**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 1-888-490-8800. 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 1-888-490-8800 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$200**/individual, **$300** (aggregate) maximum/family in-network.<br>**$300**/individual, **$700** (aggregate) maximum/family out-of-network. | Generally, you must pay all 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 the deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | **Yes**, Hospitalization charges and preventive care 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?** | **Medical: $1,500**/individual; **$3,000**/family.<br>**Prescription: $5,850**/individual; **$11,700**/family. | The out-of-pocket limit is the most you could pay in a year for covered in-network 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, health care this plan does not cover, vision, prescription drugs, penalties for failure to obtain pre-admission, and out-of-network coverage. | 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.** Go to www.aetna.com or call 1-888-490-8800 for a list of participating 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 in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. |

| | | |
|---|---|---|
| **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 | $15 copay/visit | 25% coinsurance | None |
| | Specialist visit | $15 copay/visit | 25% coinsurance | None |
| | Preventive care/screening/ Immunization | $0 (no charge) | 25% coinsurance | 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) | 0% coinsurance | 25% coinsurance | When required by law, out-of-network diagnostic tests will be treated as in-network. |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance | 25% coinsurance | When required by law, out-of-network imaging will be treated as in-network. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.envisionrx.com | Generic drugs | 20% coinsurance retail 10% coinsurance MO | 20% coinsurance retail 10% coinsurance MO plus balance billing. | Retail limitation – 30-day supply Mail Order (MO) limitation – 90-day supply<br><br>Medications available "over the counter" including non-sedating antihistamines (NSAs) and proton pump inhibitors (PPIs) are not covered.<br>If a brand name drug is purchased and a generic is available, you will pay the difference in cost between the brand and generic **plus** the generic copay. |
| | Preferred brand drugs | 20% coinsurance retail 10% coinsurance MO | 20% coinsurance retail 10% coinsurance MO plus balance billing. | |
| | Non-preferred brand drugs | 20% coinsurance retail 10% coinsurance MO | 20% coinsurance retail 10% coinsurance MO plus balance billing. | |
| | Specialty drugs | 20% coinsurance retail 10% coinsurance MO | 20% coinsurance retail 10% coinsurance MO plus balance billing. | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $100 copay* 0% coinsurance | 50% coinsurance | * copay waived if admitted to an in-network provider.<br>Limited to 50% of Usual & Customary charge for the procedure performed. |
| | Physician/surgeon fees | $15 copay/visit | 25% coinsurance | When required by law, out-of-network physician/surgeon fees will be treated as in-network. |

| 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 immediate medical attention** | Emergency room care | $100 copay<br>0% coinsurance | 25% coinsurance<br>(*deductible does not apply).* | When required by law, out-of-network emergency room care will be treated as in-network. Benefits are not provided for medical expenses resulting from participation in inherently dangerous or ultra-hazardous activities. Examples are base jumping, water skiing, bungee jumping, riding on all-terrain vehicle as a passenger or driver, motor cross, etc.<br><br>Ambulance services must be by a licensed air or ground ambulance. Service covered from the place of injury or medical incident to the nearest hospital where treatment can be given.<br><br>Out-of-network Air Ambulance: 0% coinsurance |
| | Emergency medical transportation | 0% coinsurance<br>(*deductible does not apply).* | 25% coinsurance<br>(*deductible does not apply).* | |
| | Urgent care | $15 copay/visit | 25% coinsurance | When required by law, out-of-network emergency services provided at urgent care facilities licensed in the state to provide emergency care will be treated as in-network. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% coinsurance<br>(*deductible does not apply).* | 25% coinsurance | Limited to 120 days per confinement. Private duty nursing is not covered.<br><br>All hospital admissions are to be certified in advance of the proposed confinement by **Aetna** at 1-888-632-3862.<br><br>Room and board expenses are limited to the hospital's average semiprivate room rate. |
| | Physician/surgeon fees | $15 copay/visit | 25% coinsurance | When required by law, out-of-network physician/surgeon fees will be treated as in-network. |

