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?	**$400**/individual, **$600** (aggregate) maximum/family in-network. **$600**/individual, **$1400** (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 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: $1,750**/individual; **$3,500**/family. **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 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 in-network doctor or hospital may 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	25% coinsurance	None
	Specialist visit	$25 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)	$15 copay/visit	25% coinsurance	When required by law, out-of-network diagnostic tests will be treated as in-network.
	Imaging (CT/PET scans, MRIs)	$15 copay/visit	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.caremark.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 Medications available "over the counter" including non-sedating antihistamines (NSAs) and proton pump inhibitors (PPIs) are not covered. 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. Limited to 50% of Usual & Customary charge for the procedure performed.

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	$25 copay/visit	25% coinsurance	When required by law, out-of-network physician/surgeon fees will be treated as in-network.
If you need immediate medical attention	Emergency room care	$100 copay 0% coinsurance	25% coinsurance (*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. 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. Out-of-network Air Ambulance: 0% coinsurance
	Emergency medical transportation	$15 copay/visit (*deductible does not apply*)	25% coinsurance (*deductible does not apply*)	
	Urgent care	$25 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)	$15 copay/visit (*deductible does not apply*)	25% coinsurance	Limited to 120 days per confinement. Private duty nursing is not covered. All hospital admissions are to be certified in advance of the proposed confinement by **Aetna** at 1-888-632-3862. Room and board expenses are limited to the hospital's average semiprivate room rate.

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	$25 copay/visit	25% coinsurance	When required by law, out-of-network physician/surgeon fees will be treated as in-network.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit (deductible does not apply)	75% coinsurance (*deductible applies*)	None
	Inpatient services	$25 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	$25 copay/visit	25% coinsurance	Maternity care may include tests and other services described elsewhere in the SBC (i.e., ultrasound) Room and board expenses are limited to the hospital's average semiprivate room rate.
	Childbirth/delivery professional services	$25 copay/visit	25% coinsurance	
	Childbirth/delivery facility services	$15 copay/visit (*deductible does not apply)*	25% coinsurance (*deductible applies*)	
If you need help recovering or have other special health needs	Home health care	$25 copay/visit	Not Covered	None
	Rehabilitation services	$15 copay/visit (*deductible does not apply)*	75% coinsurance (*deductible applies*)	Physical & Occupational Therapy limited to 20 visits per person, per calendar year.
	Habilitation services	$15 copay/visit (*deductible does not apply)*	75% coinsurance (*deductible applies*)	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. Must be medically necessary.
	Hospice services	$15 copay/visit	Not covered	Limited to 90 days (lifetime 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.

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)	
	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. Frames limited to once every 24 months for standard or basic frame. No coverage for Fashion, Designer, or Premier frames. Benefits 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.)

- Acupuncture
- Certain Compound medications
- Cosmetic Surgery (with limited exceptions)
- Infertility treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Non-network hospice services
- Private-duty Nursing
- Routine Foot Care (except for diabetes)
- Weight Loss Programs

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)
- Behavioral Health/Substance Abuse Treatment
- Chiropractic care (limited to 20 visits per year)
- Dental Care (Adult)
- Hearing Aids (50% coinsurance; in-network only)
- 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.

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**.

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 1-888-490-8800.

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** $400
- **Specialist copayment** $25
- **Hospital (facility) copayment** $15
- **Other *(blood work)* copayment** $15

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	**$12,368**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$400
Copayments	$225
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$685**

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

- **The plan's overall deductible** $400
- **Specialist copayment** $25
- **Hospital (facility) copayment** $15
- **Other *(blood work)* copayment** $15

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	**$5,823**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$400
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,300**

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

- **The plan's overall deductible** $400
- **Specialist copayment** $25
- **Hospital (facility) copayment** $15
- **Other (*x-ray*) copayment** $15

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	$400
Copayments	$140
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$540**

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