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Summary of Benefits
(Benefit Coverage Plans A and B)

	Benefit	Benefit Coverage Plan A		Benefit Coverage Plan B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Financial	Deductible	None	$250 Individual; $500 Family	None	$300 Individual; $600 Family
	Maximum out-of-pocket cost (does not include charges in excess of allowed amount or noncovered benefits)	$1,000 Individual; $2,000 Family copayment maximum	None	$1,000 Individual; $2,000 Family copayment maximum	None
	Coinsurance	None	70%/30%	None	70%/30%
	Reimbursement rate	None	70th percentile	None	70th percentile
Preventive Care	Well-child and well-adult visits	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR
	Well-woman visits	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR
	Immunizations	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR

June 2018

The information contained herein should not be viewed as a substitute for the most recent *Summary Plan Description* and any relevant Summary of Material Modifications. In case of discrepancies or contradictions, the language and terms of the SPD and SMMs shall prevail.

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		In-Network	Out-of-Network	In-Network	Out-of-Network
Maternity Care	Obstectrical, prenatal care, delivery, and postnatal care for mother	$10 copayment for initial visit only	Paid at 100% of UCR	$10 copayment for initial visit only	Paid at 100% of UCR
Inpatient Care	Room and board	No cost	$500 copay/admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply) Paid at 70%	No cost	$500 copay/admission up to $1,500 max per individual (deductible does not apply) Paid at 70%
	Physician's services	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR
	Surgery (Physician's services)	No cost	Paid at 100% of UCR	No cost	Paid at 100% of UCR
	Restorative physical and occupational therapy	No cost	$500 copay/admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply) Paid at 70%	No cost	$500 copay/admission up to $1,500 max per individual (deductible does not apply) Paid at 70%
	Skilled nursing facility	No cost	$500 copay/admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply) Paid at 70%	No cost	$500 copay/admission up to $1,500 max per individual (deductible does not apply) Paid at 70%

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		In-Network	Out-of-Network	In-Network	Out-of-Network
Outpatient Care	Office visits	$10 copay/visit PCP; $25 copay/visit specialist	Paid at 70% of UCR	$10 copay/visit PCP; $30 copay/visit specialist	Paid at 70% of UCR
	Chiropractic care*	$10 copayment per visit	Paid at 70% of UCR	$30 copayment per visit	Paid at 70% of UCR
	Acupuncture*	$25 copayment per visit	Paid at 70% of UCR	$30 copayment per visit	Paid at 70% of UCR
	Allergy treatment*	$25 copayment per visit	Paid at 70% of UCR	$30 copayment per visit	Paid at 70% of UCR
	Restorative physical and occupational therapy*	$10 copayment per visit	Paid at 70% of UCR	$30 copayment per visit	Paid at 70% of UCR
	Cardiac rehabilitation*	$10 copayment per visit	Paid at 70% of UCR	$30 copayment per visit	Paid at 70% of UCR
	Radiology/imaging	No cost	Paid at 70% of UCR	$25 copayment	Paid at 70% of UCR
	Laboratory tests	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR
	Restorative speech therapy for up to 60 consecutive days*	$10 copayment per visit	Paid at 70% of UCR	$30 copayment per visit	Paid at 70% of UCR
	Surgery (physician's services)	No cost	Paid at 100% of UCR	No cost	Paid at 100% of UCR
	Surgery (facility charges)	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR

* If services are provided by a PCP (family/general practitioner, internist, OB/GYN, or pediatrician) $10 copay (Plans A and Plan B) applies.

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		In-Network	Out-of-Network	In-Network	Out-of-Network
Other Services	Physician house calls	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR
	Skilled home health care services	No cost	Paid at 75%	No cost	Paid at 75%
	Home hospice care (up to 210 days)	No cost	Paid at 75%	No cost	Paid at 75%
	Inpatient hospice care (up to 210 days)	No cost	$500 copay/admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply) Paid at 70%	No cost	$500 copay/admission up to $1,500 max per individual (deductible does not apply) Paid at 70%
	Durable medical equipment	Paid at 80% of cost of covered items to an unlimited maximum per participant or dependent per calendar year	Paid at 70% of cost of covered items to an unlimited maximum/ participant or dependent per calendar year	Paid at 80% of cost of covered items to an unlimited maximum/ participant or dependent per calendar year	Paid at 70% of cost of covered items to an unlimited maximum/ participant or dependent per calendar year
	In vitro fertilization services and covered fertility drugs[+] (up to a $5,000 lifetime maximum benefit. May elect to use the $5,000 max for prescriptions, if desired.)	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR
ER	At hospital emergency room (waived if admitted)	$75 copayment per visit		$100 copayment per visit	

[+] RNs at St. Joseph Hospital do not have coverage for infertility, including in vitro fertilization services and infertility drugs

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		In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health	Outpatient mental health	$25 copayment per visit	Paid at 70% of UCR	$30 copayment per visit	Paid at 70% of UCR
	Inpatient mental health care	No cost	$500 copay/ admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply) Paid at 70%	No cost	$500 copay/ admission up to $1,500 max per individual (deductible does not apply) Paid at 70%
Substance Abuse	Outpatient medical rehabilitative care for substance abuse/ alcohol addiction	$25 copayment per visit	Paid at 70% of UCR	$30 copayment per visit	Paid at 70% of UCR
	Inpatient medical rehabilitative care for substance abuse/alcohol addiction	No cost	$500 copay/admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply) Paid at 70%	No cost	$500 copay/ admission up to $1,500 max per individual (deductible does not apply) Paid at 70%

