The Summary of Benefits and Coverage (SBC) document will help you understand the benefits of the United Teamster Fund, which is referred to here as the plan. The SBC shows you how you and the plan will 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, go to www.utfonline.com or call (718) 859-1624, (718) 842-1212 or (732) 882-1901. 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 https://www.healthcare.gov/sbc-glossary or call the United Teamster Fund for more information at (718) 859-1624, (718) 842-1212 or (732) 882-1901.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For participating **providers**: $250 person / $500 family For non-participating **providers**: $3,000 person / $6,000 family	Generally, you must pay all of 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. For participating **providers: Preventive care, rehabilitation services, emergency care** (all **providers**), **diagnostic tests**, imaging, inpatient/outpatient facility, inpatient/ outpatient physician fees, **urgent care**, maternity services, **skilled nursing care**, and office visits 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?	For participating **providers**: $3,000 person / $6,000 family For non-participating **providers**: $13,000 person / $26,000 family	The **out-of-pocket limit** is the most you could pay in a year for covered 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** charges, copayments and health care this **plan** doesn't cover.	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. See **www.aetna.com/**docfind/custom/mymeritain or call **(800) 343-3140** 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 **network provider** might 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.**

When you go to a non-participating provider, the amount the plan will pay, and the amount of your coinsurance is based on, the maximum reimbursable charge or "MRC". The MRC is: (1) in the case of a claim for services for which preauthorization was not obtained, 150% of the amount which Medicare would pay the provider, or if the services are rendered in a hospital emergency room, the greater of 110% of the amount which Medicare would pay the provider or the Meritain Health contracted rate, or (2) in all other cases, 110% of the amount which Medicare would pay the provider.

At a non-participating provider, you may have to pay, in addition to the coinsurance, the excess of the service provider's charge over the MRC.

For more information about limitations and exceptions on benefits, see the plan's document – its Summary Plan Description at **www.utfonline.com**

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
		Participating Provider (You will pay the least)	Non-Participating 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 **copayment**/visit (office visit & lab) $50 **copayment**/ visit (x-rays) / No Charge (office surgery)	40% **coinsurance** of the MRC*	Out-of-network benefit is subject to yearly out-of-network deductible.
	Specialist visit	$25 **copayment**/visit (office visit & lab)/$50 **copayment**/ visit (x-rays) / No Charge (office surgery)	40% **coinsurance** of the MRC*	
	Preventive care/screening/ immunization	No Charge	40% **coinsurance** of the MRC (**preventive care** through age 5, well woman care & immunizations) / Not Covered (all other **preventive care**)*	You may have to pay for services that aren't **preventive**. Ask your **provider** if the services you need are **preventive.** Then check what your **plan** will pay for.
If you have a test	**Diagnostic test** (x-ray, blood work)	No Charge (lab)/$50 **copayment**/visit (x-ray)	40% **coinsurance** of the MRC*	Out-of-network benefit is subject to yearly out-of-network deductible.
	Imaging (CT/PET scans, MRIs)	$50 **copayment**/visit	40% **coinsurance** of the MRC*	Out-of-network benefit is subject to yearly out-of-network deductible.
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.optumrx.com**	Generic drugs	$25 **copayment**	Not Covered	----------none----------
	Brand name drugs – no generic available	$25 **copayment**	Not Covered	----------none----------
	Brand name drugs – generic available	$25 **copayment**, plus difference in cost	Not Covered	----------none----------
	Injectable medications	$50 **copayment**	Not Covered	----------none----------

* At a non-participating provider, you may have to pay, in addition to the coinsurance, the excess of the service provider's charge over the MRC.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 **copayment** per/occurrence	40% **coinsurance** of the MRC*.	**Preauthorization** required. Out-of-network benefit is subject to yearly out-of-network deductible.
	Physician/surgeon fees	No Charge	40% **coinsurance** of the MRC*	
If you need immediate medical attention	**Emergency room care**	$100 **copayment**/visit (**emergency services**)/Not Covered (non-**emergency services**)	$100 **copayment**/visit (**emergency services**)/ Not Covered (non-**emergency services**)	Non-participating **providers** paid at the participating **provider** level of benefits for **emergency services**. **Copayment** is waived if admitted to the hospital. No deductible applicable
	Emergency medical transportation	20% **coinsurance** (**emergency services**) / Not Covered (non-**emergency services**)/$250 deductible	20% **coinsurance** (**emergency services**) / Not Covered (non-**emergency services**)/$250 deductible*	Non-participating **providers** paid at the participating **provider** level of benefits for **emergency services**.
	Urgent care	$25 **copayment**/visit	40% **coinsurance** of the MRC*	**Copayment** applies per visit regardless of what services are rendered. Copay waived if admitted. Out-of-network benefit is subject to yearly out-of-network deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 **copayment**/per day up to maximum $500 **copayment**/ year	40% **coinsurance** of the MRC*	**Pre-certification** required. Out-of-network benefit is subject to yearly out-of-network **deductible**, except for anesthesiologist fees. **Deductible** is waived for anesthesiologist fees.
	Physician/surgeon fees	No Charge	20% **coinsurance** of the MRC for anesthesiologist fees; 40% **coinsurance** of the MRC for other physician/surgeon fees*.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Covered under separate mental health, behavioral health, substance abuse services program offered through the Fund Office and D.J. O'Grady Consultants*.		Contact the Fund Office for more information regarding mental health, behavioral health or substance abuse benefits.
	Inpatient services			

