MILA-MHCTF: Basic Plan - Covers Only In-Network Services

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period:01/01/2013 - 12/31/2013

MILA MANAGED HEALTH CARE TRUST FUND

This is only a summary. If you want more details about your coverage and costs, you can get the complete terms in the Summary Plan Description (SPD) at www.milamhctf.com or by calling MILA at (212) 766-5700 or by calling the phone number on each vendor's I.D. card.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: $400 person/$700 family. Doesn't apply to in-network office visits, prescription drugs, dental, urgent care or emergency room. Balance billing, excluded services, prescription co-payments and coinsurance amounts do not count toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. The deductible applies during the entire calendar year and starts over on 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?	Yes. Brand name prescription drug w/generic equivalent: $500 family/year; Dental basic and major services: $25 person/$75 family. 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. $5,000 per person.	The **out-of-pocket limit** is the most you could pay during the calendar year for your share of the cost of covered medical services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billing, health care this plan does not cover, co-payments, penalties for failure to obtain pre-authorization for services and dental deductibles and coinsurance.	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?	There is no limit on what the medical plan pays, but the dental plan will pay no more that $2,500 per person per year and $1,500 per person lifetime for Orthodontia	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Questions: Call MILA at (212) 766-5700 or visit us at www.milamhctf.com. You may also call the phone number on each vendor's I.D. card.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.milamhctf.com or call (212) 766-5700 to request a copy.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.milamhctf.com or call the number on the back of the ID card for each vendor.	If you use an in-network doctor or other health care **provider that is in-network**, 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. The Plan does not pay for out-of-network non-emergency services. 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, provided the specialist is in-network	You can see the in-network **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Except for emergency services, any out-of-network services will not be paid by this plan. Furthermore, some of the services this plan doesn't cover are listed on page 6. See your Summary Plan Description ("SPD") for additional information about **excluded services**.

- **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 30% would be $300. This may change if you haven't met your **deductible.**

Common Medical Event	Service 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	$25 copay/visit	Not covered	OB/GYN is covered as specialist for illness-related care.
	Specialist visit	$40 copay/visit	Not covered	
	Other practitioner office visit	$40 copay/visit for chiropractic and acupuncture	Not covered	Chiropractic is available in-network only and is limited to 60 visits per year. Acupuncture is available in-network only and limited to $80 maximum benefit per visit.
	Preventive care/screening/immunization	PCP - $25 copay/visit; Specialist - $40 copay/visit Immunizations - No charge	Not covered	Age and frequency limits apply.

Common Medical Event	Service 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 a test	Diagnostic test (x-ray, blood work)	30% coinsurance after deductible	Not covered	No additional charge after office visit copay if part of visit.
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	Not covered	Failure to obtain pre-authorization will result in 20% reduction in benefits. No additional charge after office visit copay if part of visit.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	Retail and Mail Order: $5 copay/prescription	Retail only: $5 copay/prescription plus additional cost for out-of-network pharmacy; no mail order	Retail up to 30-day supply plus one refill. Mail order up to 90-day supply; must be used after one refill at retail. **Note: All maintence drugs must go through CVS mail order or the CVS Maintenance Choice Program.** Some medications require prior approval from Caremark. Brand name drugs with generic equivalent (multi-source drugs) subject to $500 deductible plus excess cost of multi-source drug. Must submit claim to Caremark for out-of-network retail pharmacy. Responsible for the copay and additional cost between what the prescription would have cost at in-network pharmacy and the cost at the out-of-network pharmacy.
	Preferred brand drugs	Retail: $10 copay/prescription; Mail Order: $15 copay/prescription	Retail only: $10 copay/prescription plus additional cost for out-of-network pharmacy; no mail order	
	Non-preferred brand drugs	Retail: $25 copay/prescription; Mail Order: $50 copay/prescription	Retail only: $25 copay/prescription plus additional cost for out-of-network pharmacy; no mail order	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	Not covered	Includes outpatient surgery and non-surgery facility charges.
	Physician/surgeon fees	30% coinsurance after deductible	Not covered	Failure to obtain pre-authorization will result in 20% reduction in benefits for certain surgeries/procedures. 50% reduction of charges to the surgery of lesser charge for multiple surgeries performed during one operating session.
If you need immediate medical attention	Emergency room services	If true emergency, $50 copay/visit	If true emergency, $50 copay/visit	Copay waived if admitted within 24 hours.
	Emergency medical transportation	30% coinsurance after deductible	30% coinsurance after deductible	Licensed ambulance to and from nearest hospital, SNF or hospice and from hospital to SNF.
	Urgent care	$25 copay/visit	Not covered	Copay waived if admitted within 24 hours.

