**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services **I.B.E.W Local #143: Aetna Choice POS II**

**Coverage Period: 01/01/2025 - 12/31/2025 Coverage for:** Individual/Individual + Family | **Plan Type:** EPO

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| **The Summary of Benefits and Coverage (SBC) document will help you choose a health** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**. The SBC shows you how you and the** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **would share the cost for covered health care services. NOTE: Information about the cost of this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **(called the** [**premium**](https://www.healthcare.gov/sbc-glossary/#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 call 833-484-0454. For generaldefinitions of common terms, such as [allowed amount](https://www.healthcare.gov/sbc-glossary/#allowed-amount), [balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing), [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance), [copayment](https://www.healthcare.gov/sbc-glossary/#copayment), [deductible](https://www.healthcare.gov/sbc-glossary/#deductible), [provider](https://www.healthcare.gov/sbc-glossary/#provider), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary>or call 833-484-0454 to request a copy. |
| **Important Questions** | **Answers** | **Why This Matters:** |
| **What is the overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | For [in-network providers](https://www.healthcare.gov/sbc-glossary/#network-provider): **None** For [out-of-network providers](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider): **Not Applicable** | Generally, you must pay all of the costs from [providers](https://www.healthcare.gov/sbc-glossary/#provider) up to the [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount before this [plan](https://www.healthcare.gov/sbc-glossary/#plan) begins to pay. If you have other family members on the [plan](https://www.healthcare.gov/sbc-glossary/#plan), each family member must meet their own individual [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) until the total amount of [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) expenses paid by all family members meets the overall family [deductible](https://www.healthcare.gov/sbc-glossary/#deductible). |
| **Are there services covered before you meet your** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | The plan does not require that you meet a deductible before covered services and treatments are provided.  | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers some items and services even if you haven’t yet met the [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount. But a [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) or [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) may apply. For example, this [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers certain [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care) without [cost-sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) and before you meet your [deductible](https://www.healthcare.gov/sbc-glossary/#deductible). See a list of covered [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care) at <https://www.healthcare.gov/coverage/preventive-care-benefits/>. |
| **Are there other** [**deductibles**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | No. | You don't have to meet [deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) for specific services. |
| **What is the** [**out-of-pocket**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)[**limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) **for this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**?** | For [in-network providers](https://www.healthcare.gov/sbc-glossary/#network-provider): **$5,000**/individual or **$10,000**/family; For [out-of-network providers](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider): **Not Applicable** | The [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) is the most you could pay in a year for covered services. If you have other family members in this [plan](https://www.healthcare.gov/sbc-glossary/#plan), they have to meet their own [out-of-pocket limits](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) until the overall family [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) has been met. |
| **What is not included in the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)**?** | Penalties for failure to obtain [pre-authorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) for services, [premiums](https://www.healthcare.gov/sbc-glossary/#premium), [balance-billing](https://www.healthcare.gov/sbc-glossary/#balance-billing) charges, and health care this [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn’t cover. | Even though you pay these expenses, they don't count toward the [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit). |

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| **Important Questions** | **Answers** | **Why This Matters:** |
| **Will you pay less if you use a** [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** | Yes. See [**www.aetna.com/individuals-families/find-a-doctor.html**](http://www.aetna.com/individuals-families/find-a-doctor.html%20) **or call** 833-484-0454 for a list of [network providers](https://www.healthcare.gov/sbc-glossary/#network-provider). | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) uses a [provide](https://www.healthcare.gov/sbc-glossary/#provider)r [network](https://www.healthcare.gov/sbc-glossary/#network). The Plan only provides benefits for Network treatments and services except for emergency care from out-of-network providers and facilities, certain services performed by an out-of-network provider at an in-network hospital or ambulatory surgical center, and air ambulance services as required by the No Surprises Act which was enacted as part of the Consolidated Appropriations Act, 2021. |
| **Do you need a** [**referral**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)**?** | No. | You can see the [specialist](https://www.healthcare.gov/sbc-glossary/#specialist) you choose without a [referral](https://www.healthcare.gov/sbc-glossary/#referral). |

