Iron Workers' Locals No. 15&424 EB Fund:Aetna Choice® POS II Coverage Period: 07/01/2015 – 06/30/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual & Family | **Plan Type:** POS/2

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.HealthReformPlanSBC.com** or by calling **1-866-658-2455**. You can also contact the Fund Office for eligibility and other questions by calling **(203) 238-1204** or **1-800-982-3709** (toll free).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: Individual **$0**/Family **$0;** Out-of-network: Individual **$200**/Family **$400**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, In-network: Individual **$2,000**/ Family **$4,000;** Out-of-network: Individual **$3,000**/Family **$6,000**.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, expenses that are reimbursed at less the Plan rate coinsurance, penalties for failure to obtain pre-authorization for services and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network **providers,** see www.aetna.com or call 1-888-982-3862.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. 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**. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist.**	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services.**

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit*	20% coinsurance of first $5,000 and after that no charge.	----------None----------
	Specialist visit	$20 copay per visit*	20% coinsurance of first $5,000 and after that no charge.	----------None----------
	Other practitioner office visit	$20 copay per visit*	20% coinsurance of first $5,000 and after that no charge.	Coverage is limited to 35 visits per calendar year for Chiropractic care.
	Preventive care/ screening/immunization	No charge	20% coinsurance of first $5,000 and after that no charge.	Age and frequency schedules may apply.
If you have a test	Diagnostic tests)	$20 copay per visit*	20% coinsurance of first $5,000 and after that no charge.	----------None----------
	Imaging (CT/PET scans, MRIs)	$20 copay per visit*	20% coinsurance of first $5,000 and after that no charge.	----------None----------

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families	Generic drugs	$10 copay/ prescription (retail), $20 copay/ prescription (mail order)	$10 copay/ prescription (retail)	Covers up to 30-day supply (retail); 31-90 day supply (mail order). Viagra and related drugs are limited to 10 tablets per month. Mandatory generic with Dispense as Written (DAW) override. If brand requested when generic available and doctor has not specified that the brand is Medically Necessary, then you pay the brand co-pay PLUS the difference in drug cost. No charge for formulary generic FDA-approved women's contraceptives in-network.
	Preferred brand drugs	$25 copay/ prescription (retail), $50 copay/ prescription (mail order)	$25 copay/ prescription (retail)	
	Non-preferred brand drugs	$40 copay/ prescription (retail), $80 copay/ prescription (mail order)	$40 copay/ prescription (retail)	
	Specialty drugs	$40 copay/ prescription (retail), $80 copay/ prescription (mail order)	$40 copay/ prescription (retail)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance of first $5,000 and after that no charge.	----------None----------
	Physician/surgeon fees	No charge	20% coinsurance of first $5,000 and after that no charge.	----------None----------
If you need immediate medical attention	Emergency room services	$100 copay per visit *	$100 copay per visit	Copay waived if admitted.
	Emergency medical transportation	No charge	20% coinsurance of first $5,000 and after that no charge.	----------None----------
	Urgent care	$20 copay per visit for urgent and non-urgent care*	20% coinsurance of first $5,000 and after that no charge.	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay per admission*	20% coinsurance of first $5,000 and after that no charge.	Pre-certification required for out-of-network care.
	Physician/surgeon fee	No charge	20% coinsurance of first $5,000 and after that no charge.	----------None----------

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay per visit*	20% coinsurance of first $5,000 and after that no charge.	----------None----------
	Mental/Behavioral health inpatient services	$200 copay per admission*	20% coinsurance of first $5,000 and after that no charge.	Pre-certification required for out-of-network care.
	Substance use disorder outpatient services	$20 copay per visit*	20% coinsurance of first $5,000 and after that no charge.	----------None----------
	Substance use disorder inpatient services	$200 copay per admission*	20% coinsurance of first $5,000 and after that no charge.	Pre-certification required for out-of-network care.
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance of first $5,000 and after that no charge.	No coverage for dependent children unless the Active or Retired Member is a legal resident of MA or the dependent child is covered under COBRA on an *individual* basis in the Plan.
	Delivery and all inpatient services	$200 copay per admission*	20% coinsurance of first $5,000 and after that no charge.	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance of first $5,000 and after that no charge.	Coverage is limited to 80 visits per calendar year. Pre-certification required for out-of-network care.
	Rehabilitation services	$20 copay per visit*	20% coinsurance of first $5,000 and after that no charge.	Coverage is limited to 60 visits for Speech, Physical and Occupational Therapy combined.
	Habilitation services	Not covered	Not covered	You must pay 100% of these costs.
	Skilled nursing care	$200 inpatient copay*	20% coinsurance of first $5,000 and after that no charge.	Coverage is limited to 60 days per calendar year. Pre-certification required for out-of-network care.
	Durable medical equipment	No charge	20% coinsurance of first $5,000 and after that no charge.	----------None----------
	Hospice service	No charge	20% coinsurance of first $5,000 and after that no charge.	Lifetime maximum of 90 days. Pre-certification required for out-of-network care.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam (provided through Davis Vision; (800) 999-5431 or www.davisvision.com)	No charge	Anything over $50 per exam.	Coverage is provided under Active program only and is limited to 1 routine vision exam every 24 months.
	Glasses (also provided through Davis Vision)	No charge if from Davis Vision selection, but there may be additional charges for optional frames, lens types and coatings.	Anything over $45 for frames or over $45 for single vision lenses.	Coverage is provided under Active program only and is limited to 1 pair of glasses every 24 months. Different dollar limits apply to other out-of-network lenses and contacts.
	Dental check-up (provided through Delta Dental; (800) 452-9310 or www.deltadental.com)	No charge	Any balance billing.	Coverage is provided under Active program only and is limited to 2 exams every calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care – limited to 35 visits per calendar year
- Dental Care (Adult-age 19 and older); Active program only
- Hearing aids - Active program only; provided through UConn Speech & Hearing and certain limitations apply
- Infertility treatment – certain limitations apply
- Private-duty nursing – Coverage is limited to 200 8-hour shifts per calendar year.
- Routine eye care (Adult-age 19 and older); Active Program only – Coverage is limited to 1 routine vision exam every 24 months.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the Fund Office at (203) 238-1204 or 1-800-982-3709 (toll free) or Aetna at 1-866-658-2455. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Aetna at 1-866-658-2455, the Fund Office at (203) 238-1204 or 1-800-982-3709 (toll free), the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file an **appeal**. Contact information is at http://www.aetna.com/individuals-families-health-insurance/member-guidelines/complaints-grievances-appeals.html.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-658-2455.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-658-2455.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-658-2455.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-658-2455.

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

Coverage Examples

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,110
- **Patient pays:** $430

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$280
Co-insurance	$0
Limits or exclusions	$150
Total	**$430**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,700
- **Patient pays:** $700

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$620
Co-insurance	$0
Limits or exclusions	$80
Total	**$700**

Coverage Examples

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.