		Your Cost if You Use an		

Common Medical Event	Service You May Need	In-Network Provider	Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 copay/first admission per year; then 30% coinsurance after deductible	Not covered	Failure to obtain pre-authorization will result in 20% reduction in benefits. Limited to semi-private room negotiated rate.
	Physician/surgeon fee	30% coinsurance after deductible	Not covered	50% reduction of charges to the surgery of lesser charge for multiple surgeries performed during one operating session.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 co-pay/office visit, 30% coinsurance after deductible for other outpatient services	Not covered	Includes individual, group and intensive outpatient treatment. Intensive outpatient treatment must be approved by Cigna Behavioral Health.
	Mental/Behavioral health inpatient services	$350 copay/first admission per year; then 30% coinsurance after deductible	Not covered	Failure to obtain pre-authorization will result in 20% reduction in benefits. Limited to semi-private room negotiated rate.
	Substance use disorder outpatient services	$15 co-pay/office visit, 30% coinsurance after deductible for other outpatient services	Not covered	Includes individual, group and intensive outpatient treatment. Intensive outpatient treatment must be approved by Cigna Behavioral Health.
	Substance use disorder inpatient services	$350 copay/first admission per year; then 30% coinsurance after deductible	Not covered	Failure to obtain pre-authorization will result in 20% reduction in benefits. Limited to semi-private room negotiated rate.
If you are pregnant	Prenatal and postnatal care	$25 copay/initial visit; no charge for subsequent visits	Not covered	Copay only applies to first visit to confirm pregnancy.
	Delivery and all inpatient services	$350 copay/first admission per year; then 30% coinsurance after deductible	Not covered	Includes inpatient hospital and birthing center; nurse midwives in-network only.

Common Medical Event	Service You May Need	Your Cost if You Use an	Limitations & Exceptions

Medical Event		In-Network Provider	Out-of-Network	
If you need help recovering or have other special health needs	Home health care	30% after deductible	Not covered	120-days maximum/calendar year. 4 hours = 1 visit. Failure to obtain pre-authorization will result in 20% reduction in benefits.
	Rehabilitation services	$40 copay/visit	Not covered	Short-term outpatient rehab limited to combined total of 60 visits/year. Inpatient SNF, rehab and sub-acute facility limited to combined total of 100 days/year. Failure to obtain pre-authorization will result in 20% reduction in benefits.
	Habilitation services	Not covered	Not covered	You must pay 100% of these expenses.
	Skilled nursing care	30% coinsurance after deductible	Not covered	Inpatient SNF, rehab and sub-acute facility limited to combined total of 100 days/year. Failure to obtain pre-authorization will result in 20% reduction in benefits.
	Durable medical equipment	30% coinsurance after deductible	Not covered	Limited to approved equipment.
	Hospice service	30% coinsurance after deductible	Not covered	Failure to obtain pre-authorization will result in 20% reduction in benefits. Maximum 180-days/lifetime.
If your child needs dental or eye care	Eye exam	$10 copay/exam	No charge up to $40	One exam/12 months (with dilation and refraction as necessary). Out-of-network maximum of $30 per exam.
	Glasses	$15 copay/glasses plus 80% of balance over $100	Frames - No charge up to $40; Lenses - no charge up to $25 (single focus)	Frames - one/every 24 months; lenses - one/every 12 months. Out-of-network limit of $40 for frames and $25 for single vision lenses.
	Dental check-up	No charge	No charge up to allowable amount	Limit 2/year. For out-of-network providers, you are responsible for difference between allowable amount and out-of-network dentist charges.

Excluded Services & Other Covered Services:

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

- Cosmetic surgery (except for accidental injury or congenital abnormality of dependent child)
- Habilitation services
- Hearing aids
- Infertility treatment (aids to conception, actual or attempted impregnation or other fertilization expenses)
- Long-term care
- Weight loss programs (discounts available through Cigna Healthy Rewards Program)

Other Covered Services (This isn't a complete list. Check your SPD for other covered services and your costs for those services.)

- Acupuncture (all conditions including acupressure to max of $80 benefit/visit, in-network only)
- Bariatric surgery (if medically necessary)
- Chiropractic care (excludes massage therapy; maximum of 60 visits/year)
- Dental care (Adult) (annual benefit maximum $2,500 and lifetime maximum orthodontia benefit of $1, 500)
- Non-emergency care when traveling outside the U.S. (limited to residents of US)
- Private-duty nursing (outpatient, 70 visits/year; one visit = 4 hours)
- Routine eye care (Adult) (exams one/12 mos., frames one/24 mos., lenses one/12 mos.)
- Routine foot care ($1,000 max/calendar year)

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. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the Plan at MILA Managed Healthcare Trust Fund, 111 Broadway, Suite 502, New York, NY 10006-1901; Phone (212) 766-5700. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323, option 4, 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: MILA Managed Healthcare Trust Fund, 111 Broadway, Suite 502, New York, NY 10006-1901; Phone (212) 766-5700. You may contact the applicable Claims Administrator at the number listed on the back of your ID card. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 212-766-5700.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 212-766-5700.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 212-766-5700.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 212-766-5700.

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** $6,865
- **Patient pays** $675

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	$400
Co-pays	$35
Co-insurance	$90
Limits or exclusions	$150
Total	**$675**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,110
- **Patient pays** $1,290

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	$400
Co-pays	$510
Co-insurance	$300
Limits or exclusions	$80
Total	**$1,290**

NOTE: The Coverage Examples are based on treatment which the government assumes the average patient will require. The costs which a MILA participant will pay will depend upon the actual treatment he or she receives.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums since MILA charges no 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 and used only generic prescriptions.. If the patient had received care from out-of-network providers or used brand drugs, the 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 **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 may pay for other plans since MILA has no premuim. Generally, the lower your **premium,** the more you'll pay in out-of-pocket costs, such as **co-payments, 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.

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