* At a non-participating provider, you may have to pay, in addition to the coinsurance, the excess of the service provider's charge over the MRC.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you are pregnant	Office visits	No Charge ($25 **copayment** for initial visit)	40% **coinsurance** of the MRC*	
	Childbirth/delivery professional services	No Charge	40% **coinsurance** of the MRC*	Out-of-network benefit is subject to yearly out-of-network deductible, except for anesthesiologist fees. **Deductible** is waived for anesthesiologist fees
	Childbirth/delivery facility services	$100 **copayment**/per day up to maximum $500 **copayment**/ year	20% **coinsurance** of the MRC for anesthesiologist fees; 40% **coinsurance** of the MRC for other physician/surgeon fees*	**Preauthorization** required for maternity stay in excess of days otherwise allowed. Depending on the type of service a **copayment**, **coinsurance,** or **deductible** may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby counts towards the mother's expense.
If you need help recovering or have other special health needs	**Home health care**	20% **coinsurance**	40% coinsurance of the MRC*	Limited to 40 visits per year and 16 hours per day. **Preauthorization** required. In-network benefit is subject to yearly in-network deductible. Out-of-network benefit is subject to yearly out-of-network deductible.
	Rehabilitation services	$100 **copayment**/day up to maximum $500 **copayment**/ year (inpatient) / $25 **copayment** / visit (outpatient)	40% coinsurance of the MRC*	Out-of-network benefit is subject to yearly out-of-network deductible. Physical, speech, occupational, cognitive, pulmonary therapy & cardiac rehab are limited to a combined maximum of 60 visits per year. **Preauthorization** required. If you don't get **preauthorization,** benefits could be reduced by the total cost of the service.
	Habilitation services	Not Covered	Not Covered	

* At a non-participating provider, you may have to pay, in addition to the coinsurance, the excess of the service provider's charge over the MRC.

	Skilled nursing care	$100 **copayment**/day up to maximum $500 **copayment**/ year	40% **coinsurance** of the MRC*	Limited to 60 days per year for inpatient services. **Preauthorization** required. If you don't get **preauthorization,** benefits could be reduced by the total cost of the service. Out-of-network benefit is subject to yearly out-of-network deductible. $100 copay is subject to $500 Out-of-Pocket max per year.
	Durable medical equipment	20% **coinsurance**	40% **coinsurance** of the MRC*	**Preauthorization** required for any item in excess of $500. In-network benefit is subject to yearly in-network deductible. Out-of-network benefit is subject to yearly out-of-network deductible.
	Hospice services	20% **coinsurance**	40% **coinsurance** of the MRC*	Bereavement counseling is covered. **Preauthorization** required. If you don't get **preauthorization**, benefits could be reduced by the total cost of the service. In-network benefit is subject to yearly in-network deductible. Out-of-network benefit is subject to yearly out-of-network deductible.
If your child needs dental or eye care	Eye exam	Costs over $15	Costs over $15	Maximum one exam per year. **This benefit is covered through Healthplex.**
	Glasses	Costs over $65	Costs over $65	Maximum one pair of glasses per year. **This benefit is covered through Healthplex.**
	Dental check-up	$0	Not covered.	$2,000 annual maximum. $1,650 lifetime maximum for orthodontia. **This benefit is covered through Dentcare.**

* At a non-participating provider, you may have to pay, in addition to the coinsurance, the excess of the service provider's charge over the MRC.

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
- Ambulance transportation for non-emergency services
- Cosmetic surgery
- Emergency room services for a non-emergency services
- Habilitation services Infertility treatment
- Infertility treatments
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (except for home health care & hospice)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)

- Bariatric surgery (for treatment of morbid obesity only)
- Chiropractic care
- Dental care
- Glasses
- Hearing aids
- Mental health disorders
- Routine eye care
- Routine foot care
- Substance use disorders

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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa/healthreform or United Teamster Fund at (718) 859-1624. 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 at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa /healthreform or United Teamster Fund at (718) 859-1624.

Additionally, a consumer assistance program can help you file your **appeal.** Contact the Community Service Society of New York, Community Health Advocates at (888) 614-5400.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-378-1179.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-378-1179.

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

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**	$250
Primary care physician **copayment**	$25
Hospital (facility) **copayment**/day	$100
Other **coinsurance**	20%

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	$12,840

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$360

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

The **plan's** overall **deductible**	$250
Specialist **copayment**	$25
Hospital (facility) **copayment**/day	$100
Other **coinsurance**	20%

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	$7,460

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$1,350
Coinsurance	$346
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$2,001

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

The **plan's** overall **deductible**	$250
Specialist **copayment**	$25
Hospital (facility) **copayment**/day	$100
Other **coinsurance**	20%

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	$2,010

In this example, Mia would pay:

Cost Sharing	
Deductibles	$29
Copayments	$325
Coinsurance	$158
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$513