WELFARE & PENSION FUNDS

425 MERRICK AVENUE, WESTBURY, NY 11590
TEL: 516-214-1300

December 4, 2015

Re: PT ACA Plan Summary of Benefits and Coverage (SBC)

Dear Participant:

Enclosed please find the PT ACA Plan Summary of Benefits and Coverage (SBC). The SBC document provides a general description of the health benefits provided by our Fund. SBCs are required by the Affordable Care Act (ACA). The federal government developed the SBC form primarily to help people who will be shopping for individual coverage on the health care exchanges. They are designed so that individuals can compare "apples to apples" when comparing plans. For that reason, the Fund is not allowed to customize much of the SBC.

ACA Requirements for SBCs

The ACA has some very strict requirements for producing the SBCs—the maximum number of pages, the font size, the colors, etc.

Also included in the SBC are two examples—one for having a baby and one for managing type 2 diabetes. The examples show the health care costs for you and the Fund associated with each of these two situations. **As you read these examples, it's very important to note that these costs are national averages; they do not reflect what the actual services might cost in your area.** Similarly, your course of treatment might also be very different depending on your doctor's approach, your age, your other health issues, and many other factors.

You may find that the SBC discusses the Fund's benefits in ways that may seem unfamiliar to you. For instance, there may be terms you haven't seen before, or terms that you have seen before but are being used differently. The SBC also refers to a "Glossary of Health Coverage and Medical Terms," which cannot be customized for our Fund. If you read the SBC or the Glossary and find yourself confused at any time, we recommend that you refer to your SPD and the other materials describing your benefits that you have received from the Fund.

For More Information

Please keep the SBC for easy reference. Please note, receipt of this document does not constitute a determination of your eligibility. If you have any questions about coverage provided by the Fund, please call the Fund Office at 516-214-1300 or Associated Administrators, LLC at (855) 266-1500. If you have general questions about the SBC or the Glossary, you may want to contact the Employee Benefits Security Administration of the U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (877) 267-2323 Ext. 61565 or www.cciio.cms.gov.

Sincerely,

The Board of Trustees

ALLIED PRINTING TRADES UNION LABEL COUNCIL NEW YORK 505

UFCW Local 1500 Welfare Fund: Part-Time ACA Plan Coverage Period: January 1, 2016 – December 31, 2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Spouse* | **Plan Type:** EPO

*This Plan covers Employees only. Spouses are covered for Dental and Vision benefits only.

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 **1-800-522-0456**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$5,600/per calendar year. Balance billing and excluded services do not count toward the **deductible.**	The Fund pays the 1st $400 @ 100% of the Anthem allowance for all eligible expenses, then deductible is applied. 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 other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $5,600 for Medical Benefit and $1,000 for Prescription Drug Benefit	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?	Weekly Premiums, balance-billed charges, 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	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.anthem.com or call 1-800-810-BLUE	If you use an in-network doctor or other health care **provider**, 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. 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 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**.

- **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 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 **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services 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	No Charge	Not Covered	None
	Specialist visit	No Charge	Not Covered	None
	Other practitioner office visit	No Charge	Not Covered	Chiropractic visits limited to 50 visits per calendar year.
	Preventive care/ screening/ immunization	No Charge	Not Covered	Deductible does not apply.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Precertification required. Failure may result in a denial or reduction of benefits.

