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, please contact the Fund Administrator, c/o Benefit Program Administration at 1-800-386-4350. 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 http://www.healthcare.gov/sbc-glossary or call 1-800-386-4350 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$350** person/In Network **$1,050** family **$700** person/Out of Network **$2,100** family	You must pay all of 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?	Yes	In accordance with the provisions of the Affordable Care Act (ACA) Preventative Care (as recommended by the U.S. Preventative Services Task Force) In Network preventative care is not subject to the deductible. Preventative Care provided Out of Network are subject to the deductible.
Are there other deductibles for specific services?	No	There are no other specific deductibles. 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?	The following Out of Pocket Limits are calendar year. **$4,300** person/In Network Medical Providers **$8,600** family/In Network Medical Providers **$3,050** person/Express Scripts **$6,100** family/Express Scripts Non-network providers, **$4,000** person/for most services.	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. Note: Out-of-network hospital charges do not apply.
What is not included in the out-of-pocket limit?	Balance-billed charges, non-covered charges, and penalties for failure to obtain pre-authorization.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. See pages 2-5.
Will you pay less if you use a network provider?	Yes	You benefit directly when you use AETNA Choice POS II physicians and network hospitals because AETNA providers have agreed to accept contractual rates. Covered expenses are paid at 80% for AETNA Choice POS II medical facilities and physician charges (compared to 60% of usual, customary and reasonable charges for non-PPO providers.
Do you need a referral to see a specialist?	No	A physician referral is not required to see a Specialist. The plan does require Pre-Authorization of all non-emergency hospitalizations. Failure to obtain a Pre-Authorization will result in a 30% reduction in the applicable benefit.

* For more information about limitations and exceptions, see the plan SPD.

Important Questions	Answers	Why This Matters:

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	20% coinsurance	40% coinsurance of UCR charges	Must be medically necessary. See the Summary Plan Description (SPD) for What is Not Covered.
	Specialist visit	20% coinsurance	40% coinsurance of UCR charges	Must be medically necessary, see SPD.
	Preventive care/screening/ immunization	No charge	40% coinsurance of UCR charges	As recommended by U.S. Preventative Services Task Force
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance of UCR charges	Must be medically necessary. Certain Diagnostic tests must be pre-authorized. Call 1-888-632-3862 – 30% penalty for non-compliance.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance of UCR charges	Must be medically necessary. Certain Diagnostic tests must be pre-authorized. Call 1-888-632-3862 – 30% penalty for non-compliance.
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	**$20** co-pay per prescription (retail)	40% coinsurance after the $700 Major Medical deductible is satisfied.	Up to a one-month supply (retail) and 90-day supply (mail order) for medically necessary, FDA-approved drugs - through Express Scripts participating pharmacy. Mail order co-pays are twice the retail co-pay. Must use mail order Specialty Pharmacy Program through Accredo phone number is 1-866-848-9870
	Brand drugs	**$30** co-pay per prescription (retail)	40% coinsurance after the $700 Major Medical deductible is satisfied.	
	Specialty drugs	See Above	40% coinsurance after the $700 Major Medical deductible is satisfied.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance of UCR charges	Pre-Notification required on certain elective surgeries. Call 1-888-632-3862
	Physician/surgeon fees	20% coinsurance	Same as above	Same as above
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance of UCR charges	Must be medically necessary; see SPD.
	Emergency medical transportation	40% coinsurance	40% coinsurance of UCR charges	Must be medically necessary. Local, surface ambulance transportation to and from the nearest hospital where care and treatment of the illness and injury can be given.
	Urgent care	20% coinsurance	40% coinsurance of UCR charges	Must be medically necessary; see SPD.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance semi-private room	40% coinsurance of UCR charges	Pre-Notification required on certain elective surgeries. Call 1-888-632-3862; Must be medically necessary; see SPD.
	Physician/surgeon fees	20% coinsurance	40% coinsurance of UCR charges	SPD.

* For more information about limitations and exceptions, see the plan SPD.

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	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	Must be medically necessary; Group therapy, hypnotherapy and family counseling is not covered, see SPD.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Must be medically necessary; Group therapy, hypnotherapy and family counseling is not covered, see SPD.
	Substance use disorder outpatient services	Not covered	Not covered	
	Substance use disorder inpatient services	Not covered	Not covered	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance of UCR charges	——————None——————
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance of UCR charges	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance of UCR charges	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance of UCR charges	Speech and Occupational Therapy is not covered, see SPD
	Rehabilitation services	20% coinsurance	40% coinsurance of UCR charges	
	Habilitation services	20% coinsurance	40% coinsurance of UCR charges	
	Skilled nursing care (licensed)	20% coinsurance	40% coinsurance of UCR charges	Must be medically necessary. Limited to 60-day maximum per disability when confinement is preceded by at least 3-days in a hospital; is for the same condition preceding the confinement; commences within 7-days after discharge from such confinement. See SPD.
	Durable medical equipment	20% coinsurance	40% coinsurance of UCR charges	Plan will cover only up to purchase price.
	Hospice services (licensed)	20% coinsurance	40% coinsurance of UCR charges	With Physician diagnosis as terminally ill with prognosis of 6 months or less to live and care must be prescribed, reviewed and approved by physician. Hospice care includes services and supplies furnished by a Home Health Care Agency as well as palliative and supportive medical nursing services. See SPD.
If your child needs dental or eye care	Children's eye exam (VSP)	$25 copayment	Not Covered	Exam – once every 12 months, see SPD.
	Children's glasses (VSP)	$50 copayment	Not Covered	Once every 24 months; see SPD.
	Children's dental check-up (Basic Dental Plan)	90% of Table of Allowance	90% of Table of Allowance	$50 Annual Deductible per person. $2,000 Annual Maximum Benefit does not apply to children under 19. It is strongly recommended that services exceeding $500 be preauthorized. See SPD.

* For more information about limitations and exceptions, see the plan SPD.

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.)

- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Weight loss programs

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

- Acupuncture (if pre-approved Medical Review)
- Bariatric surgery (if pre-approved Medical Review)
- Chiropractic care
- Dental care (Adult)
- Routine eye care (Adult)
- Routine foot care

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 Administrative Office at. 1-800-386-4350 or visit us at www.opeiufunds.org for more information including a copy of your plan's Summary Plan Description (SPD)..

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 1-800-386-4350.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-386-4350.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-386-4350.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-386-4350.]

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

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* For more information about limitations and exceptions, see the plan SPD.

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	$350
Specialist copayment	$0
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$350
Copayments	$80
Coinsurance	$2,402
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,832**

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

The plan's overall deductible	$350
Specialist copayment	$0
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$350
Copayments	$840
Coinsurance	$1,102
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,292**

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

The plan's overall deductible	$350
Specialist copayment	$0
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$350
Copayments	$0
Coinsurance	$310
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$660**

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