GCC/IBT LOCAL 14-M HEALTH AND WELFARE FUND

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SUMMARY OF BENEFITS AND COVERAGE

Dear Member:

As part of the 2010 health reform law requirements, your Plan is providing you with a Summary of Benefits and Coverage (SBC) for the Benefit Period January 1, 2020 to December 31, 2020 for **Plan A**. This SBC will allow you to review your current benefits and costs including your out-of-pocket cost share and will also allow you to easily compare your benefit plan to other benefit plans you may be reviewing.

The SBC includes a comparison tool intended to help you and your dependents to review your covered benefits and out-of-pocket costs and the network of providers. There is a glossary of health coverage and medical terms that defines terms commonly used in the health insurance market, such as "deductible" and "co-pay", using clear language. You may request a copy of this Glossary of Terms by contacting your Benefits Administrator, *richard Gabriel associates*, at 215-773-0900, or by visiting the web at:

www.HealthReformPlanSBC.com

If you have any questions, please contact your Benefits Administrator.

Sincerely,

Board of Trustees

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, [insert contact information]. 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.HealthReformPlanSBC.com or call your Benefits Administrator at 1-215-773-0900 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**For Each Calendar Year** **$0** person/**$0** Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	N/A	No deductible.
Are there other deductibles for specific services?	**Prescription - Annual Deduct. of $50/person-$150/Family** **Dental - Annual Deduct. of $25/person-$75/Family**	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.
What is the out-of-pocket limit for this plan?	**Medical** in-network **$1,000/ individual-$2,000/**family **Rx in-network $1,000/**person-**$2,000/**family annually.	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?	Out-of-Network Costs, Premiums, Balance-billed charges, and health care services this plan does not cover.	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. Visit www.aetna.com for a list of in-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 (a balance bill). 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?	Yes. You need a referral to see a specialist.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.

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	$15 co-pay/visit	Not covered	----------none----------
	Specialist visit	$25 co-pay/visit	Not covered	Includes Internist, General Physician, Family Practitioner or Pediatrician **if** the physician is not the Member's selected PCP.
	Preventive care/screening/ immunization	No charge	Not covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	$25 co-pay	Not covered	----------none----------
	Imaging (CT/PET scans, MRIs)	$25 co-pay	Not covered	----------none----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.benecardpbf.com	Generic drugs	$10 co-pay/retail $20 co-pay/mail	Not covered	Deductible $50 Person/$150 Family Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription **2 co-pays**). Mail order **required** after 2 fills at pharmacy for maintenance drugs.
	Preferred brand drugs	$25 co-pay/retail $50 co-pay/mail	Not covered	
	Non-preferred brand drugs	$45 co-pay/retail $90 co-pay/mail	Not covered	
	Specialty drugs	Generic $20 Pref Brand $30 Non-Pref Brand $60	Not covered	----------none----------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	Not covered	----------none----------
	Physician/surgeon fees	10% co-insurance	Not covered	----------none----------
If you need immediate medical attention	Emergency room care	$100 co-pay	Not covered	Copay not waived if admitted. No coverage for non-emergency use.
	Emergency medical transportation	No charge	No charge	----------none----------
	Urgent care	$35 co-pay	Not covered	No coverage for non-emergency use.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	Not covered	----------none----------
	Physician/surgeon fees	10% co-insurance	Not covered	----------none----------

[* For more information about limitations and exceptions, see the plan or policy document at www.aetna.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 need mental health, behavioral health, or substance abuse services	Outpatient services	$25 co-pay/visit	Not covered	——————none——————
	Inpatient services	10% co-insurance	Not covered	——————none——————
If you are pregnant	Office visits	Maternity OB visit $25 co-pay 1st visit then covered 100%	Not covered	——————none——————
	Childbirth/delivery professional services	10% co-insurance	Not covered	——————none——————
	Childbirth/delivery facility services	10% co-insurance	Not covered	——————none——————
If you need help recovering or have other special health needs	Home health care	$25 co-pay/visit	Not covered	Limited to 3 visits per day (1 visit equals 4 hours or less)
	Rehabilitation services	$25 co-pay/visit	Not covered	Limited to 60 consecutive days per condition for physical, speech, and occupational therapy.
	Habilitation services	Not Covered	Not Covered	——————none——————
	Skilled nursing care	10% co-insurance	Not covered	——————none——————
	Durable medical equipment	Not covered	Not covered	——————none——————
	Hospice services – Inpatient	10% co-insurance	Not covered	——————none——————
	Hospice services – Outpatient	$25 co-pay/visit	Not covered	——————none——————
If your child needs dental or eye care	Children's eye exam	$15 co-pay	Not Covered	One exam every 12 months
	Children's glasses	Actual difference between wholesale cost/max allowance plus % of difference Lenses – 25% diff Frames – 20% diff	Not Covered	Children under age 19 – One pair of glasses every 12 months; lenses every 12 months; frames every 12 months.
	Children's dental check-up	Diagnostic/Preventive	No charge	No charge

[* For more information about limitations and exceptions, see the plan or policy document at www.aetna.com.]

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.)

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- Certain Cosmetic surgery
- Durable Medical Equipment
- Experimental Procedures not FDA approved
- Habilitation services
- Hearing Aids
- Long-term care
- Private Duty Nursing
- Routine foot care
- Non-emergency care when traveling outside the U.S.
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Infertility Treatment – Coverage includes diagnosis and treatment of underlying medical condition only.
- Chiropractic care – (medically necessary)
- Diagnostic foot care
- Most coverage provided outside the United States. **See www.aetna.com**

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 your Benefits Administrator at (215) 773-0900.

Does this plan provide Minimum Essential Coverage? Yes
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? 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:
Attention: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-696-6775 (TTY/TDD 711).

(Spanish) ATENCIÓN: Si usted habla español, los servicios de ayuda de idioma, sin ningún costo, están disponibles para usted. Llamar al 1-877-696-6775.
(Russian) ВНИМАНИЕ: Если Вы говорите на русском языке, Вам предлагаются бесплатные переводческие услуги. Позвоните по номеру 1-877-696-6775.
(Chinese) (Simplified/Mandarin)注意：如果您讲中文，可向您免费提供语言协助服务。致电 1-877-696-6775.
(Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. Gọi 1-877-696-6775.
(Korean) 비고: 한국어를사용하시고언어도움서비스가필요하시다면무료로사용하실수있습니다. 로눌러주십시오 1-877-696-6775.

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, see the plan or policy document at www.aetna.com.]

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/$0
■ Specialist *[cost sharing]*	$25
■ Hospital (facility) *[cost sharing]*	10%
■ Other *[cost sharing]*	10%

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	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$145
Coinsurance	$750
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$895**

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

■ The plan's overall deductible	$0/$0
■ Specialist *[cost sharing]*	$25
■ Hospital (facility) *[cost sharing]*	10%
■ Other *[cost sharing]*	10%

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	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$600**

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

■ The plan's overall deductible	$0/$0
■ Specialist *[cost sharing]*	$25
■ Hospital (facility) *[cost sharing]*	10%
■ Other *[cost sharing]*	10%

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	**$2,100**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

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