55 Water Street
New York, N.Y. 10041
Telephone: (212) 815 - 1234

# Health & DC37 Security Plan

**June 2021**

**The Plan wants you to understand why you are receiving the "Summary of Benefits and Coverage" (SBCs).**

- **The Patient Protection and Affordable Care Act requires that we send you an SBC summarizing the health-related benefits (including where applicable, dental and optical benefits) we provide. The SBC is meant to provide you with highly standardized information about health benefits so you can compare health plans that you are eligible for as you make decisions about your health care coverage. If you are eligible for any of the medical insurance plans provided through your employer, you should be receiving a separate SBC from your insurance carrier.**

**Please note that these notices are for your information only and they do not require you to take any action in order to maintain the benefits you are currently enrolled in.**

**Please keep this mailing in a safe place.**

# Health & DC 37 Security Plan

## Notice of "Grandfathered Status"

The DC 37 Health & Security Plan Trust ("Trust") believes its Trust, to the extent that it provides certain supplemental health-related benefits, is a "grandfathered health plan," as defined under the Patient Protection and Affordable Care Act (the "Affordable Care Act," also known as "Health Care Reform"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Trust may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits and extension of coverage to dependents up to age 26.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at DC 37, Health & Security Plan, 55 Water Street, New York, NY 10041.

## DC 37 Health & Security Plan Trust

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services

**Coverage Period: 07/01/2021-06/30/2022**
**Coverage for: Individuals + Dependents**
**Plan Type: Supplemental**

**This is only a Summary.** If you want more detail about your coverage and costs, you can get the complete terms in plan document posted at **https://www.dc37.net** or by calling **212-815-1234** (or **1-877-323-7738 for out of state retirees**). This Summary will be posted on the DC 37 website.

**This document only describes your supplemental benefits, which include prescription drug, dental and optical coverage** provided by the **DC 37 Health & Security Plan Trust.** This SBC shows you how you and the plan would share the cost for these covered supplemental services. You may receive medical or other health coverage from your employer or other sources.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$0** | See the chart starting on page 2 for your costs for services this plan covers |
| **Are there services covered before you meet your deductible?** | **No - N/A** | There are no deductibles for these supplemental services |
| **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. |
| **What is the out-of-pocket limit for this plan?** | **No - N/A** | Not applicable because there is no out-of- pocket limit on your expenses. |
| **What is not included in the out-of-pocket limit?** | **No - N/A** | Not applicable because there's no out-of-pocket limit on your expenses. |
| **Will you pay less if you use a network provider?** | **Yes.** For a list of participating provides see https://www.DC37.net or call 212-815-1234 or 1-877-323-7738 for out of state retirees. | 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 providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers. |
| **Do you need a referral to see a specialist?** | **No** | You can choose the in-network specialist you want without permission from this plan. |
| | | |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. Since this is a supplemental benefit, the co-pays listed below only apply to covered prescription drugs.

| 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 | Not Covered | Not Covered | You may have coverage through another plan. |
| | Specialist visit | Not Covered | Not Covered | You may have coverage through another plan. |
| | Preventive care/screening/ immunization | Not Covered | Not Covered | You may have coverage through another plan. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Not Covered | Not Covered | You may have coverage through another plan. |
| | Imaging (CG/PET scans, MRIs) | Not Covered | Not Covered | You may have coverage through another plan. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at https://www/dc37.net | Generic drugs | Not Covered | | You may have coverage through another plan. |
| | Preferred brand drugs | | | |
| | Non-preferred brand drugs | | | |
| | Specialty drugs | | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Not Covered | Not Covered | You may have coverage through another plan. |
| | Physician/surgeon fees | Not Covered | Not Covered | You may have coverage through another plan. |
| **If you need immediate medical attention** | Emergency room services | Not Covered | Not Covered | You may have coverage through another plan. |
| | Emergency medical transportation | Not Covered | Not Covered | You may have coverage through another plan. |
| | Urgent care | Not Covered | Not Covered | You may have coverage through another plan. |
| **If you are pregnant** | Prenatal and postnatal case | Not Covered | Not Covered | You may have coverage through another |

* For more information about limitations and exceptions, see the plan or policy document at https:www.dc37.net or call 212-815-1234 or 1-877-323-7738 for out of state retirees

| 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) | |
| | | | | plan. |
| | Delivery and all inpatient services | Not Covered | Not Covered | You may have coverage through another plan. |
| **If you need help recovering or have other special health needs** | Home health care<br>Rehabilitation services<br>Habilitation services<br>Skilled nursing care<br>Durable Medical equipment<br>Hospice service | Not Covered | Not Covered | You may have coverage through another plan. |
| **If your child needs dental or eye care** | Eye exam | $0 | Maximum reimbursement is $6 | The Vision Benefit may be used once every two years for each covered individual. |
| | Glasses | $0 | Maximum reimbursement is $9 for lenses & $5 for frames | |
| | Dental Check-up | $0 | Maximum reimbursement will be based upon services provided. | A maximum annual amount $1,700 will be paid for covered dental benefits. See plan document for procedures requiring prior authorizations & frequency limitations. |

**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
- Drugs, dental, optical outside U.S.A.
- Weight loss programs
- Bariatric Services
- Some Infertility Treatments
- Cosmetic Surgery
- Chiropractic Services
- Long Term Care
- Private Duty Nursing

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

- Dental Care (Adult)
- Hearing Aids
- Routine Eye Care (Adult)

* For more information about limitations and exceptions, see the plan or policy document at https:www.dc37.net or call 212-815-1234 or 1-877-323-7738 for out of state retirees

**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: [New York 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 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: [https://www.dc37.net or call 212-815-1234 or 1-877-323-7738 for out of state retirees].

**Does this plan provide Minimum Essential Coverage?** **[Yes] For prescription drugs. Health insurance may be available through another plan.**
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?** **[Not Applicable]**
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:**
Please reach out to 212-815-1234 for assistance.

*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 https:www.dc37.net or call 212-815-1234 or 1-877-323-7738 for out of state retirees

**About these Coverage Examples: The examples below do not apply to the supplemental benefits covered by the DC 37 Health & Security Plan Trust.**

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

**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 | $ |
| Copayments | $ |
| Coinsurance | $ |
| *What isn't covered* | |
| Limits or exclusions | $ |
| **The total Peg would pay is** | **$** |

## Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

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

**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** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $ |
| Copayments | $ |
| Coinsurance | $ |
| *What isn't covered* | |
| Limits or exclusions | $ |
| **The total Joe would pay is** | **$** |

## Mia's Simple Fracture

(in-network emergency room visit and follow up care)

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

**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** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $ |
| Copayments | $ |
| Coinsurance | $ |
| *What isn't covered* | |
| Limits or exclusions | $ |
| **The total Mia would pay is** | **$** |

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

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