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|  | All [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) and [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) costs shown in this chart are after your [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) has been met, if a [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) applies. |
| **Common Medical Event** | **Services You May Need** | **What You Will Pay** | **Limitations, Exceptions, & Other Important Information** |
| **In-Network Provider****(You will pay the least)** | **Out-of-Network Provider****(You will pay the most)** |
| **If you visit a health care** [**provider's**](https://www.healthcare.gov/sbc-glossary/#provider) **office or clinic** | Primary care visit to treat an injury or illness | $20 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit  | Not Covered | None |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit | $20 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit | Not Covered | None |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)/ [screening](https://www.healthcare.gov/sbc-glossary/#screening)/ immunization | No charge/visitNo charge/screeningNo charge/immunizations | Not Covered | You may have to pay for services that aren’t preventive. Ask your [provider](https://www.healthcare.gov/sbc-glossary/#provider) if the services you need are preventive. Then check what your [plan](https://www.healthcare.gov/sbc-glossary/#plan) will pay for. |
| **Common Services You May Need Medical Event** | **What You Will Pay** | **Limitations, Exceptions, & Other Important Information** |
| **In-Network Provider Out-of-Network Provider****(You will pay the least) (You will pay the most)** |
| **If you need drugs to treat your illness or condition**More information about [prescription drug coverage](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) is available at[*www.benecardpbf.com*](http://www.benecardpbf.com) or by calling 1-888-907-0070.  | Generic Drugs (Tier 1) | Retail: 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) /Mail Order: $20 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) | Not Covered | Drugs dispensed at Benecard PBF Network Pharmacy you will generally receive a 34-day supply. You can obtain up to a 90-day supply through Mail Order Program. If you choose a brand-name drug when a generic is available, you will pay the [copay](https://www.healthcare.gov/sbc-glossary/#copayment) plus cost difference between the generic and brand-name drug. This rule applies even if your doctor writes “Dispense as Written” on your prescription. This benefit is only available if you have your prescriptions filled at a Benecard PBF Network Pharmacy. Precertification may be required. |
| Brand-Name Drugs | Retail: 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) /Mail Order: $20 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) | Not Covered |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) (Tier 4) | Retail: $20 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/Mail Order: $20 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) | Not Covered |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge  | Not Covered | Precertification may be required |
| Physician/surgeon fees | No charge  | Not Covered | Precertification may be required |
| **If you need immediate medical attention** | [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) | $200 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit |  $200 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit | Per visit [copay](https://www.healthcare.gov/sbc-glossary/#copayment) is waived if admitted |
| [Emergency medical](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation)[transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) | No charge  | No charge | Non-Emergency transportation check SBC for coverage |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) | $20 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit |  $20 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge  | Not Covered | Precertification required |
| Physician/surgeon fees | No charge  | Not Covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge/visit\*\*   | Not Covered | None |
| Inpatient services | No charge | Not Covered | Precertification required. |
| **If you are pregnant** | Office visits | $20 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit | Not Covered | Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy.Depending on the type of services, a [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| Childbirth/deliveryProfessional services | No charge  | Not Covered |
| Childbirth/delivery facility services | No charge |  Not Covered |

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| **Common Medical Event** | **Services You May Need** | **What You Will Pay** | **Limitations, Exceptions, & Other Important Information** |
| **In-Network Provider****(You will pay the least)** | **Out-of-Network Provider****(You will pay the most)** |
| **If you need help recovering or have other special health needs** | [Home health care](https://www.healthcare.gov/sbc-glossary/#home-health-care) | No charge  | Not Covered | Precertification required |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | Physical Medicine, Speech & Occupational Therapy, Spinal Manipulations: No charge Other Therapy Services: No charge  |  Physical Medicine, Speech & Occupational Therapy, Other  Therapy Services: Not Covered  Spinal Manipulations: No charge | Physical Medicine & Spinal Manipulations no visit limit per Benefit Period. Occupational and Speech Therapy limited to 12 visits per Benefit period per therapyOther Therapy Services: Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) | No charge  |  Not Covered | Services are covered when Medically Necessary to treat a mental health condition (e.g. autism).Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | No charge  |  Not Covered | Precertification required |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) | No charge |  Not Covered |  Precertification may be required |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) | No charge  |  Not Covered  |  Precertification may be required |

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# Excluded Services & Other Covered Services:

**Services Your** [**Plan**](https://www.healthcare.gov/sbc-glossary/#plan) **Generally Does NOT Cover (Check your policy or** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services)**.)**

* Acupuncture
* Cosmetic surgery
* Hearing aids
* Infertility treatment
* Long-term care
* Non-emergency care when traveling outside the U.S.
* Routine eye care (Adult)
* Routine foot care
* Weight loss programs
* Orthoptic/Visual Therapy
* Speech Therapy 12 visits per Benefit period
* Occupational Therapy 12 visits per Benefit period
* Autism Spectrum Disorder including Applied Behavioral Analysis

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document.)**

**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: Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace). For more information about the [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace), visit [www.HealthCare.gov](http://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](https://www.healthcare.gov/sbc-glossary/#plan) for a denial of a [claim](https://www.healthcare.gov/sbc-glossary/#claim). This complaint is called a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) or [appeal](https://www.healthcare.gov/sbc-glossary/#appeal). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](https://www.healthcare.gov/sbc-glossary/#claim). Your [plan](https://www.healthcare.gov/sbc-glossary/#plan) documents also provide complete information to submit a [claim](https://www.healthcare.gov/sbc-glossary/#claim), [appeal](https://www.healthcare.gov/sbc-glossary/#appeal), or a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) for any reason to your [plan](https://www.healthcare.gov/sbc-glossary/#plan). For questions about your rights, this notice, or assistance, you can contact Customer service at 888-246-8792.

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](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your [appeal](https://www.healthcare.gov/sbc-glossary/#appeal). Contact the program for this [plan's](https://www.healthcare.gov/sbc-glossary/#plan) situs state: Pennsylvania Consumer Assistance Program at 877-881-6388. However, for information regarding your own state's consumer assistance program refer to [www.healthcare.gov](http://www.healthcare.gov/).

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn't meet the [Minimum Value Standards](https://www.healthcare.gov/sbc-glossary/#minimum-value-standard), you may be eligible for a [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits) to help you pay for a [plan](https://www.healthcare.gov/sbc-glossary/#plan) through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace).