



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 by calling 718-416-4020.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes. \$5,000 per person for in-patient or out-patient hospital services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers \$6,350 person / \$12,700 family	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, non-essential health benefits 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. There is no overall annual limit on what the plan pays for Essential Health Benefits.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services.
Does this plan use a network of providers?	Yes. For a list of preferred providers (PPO providers) call 1-888-632-3862.	If you use a PPO doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your PPO provider or hospital may use a 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 do not 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.

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, \$50) 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 a PPO Provider	Your Cost If You Use a Non-PPO provider	Limitations & Exceptions
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	\$0 copay for preventive care. \$25 copay non-preventive	Your cost per visit is any amount above 100% of the Medicare rate	Primary care practice is family practice, general practice, internal medicine, pediatric, physician assistant and nurse practitioners. Chiropractor and Podiatrist visits require a \$50 copay. One preventative visit per year is covered for each covered person.
	Preventive care/screening/immunization			
	Other practitioner office visit	\$50 copay/visit	Your cost per visit is any amount above 100% of the Medicare rate	
	Specialist visit			
If you have a test	Diagnostic test (x-ray, blood work)	\$25 copay/visit	Your cost per test is any amount above 100% of the Medicare rate	_____none_____
	Imaging (CT/PET scans, MRIs)	\$75 copay/test	Your cost per test is any amount above 100% of the Medicare rate	Pre-certification required for all scans except mammography.

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.

United Benefit Fund – Aetna PPO – UltracareB -

Coverage Period: 1/1/2015 – 12/31/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual or Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at (877) 647-4026.	Generic drugs	\$0 copay	\$0 copay	Brand name prescription drugs are not covered.
	Brand drugs	Not covered.	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$5,000 deductible	\$5,000 deductible plus any amount above 100% of the Medicare rate	The \$5,000 deductible is for the facility and physician fees combined. Pre-certification required.
	Physician/surgeon fees/surgical benefits	\$5,000 deductible	\$5,000 deductible plus any amount above 100% of the Medicare rate	The \$5,000 deductible is for the facility and physician fees combined. Pre-certification required.
If you need immediate medical attention	Emergency room services	\$500 copay	\$500 copay and any amount above the usual and customary.	The \$500 copay is for all emergency services combined.
	Emergency medical transportation	\$500 copay	\$500 copay and any amount above the usual and customary.	The \$500 copay is for all emergency services combined.
	Urgent care	\$100 copay	\$100 copay and any amount above the usual and customary.	—————None—————
If you have a hospital stay	Facility fee (e.g., hospital room)	\$5,000 deductible	\$5,000 deductible plus any amount above 100% of the Medicare rate	The \$5,000 deductible is for the facility and physician fees combined. Pre-certification required.
	Physician/surgeon fee/surgical benefits	\$5,000 deductible	\$5,000 deductible plus any amount above 100% of the Medicare rate	The \$5,000 deductible is for the facility and physician fees combined. Pre-certification required.

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.

United Benefit Fund – Aetna PPO – UltracareB -

Coverage Period: 1/1/2015 – 12/31/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual or Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	Not covered	Not Covered
	Mental/Behavioral health inpatient services	\$5,000 deductible	\$5,000 deductible plus any amount above 100% of the Medicare rate	The \$5,000 deductible is for the facility and physician fees combined. Pre-certification required.
	Substance use disorder outpatient services	Not covered	Not covered	Not Covered
	Substance use disorder inpatient services	\$5,000 deductible	\$5,000 deductible plus any amount above 100% of the Medicare rate	The \$5,000 deductible is for the facility and physician fees combined. Pre-certification required.
If you are pregnant	Prenatal and postnatal care	\$50 copay per visit	Your cost is any amount above 100% of the Medicare rate	—————None—————
	Delivery and all inpatient services	\$5,000 deductible	\$5,000 deductible plus any amount above 100% of the Medicare rate	The \$5,000 deductible is for the combined facility and medical fees. Pre-certification required.
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	Not Covered
	Rehabilitation services	\$50 copay per visit	Your cost is any amount above 100% of the Medicare rate	—————None—————
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Not Covered	Not Covered	Not Covered
	Durable medical equipment	\$25 copay	Your cost is any amount above 100% of the Medicare rate	Pre-certification is required.
	Hospice service	Not Covered	Not Covered	Not Covered
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	Not Covered

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.

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
- Dental Care
- Infertility treatment
- Habilitation Services
- Hearing aids
- Hospice service
- Home Health Care
- Long-term care
- Private-duty nursing
- 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 (when medically necessary)
- Chiropractic care
- Mental/Behavioral Health Inpatient Services
- Podiatry Care
- Rehabilitative Speech Therapy
- Substance Abuse Disorder Inpatient 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.

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 718-416-4020. 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.*—————

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.

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 \$2,450
- Patient pays \$5,090

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	\$4,470
Copays	\$470
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$5,090

Note: this example assumes that the deductible had not already been met, the patient did not meet her annual out-of-pocket limit, all providers were **in-network** PPO providers and that pre-certification was properly made. 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

- Amount owed to providers: \$5,400
- Plan pays \$4,490
- Patient pays \$910

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	\$830
Coinsurance	\$0
Limits or exclusions	\$90
Total	\$910

Note: this example assumes that the patient did not meet her annual out-of-pocket limit, all providers were **in-network** PPO providers. If you have diabetes and you do not use PPO-providers your costs may be higher. For more information please contact the plan at: (718) 416-4020.

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.

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.

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.