
 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. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see the Summary Plan Description (SPD) at www.milamhctf.com or call MILA at (212) 766-5700 or call the phone number on each vendor's I.D. card. 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.healthcare.gov/sbc-glossary or www.milamhctf.com or call 212-766-5700 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>In-Network providers</u> : \$400/individual or \$700/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. <u>In-network</u> office visits and <u>preventive care</u> , <u>in-network</u> urgent care, <u>emergency room care</u> , <u>in-network</u> maternity professional services, <u>prescription drugs</u> , dental and optical benefits are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other deductibles for specific services?	Yes. All brand name <u>prescription drugs</u> with generic equivalent: \$500/individual; Dental: \$25/individual or \$75/family There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical benefits: <u>In-network providers</u> : \$5,000/individual.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	<u>Prescription drug</u> , dental and optical benefits, <u>copayments</u> on certain services, <u>premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. For a list of <u>in-network providers</u> , see www.milamhctf.com to be directed to each vendor's website or call the number on the back of the ID card for each vendor. The plan only pays for <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the full cost if you use an <u>out-of-network provider</u> . Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>in-network specialist</u> you choose without a <u>referral</u> .

 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	\$25 <u>copay</u> /visit for primary care and in-store health clinics; Deductible does not apply	Not covered	Primary Care Physician (PCP) includes internist, family practitioner, pediatrician and OB/GYN for primary care. In-store health-clinic visits to treat minor illnesses and injuries—all for a primary care <u>copay</u> of \$25.
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit; <u>Deductible</u> does not apply	Not covered	Chiropractic is limited to 60 visits per year. Acupuncture is limited to \$80 maximum benefit per visit. <u>Specialists</u> include cardiologist, gastroenterologist, rheumatologist, ophthalmologist, podiatrist, nutritionist, acupuncturists, radiologist, etc. OB/GYN is covered as <u>specialist</u> for illness-related care. *See the Definition section of the Summary <u>Plan</u> Description (SPD).
	<u>Preventive care/screening/immunization</u>	PCP - \$25 <u>copay</u> /visit; Specialist - \$40 <u>copay</u> /visit Immunization - No charge <u>Deductible</u> does not apply	Not covered	Age and frequency limits apply. *See Preventive section of the Summary <u>Plan</u> Description (SPD).
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	Not covered	No additional charge after office visit <u>copay</u> if part of visit.
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	Not covered	Failure to obtain <u>preauthorization</u> will result in 20% reduction in benefits. No additional charge after office visit <u>copay</u> if part of visit

* For more information about limitations and exceptions, see the Summary Plan Description at www.milamhctf.com.

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)	
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com</p>	Generic drugs	Retail and Mail Order: \$5 <u>copay</u> /prescription	Retail only: \$5 <u>copay</u> /prescription plus additional cost for <u>out-of-network</u> pharmacy; Mail order: Not covered	Overall <u>deductible</u> does not apply. <u>Cost sharing</u> does not count toward <u>out-of-pocket limit</u> . Brand name drugs with generic equivalent (multi-source drugs) subject to separate \$500 individual <u>deductible</u> plus excess cost of multi-source drug.
	Preferred brand drugs	Retail: \$10 <u>copay</u> /prescription; Mail Order: \$15 <u>copay</u> /prescription	Retail only: \$10 <u>copay</u> /prescription plus additional cost for <u>out-of-network</u> pharmacy; Mail order: Not covered	Retail up to 30-day supply plus one refill. Mail order up to 90-day supply; must be used after one refill at retail. All maintenance drugs must go through CVS mail order or the CVS Maintenance Choice Program.
	Non-preferred brand drugs (Including Brand name drugs with generic equivalent)	Retail: \$25 <u>copay</u> /prescription; Mail Order: \$50 <u>copay</u> /prescription	Retail only: \$25 <u>copay</u> /prescription plus additional cost for <u>out-of-network</u> pharmacy; Mail order: Not covered	Members age 18 and older can access seasonal flu shots and other vaccinations through any CVS/Caremark pharmacy location as well as most other <u>in-network</u> pharmacies at no cost. Some medications require prior approval from Caremark. Must submit claim to Caremark for <u>out-of-network</u> retail pharmacy. Responsible for the <u>copay</u> and additional cost between what the prescription would have cost at <u>in-network</u> pharmacy and the cost at the <u>out-of-network</u> pharmacy.
	<u>Specialty drugs</u>	Retail; Not covered; Specialty Pharmacy only: Generic: \$5 <u>copay</u> /prescription Preferred brand: \$10 <u>copay</u> /prescription Non-preferred brand: \$25 <u>copay</u> /prescription	Not covered	<u>Specialty drugs</u> must go through CVS Caremark Specialty Pharmacy. No retail or <u>out-of-network</u> available. Please call the number on the back of your I.D. card for more information on <u>Specialty Drugs</u> or see the <u>Prescription Drug</u> section of the SPD*.

