



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](http://www.healthcare.gov/sbc-glossary) or call 1-888-490-8800 to request a copy.

Important Questions	Answers	Why This Matters:
<a href="#">What is the overall deductible?</a>	<a href="#">\$200/individual, \$300 (aggregate) maximum/family <u>in-network</u>.</a> <a href="#">\$300/individual, \$700 (aggregate) maximum/family <u>out-of-network</u>.</a>	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of the <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<a href="#">Are there services covered before you meet your <u>deductible</u>?</a>	<a href="#">Yes</a> , Hospitalization charges and preventive care are covered before you meet your deductible.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<a href="#">Are there other <u>deductibles</u> for specific services?</a>	<a href="#">No</a> .	You don't have to meet <a href="#">deductibles</a> for specific services.
<a href="#">What is the <u>out-of-pocket limit</u> for this <a href="#">plan</a>?</a>	<a href="#">Medical: \$1,500/individual; \$3,000/family.</a> <a href="#">Prescription: \$5,850/individual; \$11,700/family.</a>	The <a href="#">out-of-pocket</a> limit is the most you could pay in a year for covered in-network services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<a href="#">What is not included in the <u>out-of-pocket limit</u>?</a>	<a href="#">Premiums</a> , <a href="#">balance billing</a> , health care this <a href="#">plan</a> does not cover, vision, prescription drugs, penalties for failure to obtain pre-admission, and <a href="#">out-of-network</a> coverage.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<a href="#">Will you pay less if you use a <u>network provider</u>?</a>	<a href="#">Yes</a> . Go to <a href="http://www.aetna.com">www.aetna.com</a> or call 1-888-490-8800 for a list of participating providers.	This <a href="#">plan</a> uses a <a href="#">provider</a> network. You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge

		and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>in-network</u> doctor or hospital may use an <u>out-of-network provider</u> for some services. Plans use the term <u>in-network, preferred</u> , or participating for <u>providers</u> in their <u>network</u> .
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 copay/visit	25% coinsurance	None
	<u>Specialist</u> visit	\$15 copay/visit	25% coinsurance	None
	<u>Preventive care/screening/</u> 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	<u>Diagnostic test</u> (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 <u>prescription drug coverage</u> is available at <a href="http://www.envisionrx.com">www.envisionrx.com</a>	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
	Preferred brand drugs	20% coinsurance retail 10% coinsurance MO	20% coinsurance retail 10% coinsurance MO plus balance billing.	Medications available "over the counter" including non-sedating antihistamines (NSAs) and proton pump inhibitors (PPIs) are not covered.
	Non-preferred brand drugs	20% coinsurance retail 10% coinsurance MO	20% coinsurance retail 10% coinsurance MO plus balance billing.	If a brand name drug is purchased and a generic is available, you will pay the difference in cost between the brand and generic <b>plus</b> the generic copay.
	<u>Specialty drugs</u>	20% coinsurance retail 10% coinsurance MO	20% coinsurance retail 10% coinsurance MO plus balance billing.	
If you have outpatient	Facility fee (e.g., ambulatory	\$100 copay*	50% coinsurance	* copay waived if admitted to an in-network

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](http://www.ourbenefitoffice.com/teamsters966benefits/Benefits).

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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)	
surgery	surgery center)	0% coinsurance		provider. 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.
If you need immediate medical attention	<u>Emergency room care</u>	\$100 copay 0% coinsurance	25% coinsurance ( <i>deductible does not apply</i> ).	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.
	<u>Emergency medical transportation</u>	0% coinsurance ( <i>deductible does not apply</i> ).	25% coinsurance ( <i>deductible does not apply</i> ).	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
	<u>Urgent care</u>	\$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 ( <i>deductible does not apply</i> ).	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 <b>Aetna</b> at 1-888-632-3862.

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](http://www.ourbenefitoffice.com/teamsters966benefits/Benefits).

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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)	
				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.
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)
	Childbirth/delivery professional services	\$15 copay/visit	25% coinsurance	
	Childbirth/delivery facility services	0% coinsurance <i>(deductible does not apply).</i>	25% coinsurance	Room and board expenses are limited to the hospital's average semiprivate room rate.
If you need help recovering or have other special health needs	<u>Home health care</u>	\$15 copay/visit	Not Covered	None
	<u>Rehabilitation services</u>	\$15 copay/visit	25% coinsurance	Physical & Occupational Therapy limited to 20 visits per person, per calendar year.
	<u>Habilitation services</u>	\$15 copay/visit	25% coinsurance	Physical & Occupational Therapy limited to 20 visits per person, per calendar year.
	<u>Skilled nursing care</u>	\$15 copay/visit	25% coinsurance	None
	<u>Durable medical equipment</u>	\$15 copay/visit	25% coinsurance	Rental or purchase whichever is less. Must be medically necessary.
	<u>Hospice services</u>	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.

Questions: Call 1-888-490-8800.

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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.
	Children's dental check-up	By Fee Schedule	By Fee Schedule	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.

### 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.)

<ul style="list-style-type: none"> <li>• Cosmetic Surgery (with limited exceptions)</li> <li>• Acupuncture</li> <li>• Cosmetic Surgery</li> <li>• Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Non-Emergency Care when traveling outside the US</li> <li>• Non-network hospice services</li> <li>• Long-Term Care</li> </ul>	<ul style="list-style-type: none"> <li>• Private Duty Nursing</li> <li>• Routine Foot Care (except for diabetes)</li> <li>• Weight Loss Programs</li> <li>• Certain Compound medications</li> </ul>
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#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

<ul style="list-style-type: none"> <li>• Bariatric surgery (for morbid obesity only; pre-certification is required)</li> <li>• Chiropractic (limited to 20 visits per year)</li> <li>• Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing Aids (50%; in-network only)</li> <li>• Behavioral Health/Substance Abuse Treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Eye Care (Adult) (limited to \$300 per person per calendar year)</li> </ul>
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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: U.S. Department of Labor, Employee Benefits Security Administration, 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage

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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 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](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 1-888-490-8800.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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**Questions: Call 1-888-490-8800.**

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$200
■ <a href="#">Specialist copay</a>	\$15
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other ( <i>blood work</i> )	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*)

<b>Total Example Cost</b>	<b>\$13,523</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$285
Coinsurance	\$7
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$552</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$200
■ <a href="#">Specialist copay</a>	\$15
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other ( <i>blood work</i> )	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*)

<b>Total Example Cost</b>	<b>\$9,223</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$660
Coinsurance	\$852
What isn't covered	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,767</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$200
■ <a href="#">Specialist copay</a>	\$15
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other (x-ray) <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,453</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$265
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$465</b>

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

