DC 37 Health & Security Plan Trust

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

Coverage Period: 07/01/2018 – 06/30/2019
Coverage for: Individual + 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 the policy or plan document at **http://www.dc37.net** or by calling **212-815-1234 (or 1- 877-323-7738 for out of state retirees)**.

This document only describes your supplemental benefits (including prescription drug, dental and optical coverage) provided by the DC37Health & Security Plan Trust. You may be receiving medical or other health coverage from an alternate source.

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 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?	No	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services
What is not included in the out–of–pocket limit?	This plan has no out-of-pocket limit.	Not applicable because there's no out-of-pocket limit on your expenses.
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 **participating providers** see http://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 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 4. See your policy or plan document for additional information about excluded services.

Questions: Call **212-815-1234 (or 1- 877-323-7738 for out of state retirees)** or visit us at **http://www.dc37.net**
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 call **212-815-1234 (or 1- 877-323-7738 for out of state retirees)** to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

- **Co-payments** are fixed dollar amounts (for example, $15 you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** 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	Not Covered	Not Covered	See your employer's SBC for a description of what medical coverage is provided.
	Specialist visit			
	Other practitioner office visit			
	Preventive care/screening/immunization			
If you have a test	Primary care visit to treat an injury or illness	Not Covered	Not Covered	See your employer's SBC for a description of what medical coverage is provided.
	Specialist visit			
If you need drugs to treat your illness or condition. [More information about **prescription drug coverage** is available at http://www.dc37.net]	Generic drugs	$10- $30	Reimbursement is according to the plan's fee schedule.	Some drugs are subject to prior authorization (no coverage if not obtained), step therapy, or quantity limits.
	Preferred brand drugs	$20 - $60		
	Non-preferred brand drugs	$45.50 - $136.50		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	See your employer's SBC for a description of what medical coverage is provided.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	Not Covered	Not Covered	See your employer's SBC for a description of what medical coverage is provided.
	Emergency medical transportation			
	Urgent care			

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 a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	See your employer's SBC for a description of what medical coverage is provided.
	Physician/surgeon fee			
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not Covered	Not Covered	See your employer's SBC for a description of what medical coverage is provided.
	Mental/Behavioral health inpatient services			
	Substance use disorder outpatient services			
	Substance use disorder inpatient services			
If you are pregnant	Prenatal and postnatal care	Not Covered	Not Covered	See your employer's SBC for a description of what medical coverage is provided.
	Delivery and all inpatient services			
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	See your employer's SBC for a description of what medical coverage is provided.
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice service			
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 and $5 for frames.	
	Dental check-up	$0	Maximum Reimbursement available is based on the services provided.	A maximum of $1,700 will be paid as dental benefits for each covered person in a single calendar year.

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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Drugs, dental, optical outside US
- Infertility Treatment
- Long-term care
- Private-duty nursing
- Weight loss programs

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.)

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

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**, 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 rights to continue coverage, contact the plan at 212-815-1234 (or 1- 877-323-7738 for out of state retirees). 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.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: The Inquiry Unit at 212-815-1234 (or 1- 877-323-7738 for out of state retirees) or by visiting Room 300 at 125 Barclay Street, New York, NY 10007.

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, when considered alone, does not provide minimum essential coverage. However, in combination with employer-sponsored health benefits which may be available to you and which you may elect to be covered by, these benefits together would meet the "minimum essential coverage" standard.

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). In combination with other employer-sponsored health benefits which may be available to you and which you may elect to be covered by, these benefits together would meet the minimum value standard.

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** $180
- **Patient pays** $7,360*

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	$0
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$0
Total	**$7,360**

* Most costs cited above do not specifically apply to Trust supplemental benefits. See your employer's SBC for a description of what medical coverage is provided.

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

- **Amount owed to providers:** $4,100
- **Plan pays** $0
- **Patient pays** $4,100*

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$0
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$0
Total	**$4,100**

* The costs cited above do not specifically apply to Trust supplemental benefits. See your employer's SBC for a description of what medical coverage is provided.

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.