* For more information about limitations and exceptions, see the Summary Plan Description at www.milamhctf.com.

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)	30% <u>coinsurance</u>	Not covered	Includes outpatient surgery and non-surgery facility charges.
	Physician/surgeon fees	30% <u>coinsurance</u>	Not covered	Failure to obtain <u>preauthorization</u> will result in 20% reduction in benefits for certain surgeries/procedures. If multiple surgeries performed during one operating session, 50% reduction made to surgery of lesser charge. *See the Surgery and Approving Your Care sections of the SPD.
If you need immediate medical attention	<u>Emergency room care</u>	If true emergency, \$50 <u>copay/visit</u> ; <u>deductible</u> does not apply	If true emergency, \$50 <u>copay/visit</u> ; <u>deductible</u> does not apply	Emergency room coverage is only for valid emergency. <u>Copay</u> waived if admitted within 24 hrs. Professional/physician charges may be billed separately.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Licensed ambulance to and from nearest hospital, SNF or hospice and from hospital to SNF. Must be considered <u>medically necessary</u> to be covered.
	<u>Urgent care</u>	\$25 <u>copay/visit</u> ; <u>deductible</u> does not apply	Not covered	<u>Copay</u> waived if admitted within 24 hrs.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$350 <u>copay</u> /first admission per year; then 30% <u>coinsurance</u>	Not covered	Failure to obtain <u>preauthorization</u> will result in 20% reduction in benefits. Limited to semi-private room negotiated rate.
	Physician/surgeon fees	30% <u>coinsurance</u>	Not covered	50% reduction of charges to the surgery of lesser charge for multiple surgeries performed during one operating session. *See the Surgery and Approving Your Care sections of the SPD.

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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 need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: \$25 <u>copay</u> /office visit; <u>deductible</u> does not apply, Other outpatient services: 30% <u>coinsurance</u>	Not covered	Includes individual, group and intensive outpatient treatment. Failure to obtain <u>preauthorization</u> for intensive outpatient treatment will result in 20% reduction in benefits. *See the What is Covered under the Behavioral Health Program section of the SPD.
	Inpatient services	\$350 <u>copay</u> /first admission per year; then 30% <u>coinsurance</u>	Not covered	Failure to obtain <u>pre-authorization</u> will result in 20% reduction in benefits. Limited to semi-private room negotiated rate. *See the What is Covered under the Behavioral Health Program section of the SPD.
If you are pregnant	Office visits	\$25 <u>copay</u> /initial visit; no charge for subsequent visits; <u>deductible</u> does not apply	Not covered	<u>Copay</u> only applies to first visit to confirm pregnancy. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Depending on the service, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. *See the Maternity Care section of the SPD.
	Childbirth/delivery professional services	No charge; <u>deductible</u> does not apply	Not covered	None
	Childbirth/delivery facility services	\$350 <u>copay</u> /first admission per year; then 30% <u>coinsurance</u>	Not covered	Includes inpatient hospital and birthing center.