Common Medical Event	Services 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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Express-Scripts.com	Generic drugs	Retail: 20% coinsurance up to a maximum charge of $20; Mail Order $40 co-pay	Not Covered	Retail limited to 34-day supply; mail order limited to 3-month supply; if you obtain a brand name medication when a generic equivalent is available, you pay the applicable generic coinsurance plus the difference between the cost of the brand name drug and the generic. Utilization Management Program in effect. Precertification required for some drugs. Failure to do so may result in a denial of benefits. For more information contact Express Scripts at 1- 877- 861-8145.
	Preferred brand drugs	Retail: 20% coinsurance up to a maximum charge of $30; Mail Order $60 co-pay	Not Covered	
	Non-preferred brand drugs	Retail: 20% coinsurance up to a maximum charge of $60; Mail Order $120 co-pay	Not Covered	
	Specialty drugs	Same as non-preferred	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Precertification required for certain services. Failure may result in a denial or reduction of benefits.
	Physician/surgeon fees	No Charge	Not Covered	
If you need immediate medical attention	Emergency room services	$100 copayment	$100 copayment and balance between charge and In-network rate.	Copayment waived if admitted. Out-of-network: Covered only in true emergency situations and/or where there is no control over certain providers. Paid at the In-network level.
	Emergency medical transportation	No Charge	Not Covered	If air ambulance, condition must warrant air ambulance services.
	Urgent care	No Charge	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered – except in emergencies	Precertification required. Failure may result in a denial or reduction of benefits.
	Physician/surgeon fee	No Charge	Not Covered	None

Common Medical Event	Services 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 mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	Not Covered	None
	Mental/Behavioral health inpatient services	No Charge	Not Covered	Precertification required. Failure may result in a denial or reduction of benefits.
	Substance use disorder outpatient services	No Charge	Not Covered	None
	Substance use disorder inpatient services	No Charge	Not Covered	Precertification required. Failure may result in a denial or reduction of benefits.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	None
	Delivery and all inpatient services	No Charge	Not Covered	None
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	200 visits per calendar year. Precertification required. Failure may result in a denial or reduction of benefits.
	Rehabilitation services	No Charge	Not Covered	30 days per calendar year. Precertification required. Failure may result in a denial or reduction of benefits.
	Habilitation services	No Charge	Not Covered	30 days per calendar year. Precertification required. Failure may result in a denial or reduction of benefits.
	Skilled nursing care	No Charge	Not Covered	60 days per calendar year. Precertification required. Failure may result in a denial or reduction of benefits.
	Durable medical equipment	No Charge	Not Covered	Precertification required. Failure may result in a denial or reduction of benefits.
	Hospice service	No Charge	Not Covered	210 days per lifetime. Precertification required. Failure may result in a denial or reduction of benefits.
If your child needs dental or eye care	Eye exam	Not covered for children	Not covered for children	
	Glasses			
	Dental check-up			

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.)

- Cosmetic surgery (except reconstructive surgery that is incidental to or follows surgery for injury or disease to the involved party or to correct a functional defect)
- Hearing Aids
- Infertility treatment
- Long-Term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care (except capsular or bone surgery related to bunions and hammertoes or peripheral vascular disease.)
- Nutritional counseling, unless qualified under ACA preventive list
- Weight Loss Programs
- No coverage for spouse, except Dental and Vision benefits

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.)

- Chiropractic Care
- Bariatric Surgery
- Acupuncture
- Dental Care (limited to annual maximum of$2,000 per calendar year for employee and$1,500 for spouse) See the Plan's dental fee schedule
- Routine Eye Care (for employees and spouses) including unlimited pediatric vision care, where applicable. See the Plan's vision care fee schedule
- Private-duty nursing (must be precertified; limited to 30 days during any one period of illness)

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 the **cost of coverage**, 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 right to continue coverage, contact the plan at 1-800-522-0456. 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.coms.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 1-800-522-0456. 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 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 or policy 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 1-800-522-0456.

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** $ 840
- **Patient pays** $ 6,700

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	$5,600
Copays	$0
Coinsurance	$0
Limits or exclusions	$1,100
Total	**$6,700**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,760
- **Patient pays** $ 2,640

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	$2,100
Copays	$500
Coinsurance	$0
Limits or exclusions	$40
Total	**$2,640**

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 1-855-522-0456 or visit us at www.associated-admin.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.associated-admin.com or call **1-800-522-0456** to request a copy.