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.unitedbenefitfund.com** or by calling **718-416-4020**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** person / **$0** family	See the chart starting on page 2 for your costs for services this plan covers.
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?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	The plan has no **out-of-pocket limit.**	Not applicable because there is no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	No. There is no annual limit on what the play pays for "essential health benefits". However, you should note that once the plan pays out $50,000 annually, all claims thereafter will be paid at the rate of 60% of the plan's schedule of benefits until the end of the year.	Once the plan pays out $50,000 annually, you are responsible for 40% of the schedule's rate for the services you and your eligible dependents receive. If you see an out-of-network provider you may be responsible for any charges above the plan's schedule of benefits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers (PPO providers)** call **718-416-4020**	If you use a **PPO** doctor or other health care **PPO-provider**, this plan will pay some or all of the costs of covered services. Be aware, your **PPO-provider** or hospital may use an **non-PPO-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.	See your policy or plan document for information about **excluded services**.

Questions: Call **718-416-4020** or visit us at **www.unitedbenefitfund.com.**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebs/healthreform or www.cciio.cms.gov or call **718-416-4020** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 **PPO-providers** by charging you lower **deductibles**, **copayments** and **coinsurance** 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	$10 copay/visit	$10 copay/visit plus any amount above the Medicare rate	Primary care practice is family practice, general practice, internal medicine, pediatric, physician assistant and nurse practitioners.
	Specialist visit	$40 copay/visit	$40 copay/visit plus any amount above the Medicare rate	Subject to plan limitations.
	Other practitioner office visit	$40 copay/visit	$40 copay/visit plus any amount above the Medicare rate	Coverage is limited to 30 visits per year.
	Preventive care/screening/immunization	$10 copay/visit	$10 copay/visit plus any amount above the Medicare rate	Coverage is limited to one preventive care physical per family member per year with primary care physician and includes immunizations.
If you have a test	Diagnostic test (x-ray, blood work)	$5 copay/visit	$5 copay/visit plus any amount above the Medicare rate	Subject to plan limitations.

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
	Imaging (CT/PET scans, MRIs)	$10 copay/visit	$10 copay/visit plus any amount above the Medicare rate	Pre-certification for all scans except mammography.
If you need drugs to treat your illness or condition For more information about **prescription drug coverage** call **718-416-4020**	Generic drugs	$15 copay	$15 copay plus any amount above the Medicare rate	Subject to plan limitations.
	Brand drugs	$25 copay	$25 copay plus any amount above the Medicare rate	Subject to plan limitations.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0 copay	$0 copay plus any amount above the Medicare rate	Pre-certification required.
	Physician/surgeon fees	$365copay	$365 copay plus any amount above the Medicare rate	Pre-certification required. Additional copay for each surgical procedure. If multiple procedures through same incision plan pays highest priced procedure only.
If you need immediate medical attention	Emergency room services	$260 copay	$260 copay plus any amount above the Medicare rate	Subject to plan limitations.
	Emergency medical transportation	$0 copay	$0 copay	You are responsible for any charge over $1500.
	Urgent care	$60 copay	$60 copay plus any amount above the Medicare rate	Subject to plan limitations.
If you have a hospital stay	Facility fee (e.g., hospital room)	$365 copay	$365 copay plus any amount above the Medicare rate	Pre-certification required.

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
	Physician/surgeon fee	$365 copay	$365 copay plus any amount above the Medicare rate	Pre-certification required. Additional copay for each surgical procedure. If multiple procedures through same incision plan pays highest priced procedure only.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not Covered.	Not Covered.	——————None——————
	Mental/Behavioral health inpatient services	Not Covered.	Not Covered.	——————None——————
	Substance use disorder outpatient services	Not Covered.	Not Covered.	——————None——————
	Substance use disorder inpatient services	Not Covered.	Not Covered.	——————None——————
If you are pregnant	Prenatal and postnatal care	$40 copay	$40 copay plus any amount above the Medicare rate	Subject to plan limitations.
	Delivery and all inpatient services	$40 copay	$40 copay plus any amount above the Medicare rate	Pre-certification required.
If you need help recovering or have other special health needs	Home health care	$45 copay	$45 copay plus any amount above the Medicare rate	Pre-certification is required. 200 day maximum.
	Rehabilitation services	$40 copay	$40 copay plus any amount above the Medicare rate	Subject to plan limitations.
	Habilitation services	Not Covered.	Not Covered.	——————None——————
	Skilled nursing care	Not Covered.	Not Covered.	——————None——————
	Durable medical equipment	$10 copay	$10 copay plus any amount above the Medicare rate	Pre-certification required. $1500 annual maximum.
	Hospice service	$40 copay	$40 copay plus any amount above the Medicare rate	210 days lifetime maximum.
If your child needs	Eye exam	$20 copay	Not covered.	Coverage limited to one annual exam.

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
dental or eye care	Glasses	$10 copay	Not covered.	Coverage limited to one pair of lenses or contacts every year and frames every 2 years.
	Dental check-up	Not covered.	Not covered.	——————None——————

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.)

- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Infertility treatment
- Long-term care
- Mental health and substance abuse
- Private-duty nursing
- Routine foot care
- Skilled nursing 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 (when medically necessary)
- Chiropractic care (30 annual visit maximum)
- Abortion
- Allergist
- Organ Transplant
- Hearing aids (one device every four years)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Acupuncture
- Physical Therapy
- Hospice Care
- Occupational and/or Speech Therapy

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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 plan at [contact number]. 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 the plan at: [contact number] or the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or New York State Department of Insurance at www.dfs.ny.gov. Additionally, a consumer assistance program can help you file your appeal. Contact www.communityhealthadvocates.org or healthcareombudsman@dc.gov.

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 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 **718-416-4020**.

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

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** $7,175
- **Patient pays** $365

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
Copays	$365
Coinsurance	$0
Limits or exclusions	$0
Total	**$365**

Note: This number assumes all providers are in-network PPO-providers and that the patient pre-certified her pregnancy with the plan. If you are pregnant and you use non-PPO providers and/or you did not pre-certify with the plan, your costs may be higher. For more information please call: **718-416-4020**.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,92
5
- **Patient pays** $475

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
Copays	$175
Coinsurance	$0
Limits or exclusions	$300
Total	**$475**

Note: This number assumes all providers used were in network PPO providers, and only generic drugs were purchased. If you have diabetes and you do not use PPO-providers your costs may be higher. For more information please call: **718-416-4020**.

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.