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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 need help recovering or have other special health needs	<u>Home health care & Private duty nursing</u>	30% <u>coinsurance</u>	Not covered	Services limited to a combined total of 200 visits. Any four hours of service, whether continuous or not in a 24-hour period, will be considered one visit. Failure to obtain <u>preauthorization</u> will result in 20% reduction in benefits.
	<u>Rehabilitation services</u>	Inpatient: \$350 <u>copay</u> /first admission per year, then 30% <u>coinsurance</u> Outpatient: \$40 <u>copay</u> /visit; <u>deductible</u> does not apply to office visit	Not covered	Inpatient skilled nursing facility, rehabilitation and sub-acute facility limited to combined total of 100 days/year. Short-term outpatient rehabilitation limited to combined total of 60 visits/year. Failure to obtain <u>preauthorization</u> will result in 20% reduction in benefits.
	<u>Habilitation services</u>	Not covered	Not covered	You must pay 100% of these expenses even <u>in-network</u> .
	<u>Skilled nursing care</u>	\$350 <u>copay</u> /first admission per year, then 30% <u>coinsurance</u>	Not covered	Inpatient skilled nursing facility, rehabilitation and sub-acute facility limited to combined total of 100 days/year. Failure to obtain <u>preauthorization</u> will result in 20% reduction in benefits.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	Not covered	Limited to approved equipment.
	<u>Hospice services</u>	30% <u>coinsurance</u>	Not covered	Failure to obtain <u>preauthorization</u> will result in 20% reduction in benefits. Maximum 180 days/lifetime.
If your child needs dental or eye care	Children's eye exam	\$10 <u>copay</u> /exam	Balances over \$30 <u>Plan</u> allowance	Vision benefits separately administered by EyeMed. <u>Deductible</u> does not apply and <u>cost sharing</u> does not count toward <u>out-of-pocket</u> limit.
	Children's glasses	\$15 <u>copay</u> /frames and \$10 <u>copay</u> /lenses plus 80% of balance over \$100 <u>Plan</u> allowance	Frames: Balances over \$40 <u>Plan</u> allowance Lenses: Balances over \$25 (single vision) <u>Plan</u> allowance	One exam/12 months (with dilation and refraction as necessary). Out-of-network maximum of \$30 per exam. Frames - one/every 24 months; lenses - one/every 12 months. <u>Out-of-network</u> limit of \$40 for frames and \$25 for single vision lenses.
	Children's dental check-up	No Charge: Separate dental <u>deductible</u> does not apply.	Balances over <u>allowed amount</u>	Dental benefits separately administered by Aetna. Limit 2/year. For <u>out-of-network</u> providers, you are responsible for difference between <u>allowed amount</u>

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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)	
				and <u>out-of-network</u> dentist charges.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)			
<ul style="list-style-type: none"> Cosmetic surgery (except for accidental injury or congenital abnormality of dependent child) 	<ul style="list-style-type: none"> <u>Habilitation services</u> Long-term care 	<ul style="list-style-type: none"> Weight loss programs (discounts available through Cigna Healthy Rewards Program) 	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)			
<ul style="list-style-type: none"> Acupuncture (all conditions incl. acupressure to max of \$80/visit, <u>in-network</u> only) Bariatric surgery (if <u>medically necessary</u>) Chiropractic care (excludes massage therapy; maximum of 60 visits/year) Dental care (Adult) (\$2,500 max/year; \$1,500 lifetime maximum orthodontia) 	<ul style="list-style-type: none"> Hearing aids (Maximum \$1,500 per ear once every 3 years to total of \$3,000 every 3 years) Infertility treatment (Provided through the Progyny network only) Non-emergency care when traveling outside the U.S. (limited to residents of US) 	<ul style="list-style-type: none"> Private-duty nursing (Limitations apply) Routine eye care (Adult) (exams one/12 mos., frames one/24 mos., lenses one/12 mos.) Routine foot care (Only covered in connection with treatment for metabolic or peripheral vascular disease or neurological conditions.) 	

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-EBSA (3272) or www.dol.gov/ebsa/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 on how 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 Plan at MILA Managed Healthcare Trust Fund, 111 Broadway, Suite 502, New York, NY 10006-1901; Phone (212) 766-5700. 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.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 1-212-766-5700.

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

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 \$400
- Hospital (facility) copayment \$350
- Hospital (facility) coinsurance 30%
- Other coinsurance (x-ray and lab) 30%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$360
<u>Coinsurance</u>	\$2,340
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,160

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

- The plan's overall deductible \$400
- Specialist copayment \$40
- Hospital (facility) coinsurance 30%
- Other coinsurance (x-ray and lab) 30%

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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$120
<u>Copayments</u>	\$790
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$930

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

- The plan's overall deductible \$400
- Specialist copayment \$40
- Hospital (facility) coinsurance 30%
- Other coinsurance (x-ray and lab) 30%

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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$380
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$980

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