| 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 | $15 copay/visit | 25% coinsurance | None |
| | Inpatient services | $15 copay/visit | 25% coinsurance | All hospital admissions are to be certified in advance of the proposed confinement by **Aetna** at 1-888-632-3862. |
| **If you are pregnant** | Office visits | $15 copay/visit | 25% coinsurance | Maternity care may include tests and other services described elsewhere in the SBC (i.e. ultrasound)<br><br>Room and board expenses are limited to the hospital's average semiprivate room rate. |
| | Childbirth/delivery professional services | $15 copay/visit | 25% coinsurance | |
| | Childbirth/delivery facility services | 0% coinsurance (*deductible does not apply).* | 25% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | $15 copay/visit | Not Covered | None |
| | Rehabilitation services | $15 copay/visit | 25% coinsurance | Physical & Occupational Therapy limited to 20 visits per person, per calendar year. |
| | Habilitation services | $15 copay/visit | 25% coinsurance | Physical & Occupational Therapy limited to 20 visits per person, per calendar year. |
| | Skilled nursing care | $15 copay/visit | 25% coinsurance | None |
| | Durable medical equipment | $15 copay/visit | 25% coinsurance | Rental or purchase whichever is less.<br>Must be medically necessary. |
| | Hospice services | 0% coinsurance | Not covered | Limited to 90 days (aggregate) |
| **If your child needs dental or eye care** | Children's eye exam | Plan pays up to $30 | Plan pays up to $30 | Routine exams limited to once every 12 months. Benefits subject to standard medical protocols and reasonable and customary limitations. |
| | Children's glasses | Plan pays up to $270 | Plan pays up to $270 | Lenses limited to once every 12 months for clear glass or plastic lenses in any single vision, bifocal, trifocal, or lenticular prescription. No coverage for tinting or coating or other special lens treatment.<br><br>Frames limited to once every 24 months for standard or basic frame. No coverage for Fashion, Designer, or Premier frames. Benefits |

| 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) | |
| | | | | subject to standard medical protocols and reasonable and customary limitations. |
| | Children's dental check-up | By Fee Schedule | By Fee Schedule | Maximum of two exams per calendar year. |

**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 (with limited exceptions)
- Acupuncture
- Cosmetic Surgery
- Infertility treatment
- Non-Emergency Care when traveling outside the US
- Non-network hospice services
- Long-Term Care
- Private Duty Nursing
- Routine Foot Care (except for diabetes)
- Weight Loss Programs
- Certain Compound medications

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

- Bariatric surgery (for morbid obesity only; pre-certification is required)
- Chiropractic (limited to 20 visits per year)
- Dental Care (Adult)
- Hearing Aids (50%; in-network only)
- Behavioral Health/Substance Abuse Treatment
- Routine Eye Care (Adult) (limited to $300 per person per 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: U.S. Department of Labor, Employee Benefits Security Administration, 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 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 U.S. Department of Labor, Employee Benefits Security Administration, 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**
**Questions:** Call **1-888-490-8800**.
For more information about limitations and exceptions, see the plan or policy document at **www.ourbenefitoffice.com/teamsters966benefits/Benefits**.

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 1-888-490-8800.

*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 | $200 |
| Specialist copay | $15 |
| Hospital (facility) coinsurance | 0% |
| Other *(blood work)* | 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** | **$13,523** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $200 |
| Copayments | $285 |
| Coinsurance | $7 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$552** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $200 |
| Specialist copay | $15 |
| Hospital (facility) coinsurance | 0% |
| Other *(blood work)* | 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** | **$9,223** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $200 |
| Copayments | $660 |
| Coinsurance | $852 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$1,767** |

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

| | |
|---|---|
| The plan's overall deductible | $200 |
| Specialist copay | $15 |
| Hospital (facility) coinsurance | 0% |
| Other (x-ray) coinsurance | 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** | **$2,453** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $200 |
| Copayments | $265 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$465** |

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