DIVISION 1181 A.T.U. – NEW YORK WELFARE FUND
20 North Central Avenue, Valley Stream, N.Y. 11580
(718) 845-5800

Dear Participant:

Pursuant to the Patient Protection and Affordable Care Act (PPACA), the following document is a summary of benefits and coverage (SBC) through Division1181 A.T.U. – New York Welfare Fund.

Please review and keep for your reference.

The format of the enclosed SBC including some of the examples is required by Federal Law and is only a summary of your Plan of benefits. Therefore, this summary may not describe all of the benefits available to you. Please continue to refer to your Summary Plan Description (SPD) for additional information about your benefits.

If you have any questions, feel free to contact the Fund Office at (718) 845-5800.

Very truly yours,

THE FUND OFFICE

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 1-718-845-5800. 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.dol.gov/ebsa/healthreform or call 1-718-845-5800 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$ 0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
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?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.medicare.gov/find-a-doctor/provider-search.aspx or call 1-718-845-5800 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.

⚠ 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 provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	Medicare pays primary; Fund pays remainder of the bill after Medicare pays.
	Specialist visit	No charge		Medicare pays primary; Fund pays remainder of the bill after Medicare pays.
	Preventive care/screening/ immunization	No charge		Limited to one well-woman visit per year. Influenza vaccine covered only for persons with hypertension, diabetes, or cancer. 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	Diagnostic test (x-ray, blood work)	No charge	Not covered	Medicare pays primary; Fund pays remainder of the bill after Medicare pays.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling 1-718-845-5800.	Generic drugs	Not covered	Not covered	Medicare eligible members and or spouses will receive a $25 reimbursement per month per eligible person who have their own Medicare prescription plan (Medicare Plan D) or any other premium paid program (i.e. AARP).
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			

* For more information about limitations and exceptions, ask for the plan or policy document at 1-718-845-5800.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Medicare pays primary; Fund pays remainder of the bill after Medicare pays.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	No charge	Not covered	The Fund covers emergency first aid within 72 hours of accidental injury or within 12 hours of sudden serious sickness or injury. Medicare pays primary; Fund pays remainder of the bill after Medicare pays.
	Emergency medical transportation	Not covered		None.
	Urgent care	No charge		Medicare pays primary; Fund pays remainder of the bill after Medicare pays.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Up to 120 days of room and board are covered during a single hospitalization. Medicare pays primary; Fund pays remainder of the bill after Medicare pays.
	Physician/surgeon fees			Medicare pays primary; Fund pays remainder of the bill after Medicare pays.
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral outpatient services	No charge	Not covered	Medicare pays primary; Fund pays remainder of the bill after Medicare pays. Substance use disorder services are not covered.
	Mental/Behavioral Inpatient services			Up to 120 days of room and board are covered during a single hospitalization. Medicare pays primary; Fund pays remainder of the bill after Medicare pays. Substance use disorder services are not covered.

* For more information about limitations and exceptions, ask for the plan or policy document at 1-718-845-5800.

If you are pregnant	Office visits	No charge	Not covered	Medicare pays primary; Fund pays remainder of the bill after Medicare pays.
	Childbirth / delivery professional services			
	Childbirth / delivery facility services			
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	None.
	Rehabilitation services	No charge	Not covered	Inpatient rehabilitation is not covered. Outpatient physical therapy is covered up to 4 visits per year; outpatient cardiology rehabilitation is covered up to 90 visits per calendar year. Medicare pays primary; Fund pays remainder of the bill after Medicare pays.
	Habilitation services	Not covered	Not covered	None.
	Skilled nursing care			
	Durable medical equipment			
	Hospice services	No charge	Not covered	Up to 210 days of inpatient and home care are covered with certain exceptions. Medicare pays primary; Fund pays remainder of the bill after Medicare pays.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None.
	Children's glasses			
	Children's dental check-up			

* For more information about limitations and exceptions, ask for the plan or policy document at 1-718-845-5800.

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.)		
• Chiropractic care	• Habilitation services	• Routine eye care (Adult)
• Cosmetic surgery	• Home health care	• Routine foot care
• Dental care (Adult and Children)	• Infertility treatment	• Skilled nursing care
• Durable medical equipment	• Long-term care	• Substance use disorder
• Emergency medical transport	• Prescription drug coverage	• Vision (Children)
• Hearing aids	• Private-duty nursing	• Weight loss program

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Bariatric surgery	• Most coverage provided outside the United States. See http://www.medicare.gov/Pubs/pdf/11037.pdf

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: Department of Labor's Employee Benefits Security Administration 1-866-444-EBSA or www.dol.gov/healthreform. 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: Board of Trustees – Division 1181 A.T.U – New York Welfare Fund, 20 North Central Avenue, 3rd Floor, Valley Stream, NY 11580 or at 718-845-5800, or 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 your appeal. Contact: Community Service Society of New York, Community Health Advocates 105 East 22nd Street, 8th floor, New York, NY 10010, 1-888-614-5400 or http://www.communityhealthadvocates.org/.

Does this plan provide Minimum Essential Coverage? No
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? No
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 718-845-5800.

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

* For more information about limitations and exceptions, ask for the plan or policy document at 1-718-845-5800.

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**	**$0**
■ **Specialist *[cost sharing]***	**$0**
■ **Hospital (facility) *[cost sharing]***	**0%**
■ **Other *[cost sharing]***	**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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$100**

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

■ **The plan's overall deductible**	**$0**
■ **Specialist *[cost sharing]***	**$0**
■ **Hospital (facility) *[cost sharing]***	**0%**
■ **Other *[cost sharing]***	**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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6,000
The total Joe would pay is	**$6,000**

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

■ **The plan's overall deductible**	**$0**
■ **Specialist *[cost sharing]***	**$0**
■ **Hospital (facility) *[cost sharing]***	**0%**
■ **Other *[cost sharing]***	**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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Mia would pay is	**$200**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.