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		In-Network	Out-of-Network	In-Network	Out-of-Network
Dental Care (Aetna)	Yearly deductible	None	$50/individual; $150/family	None	$50/individual; $150/family
	Maximum yearly benefit	$1,200	$1,200	$1,200	$1,200
	Orthodontia maximum	$1,000 per course of treatment separated by two years	$1,000 per course of treatment separated by two years	$1,000 per course of treatment separated by two years	$1,000 per course of treatment separated by two years
	Diagnostic and preventive services	No cost	Paid at 80% of usual and prevailing fee	No cost	Paid at 80% of usual and prevailing fee
	Basic restorative services, endodontics, periodontics, maintenance of prosthodontics, and oral surgery	Paid at 80% of fee schedule	Paid at 80% of usual and prevailing fee	Paid at 80% of fee schedule	Paid at 80% of usual and prevailing fee
	Major restorative services, installation of prosthodontics, and orthodontics	Paid at 50% of fee schedule	Paid at 50% of usual and prevailing fee	Paid at 50% of fee schedule	Paid at 50% of usual and prevailing fee
Prescription Drugs (ESI)	Yearly deductible	None	None	None	None
	Maximim network out-of-pocket cost (doesn't include clinical pharmacy program penalties)	$6,350 Individual; $12,700 Family	None	$6,350 Individual $12,700 Family	None
	Prescription drugs at retail pharmacy (up to a 34-day supply)	Tier 1: $0 Generic Tier 2: $10 Preferred Tier 3: $20 Non-preferred	Reimbursed at contracted amount minus applicable in-network copayment	Tier 1: $7 Generic Tier 2: $20 Preferred Tier 3: $35 Non-preferred	Reimbursed at contracted amount minus applicable in-network copayment
	Mail-order prescription drug program (mandatory for all maintenance prescription medications for up to a 90-day supply)	Tier 1: $0 Generic Tier 2: $20 Preferred Tier 3: $40 Non-preferred	Not applicable	Tier 1: $15 Generic Tier 2: $40 Preferred Tier 3: $70 Non-preferred	Not applicable

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Prescription Drug Programs	Mandatory generics	Applies to all drugs filled at a retail pharmacy or by mail-order. If brand-name is selected instead of generic, participant pays applicable copay and cost difference between generic and brand-name. This applies even if the physician writes "DAW."	Applies to all drugs filled at a retail pharmacy or by mail-order. If brand-name is selected instead of generic, participant pays applicable copay and cost difference between generic and brand-name. This applies even if the physician writes "DAW."
	Preferred specialty drugs	Same copays as non-specialty drugs (retail and mail-order)	Same copays as non-specialty drugs (retail and mail-order)
	High performance step therapy (The practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other more costly therapy, only if necesaary.)	Four therapeutic classes of drugs applies. Copay applies if step therapy guidelines are not followed: Retail copay - 25% or $50 max; Mail-order copay - 50% or $100 max (Automatic override will be applied for first or subsequent steps if the physician determines medical necessity; participant will pay only the copay associated with the prescribed drug, not the amount cited above for failing to follow step therapy guidelines.)	Full list of therapeutic classes applies. Copay applies if step therapy guidelines are not followed: Retail copay - 25% or $50 max; Mail-order copay - 50% or $100 max (Automatic override of first or subsequent steps will be applied for five therapeutic classes if the physician determines medical necessity. For all other drugs, waiver of first step is possible only if OptumRx determines an exception.)
	Preferred specialty pharmacy program	For growth hormone deficiency and reumatoid arthritis class. Preferred specialty copay is standard specialty copay; non-preferred specialty copay is 10% of drug cost ($200 max)	For growth hormone deficiency and reumatoid arthritis class. Preferred specialty copay is standard specialty copay; non-preferred specialty copay is 10% of drug cost ($200 max)

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	Benefit	Benefit Coverage Plans A and B In-network Plan	Benefit Coverage Plans A and B Out-of-network Plan
Vision Care (Davis Vision)	Routine eye exam every two years (every year for children up to age 18)	$10 copayment per visit	Paid at up to $75 for exam and glasses or contact lenses (every two years)
	Eyeglasses or contact lenses every 2 years (through Davis Vision)	$30 copay for lenses and/or Designer selection frames within the Davis Collection, or $150 credit toward non-plan frames, or $25 copay for disposable/planned replacement lenses	

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Disability	Short-term, nonoccupational disability (through The Hartford)	Paid at two-thirds of regular, weekly compensation, up to $215 per week for a maximum period of 26 weeks
	Long-term disability that extends beyond the qualifying period of six consecutive months (through the NYSNA Benefits Fund)	Paid at 50% of monthly base compensation, up to $350 per month, less other disability payments, to age 65 (age 70 if disabled after age 60)
Other Insurance (The Hartford)	Life	Paid at a minimum of $20,000 and a maximum of $50,000, computed by taking 150% of current base compensation, to the maximum allowable. Benefit is reduced 35% at age 65, and 50% at age 70.
	Accidental death and dismemberment and loss of sight	Paid at 100% or 50% of maximum benefit, according to specific loss