MILA Premier Plan

Benefits Summary

Shown below is the MILA Premier Plan Benefits Summary for eligible active Members, and for those Pensioners age 62 or older who are not yet eligible to enroll for Medicare. This chart allows you to see at a glance the key plan features. The copay, deductible, and coinsurance amount below reflect what you pay. MILA pays the balance of covered charges.

Summary Of The MILA National Health Plan: Premier Benefits		
	Premier	
Features	**In-Network**	**Out-Of-Network**
Calendar Year Deductible—*This deductible applies to both medical and behavioral health benefits.*		
Individual	None	$300
Family Limit	None	$600
Annual Out-of-Pocket Maximum—*This maximum includes your deductible and coinsurance payment for medical and behavioral health benefits.*		
Individual	None	$6,500
Family Limit	None	$13,000
No Lifetime Maximum Benefit		
Physician Services Copay/Visit		
Primary Care Physician (PCP)	$15 copay/visit	40% of R&C* after deductible plus excess over R&C
Specialist Physician	$30 copay/visit	40% of R&C after deductible plus excess over R&C
Short-Term Rehabilitation (STR)	$10 copay/visit	40% of R&C after deductible plus excess over R&C
Behavioral Health Provider	$15 copay/visit	40% of R&C after deductible plus excess over R&C
Preventive Care	$15 copay/visit	**In-Network Only**
Maternity Care (one/pregnancy)	$15 copay/pregnancy	40% of R&C after deductible plus excess over R&C
Hospital Care		
Hospital Inpatient Care including professional services (Precertification Required)	$0 (Paid in full by Plan)	40% of R&C after deductible plus excess over R&C
Hospital Outpatient Surgery/Testing	$0 (Paid in full by Plan)	40% of R&C after deductible plus excess over R&C
Emergency Room (emergency only/waived if admitted)	$25 copay/visit	Treated as In-Network
Urgent Care Center	$25 copay/visit	40% of R&C after deductible plus excess over R&C
Ambulance	$0 (Paid in full by Plan)	40% of R&C after deductible plus excess over R&C
Skilled Nursing (up to 100 days per the calendar year)	$0	40% of R&C after deductible plus excess over R&C
Home Health Care—(Includes up to 120 visits per the calendar year.) Visits include part-time or intermittent nursing care or for care supervised by an RN, part-time or intermittent services of a home health aide and visits for physical, occupational or speech therapy.	$0	40% of R&C after deductible plus excess over R&C
Prescription Drug	**In-Network**	**Out-Of-Network**
Prescription Brand Deductible per Family	$500 Deductible applies to all Brand Name Drugs when a generic equivalent is available	
Retail		
Retail Copay—up to 30-day supply (Generic)	$5	$5
Retail Copay—up to 30-day supply (Preferred Brand)	$10	$10
Retail Copay—up to 30-day supply (Non-Preferred Brand)	$25	$25
For Retail: Up to 30-day supply—First fill plus one refill per prescription		Plus excess over contract cost
Maintenance Choice or Mail Order		
Mail Order Copay—up to 90-day supply (Generic)	$5	NOT COVERED
Mail Order Copay—up to 90-day supply (Preferred Brand)	$15	
Mail Order Copay—up to 90-day supply (Non-Preferred Brand)	$50	
For Mail Order & Maintenance Choice: Up to 90-day supply		

