergency room care</u>                     | \$200 <u>copay</u> /visit, then 30% <u>coinsurance</u>         | \$200 <u>copay</u> /visit, then 30% <u>coinsurance</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-emergency use of <u>emergency medical transportation</u> not covered.                                 |
|   | <u>Urgent care</u>                             | \$50 <u>copay</u> /visit. <u>Deductible</u> does not apply.    | \$50 <u>copay</u> /visit                                       | None.   |
| If you have a hospital stay             | Facility fee (e.g., hospital room)             | \$500 <u>copay</u> /per admission, then 30% <u>coinsurance</u> | \$500 <u>copay</u> /per admission, then 50% <u>coinsurance</u> | Failure to pre-certify <u>Out-of-Network</u> services will result in a 50% reduction of benefits.         |
|   | Physician/surgeon fees                         | 30% <u>coinsurance</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  |
|--|---|---|---|---|
|  |   | <u>Network Provider</u><br>(You will pay the least)   | <u>Out-of-Network Provider</u><br>(You will pay the most)   |   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | Office visit: \$50 <u>copay</u> /visit, <u>Deductible</u> does not apply; Other outpatient services: 30% <u>coinsurance</u> | Office visit: \$50 <u>copay</u> /visit, then 50% <u>coinsurance</u> ; Other outpatient services: 50% <u>coinsurance</u> | Failure to pre-certify <u>Out-of-Network</u> intensive outpatient and partial <u>hospitalization</u> services will result in a 50% reduction of benefits.   |
|  | Inpatient services                        | \$500 <u>copay</u> /per admission, then 30% <u>coinsurance</u>  | \$500 <u>copay</u> /per admission, then 50% <u>coinsurance</u>  | Failure to pre-certify <u>Out-of-Network</u> services will result in a 50% reduction of benefits.   |
| <b>If you are pregnant</b>   | Office visits                             | No charge. <u>Deductible</u> does not apply.  | 50% <u>coinsurance</u>  | None. <u>Cost sharing</u> does not apply for <u>In-Network preventive services</u> . Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. |
|  | Childbirth/delivery professional services | 30% <u>coinsurance</u>  | 50% <u>coinsurance</u>  | Pre-certification required for <u>Out-of-Network</u> stays that last longer than 48 hours for vaginal delivery or 96 hours for delivery by Cesarean section. Failure to pre-certify extended <u>Out-of-Network</u> stays will result in a 50% reduction of benefits.                                    |
|  | Childbirth/delivery facility services     | \$500 <u>copay</u> /per admission, then 30% <u>coinsurance</u>  | \$500 <u>copay</u> /per admission, then 50% <u>coinsurance</u>  |   |

\* For more information about limitations and exceptions, see the plan or policy document at [www.aetna.com](http://www.aetna.com) or call 1-800-974-2873.

| Common Medical Event  | Services You May Need            | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|---|----------------------------------|---|--|--|
|   |                                  | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)   |  |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>          | \$50 <u>copay</u> /visit, then 25% <u>coinsurance</u> . <u>Deductible</u> does not apply.   | \$50 <u>copay</u> /visit, then 25% <u>coinsurance</u>  | Limited to 120 visits per calendar year. Failure to pre-certify <u>Out-of-Network</u> services will result in a 50% reduction of benefits. |
|   | <u>Rehabilitation services</u>   | Outpatient: \$50 <u>copay</u> /visit. <u>Deductible</u> does not apply.   | Outpatient: \$50 <u>copay</u> /visit, then 50% <u>coinsurance</u>  | Occupational, physical and speech therapies combined limited to 60 visits per calendar year.   |
|   | <u>Habilitation services</u>     | 100% no deductible no copay   | 50% after deductible \$50 deductible per visit   | None.  |
|   | <u>Skilled nursing care</u>      | Inpatient: 30% <u>coinsurance</u> per admission;<br>Outpatient: \$50 <u>copay</u> /visit, then 25% <u>coinsurance</u> ;<br><u>Deductible</u> does not apply | Inpatient: 50% <u>coinsurance</u> per admission<br>Outpatient: \$50 <u>copay</u> /visit, then 25% <u>coinsurance</u> | Limited to 60 days per calendar year. Failure to pre-certify <u>Out-of-Network</u> services will result in a 50% reduction of benefits.    |
|   | <u>Durable medical equipment</u> | 30% <u>coinsurance</u>  | Not covered  | None.  |
|   | <u>Hospice services</u>          | Inpatient: 30% <u>coinsurance</u><br>Outpatient: \$50 <u>copay</u> /visit, then 25% <u>coinsurance</u> ;<br><u>Deductible</u> does not apply.               | Inpatient: 50% <u>coinsurance</u><br>Outpatient: \$50 <u>copay</u> /visit, then 25% <u>coinsurance</u>               | Failure to pre-certify <u>Out-of-Network</u> services will result in a 50% reduction of benefits.  |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam              | Not covered   | Not covered  | You must pay 100% of these expenses, even <u>In-Network</u> .  |
|   | Children's glasses               | Not covered   | Not covered  | You must pay 100% of these expenses, even <u>In-Network</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 plan or policy document at [www.aetna.com](http://www.aetna.com) or call 1-800-974-2873.

## 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                     | • Hearing aids                                       | • Routine eye care (Adult)   |
| • Dental Care (Adult & Child)          | • Long-term care                                     | • Routine foot care  |
| • Eye exam and Glasses (Adult & Child) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs (except as required by the Affordable Care Act) |
| • <u>Habilitation services</u>         | • Private-duty nursing                               |  |

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

- |  |                     |                         |
|--|---------------------|-------------------------|
| • Acupuncture (Limited to 20 visits/calendar year) | • Bariatric surgery | • Infertility treatment |
|  | • Chiropractic care |                         |

**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](http://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](http://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 1-800-974-2873. 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](http://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 1-800-974-2873.

————— *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 <u>deductible</u>   | \$750 |
| ■ <u>Specialist Co-payment</u>           | \$50  |
| ■ <u>Hospital (facility) coinsurance</u> | 30%   |
| ■ <u>Other 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <u>Deductibles*</u>               | \$760          |
| <u>Copayments</u>                 | \$600          |
| <u>Coinsurance</u>                | \$2,630        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,050</b> |

### Managing Joe's Type 2 Diabetes

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

|  |       |
|--|-------|
| ■ The plan's overall <u>deductible</u>   | \$750 |
| ■ <u>Specialist Co-payment</u>           | \$50  |
| ■ <u>Hospital (facility) coinsurance</u> | 30%   |
| ■ <u>Other 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$80           |
| <u>Copayments</u>                 | \$1,420        |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$30           |
| <b>The total Joe would pay is</b> | <b>\$1,500</b> |

### Mia's Simple Fracture

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

|  |       |
|--|-------|
| ■ The plan's overall <u>deductible</u>   | \$750 |
| ■ <u>Specialist Co-payment</u>           | \$50  |
| ■ <u>Hospital (facility) coinsurance</u> | 30%   |
| ■ <u>Other 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <u>Deductibles*</u>               | \$760          |
| <u>Copayments</u>                 | \$590          |
| <u>Coinsurance</u>                | \$110          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,460</b> |

\*NOTE: This plan has other deductibles for specific services included in this coverage example.

See "Are there other deductibles for specific services?" row above.

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