**R&C means the reasonable and customary charges as defined in the Glossary at the back of this SPD.*

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. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see the Summary Plan Description (SPD) at www.milamhctf.com or call MILA at (212) 766-5700 or call the phone number on each vendor's I.D. card. 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 www.dol.gov/ebsa/healthreform or www.milamhctf.com or call 212-766-5700 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network providers: $0 Out-of-network providers: $300/individual or $600/family	In-Network providers: See the Common Medical Events chart below for your costs for services this plan covers. Out-of-Network: Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on this plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-Network providers: Not applicable. Out-of-network providers: Emergency room care, prescription drugs, dental and optical benefits are covered before you meet your deductible.	In-Network providers: This plan does not have a deductible for in-network services. Out-of-Network: This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. All brand name prescription drugs with generic equivalent: $500/family. Dental: $25/individual or $75/family 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?	In-network providers: Not Applicable Out-of-Network Providers: $6,500/person or $13,000/family	In-Network providers: This plan does not have an out-of-pocket limit on your expenses for in-network providers. Out-of-Network: The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in the plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Prescription drug, dental and optical benefits, copayments on certain services, premiums, balance-billing charges, penalties for failure to obtain preauthorization and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of in-network providers, see www.milamhctf.com to be directed to each vendor's website or call the number on the back of the ID card for each vendor.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs for out-of-network providers 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
		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 office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit for primary care and in-store health clinics; Deductible does not apply	40% coinsurance	Primary Care Physician (PCP) includes internist, family practitioner, pediatrician and OB/GYN for primary care. In-store health-clinic visits to treat minor illnesses and injuries—all for a primary care copay of $15.
	Specialist visit	$30 copay/visit	40% coinsurance	Specialists include cardiologist, gastroenterologist, rheumatologist, ophthalmologist, podiatrist, nutritionist, acupuncturists, radiologist, etc. OB/GYN is covered as specialist for illness-related care. *See the Definition section of the Summary Plan Description (SPD).
	Preventive care/screening/ immunization	PCP - $15 copay/visit; Specialist - $30 copay/visit Immunization - No charge	Not covered	Age and frequency limits apply. Not covered out-of-network. *See the preventive section of the Summary Plan Description (SPD).
If you have a test	Diagnostic test (x-ray, blood work)	$10 copay/test	40% coinsurance	No additional charge after office visit copay if part of visit.
	Imaging (CT/PET scans, MRIs)	$10 copay/test	40% coinsurance	Failure to obtain preauthorization will result in 20% reduction in benefits. No additional charge after office visit copay if part of visit.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.caremark.com**	Generic drugs	Retail and Mail Order: $5 copay/prescription	Retail only: $5 copay/ prescription plus additional cost for out-of-network pharmacy; Mail order: Not covered	Out-of-network deductible does not apply. Out-of-network cost sharing does not count toward out-of-pocket limit. Brand name drugs with generic equivalent (multi-source drugs) subject to separate $500 family deductible plus excess cost of multi-source drug. Retail up to 30-day supply plus one refill. Mail order up to 90-day supply; must be used after one refill at retail. All maintenance drugs must go through CVS mail order or the CVS Maintenance Choice Program. Members age 18 and older can access seasonal flu shots and other vaccinations through any CVS/Caremark pharmacy location as well as most other in-network pharmacies at no cost. Some medications require prior approval from Caremark. Must submit claim to Caremark for out-of-network retail pharmacy. Responsible for the copay and additional cost between what the prescription would have cost at in-network pharmacy and the cost at the out-of-network pharmacy.
	Preferred brand drugs	Retail: $10 copay/prescription; Mail Order: $15 copay/prescription	Retail only: $10 copay/ prescription plus additional cost for out-of-network pharmacy; Mail order: Not covered	
	Non-preferred brand drugs	Retail: $25 copay/prescription; Mail Order: $50 copay/prescription	Retail only: $25 copay/ prescription plus additional cost for out-of-network pharmacy; Mail order: Not covered	
	Specialty drugs	Retail; Not covered; Specialty Pharmacy only: Generic: $5 copay/prescription Preferred brand: $10 copay/prescription Non-preferred brand: $25 copay/prescription	Not covered	Specialty drugs must go through CVS Caremark Specialty Pharmacy. No retail or out-of-network available. Please call the number on the back of your I.D. card for more information on Specialty Drugs or see the Prescription Drug section of the SPD*.

* For more information about limitations and exceptions, see the Summary Plan Description (SPD) at www.milamhctf.com.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	40% coinsurance	Includes outpatient surgery and non-surgery facility charges.
	Physician/surgeon fees	No charge	40% coinsurance	Failure to obtain preauthorization will result in 20% reduction in benefits for certain surgeries/procedures. If multiple surgeries performed during one operating session, 50% reduction of charges to surgery of lesser charge. *See the Surgery and Approving Your Care sections of the SPD.
If you need immediate medical attention	Emergency room care	If true emergency, $25 copay/visit	If true emergency, $25 copay/visit; deductible does not apply	Emergency room coverage is only for valid emergency. Copay waived if admitted within 24 hours. Professional/physician charges may be billed separately.
	Emergency medical transportation	No charge	No charge	Must be considered medically necessary. Licensed ambulance to and from nearest hospital, skilled nursing facility or hospice and from hospital to skilled nursing facility.
	Urgent care	$25 copay/visit	40% coinsurance	In-network copay waived if admitted within 24 hours.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	40% coinsurance	Failure to obtain preauthorization will result in 20% reduction in benefits. Limited to semi-private room negotiated rate.
	Physician/surgeon fees	No charge	40% coinsurance	50% reduction of charges to the surgery of lesser charge for multiple surgeries performed during one operating session. *See the Surgery and Approving Your Care sections of the SPD.

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 mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: $15 copay/visit Other outpatient services: No charge	40% coinsurance	Includes individual, group and intensive outpatient treatment. Failure to obtain preauthorization for intensive outpatient treatment will result in 20% reduction in benefits. *See the What is Covered under the Behavioral Health Program section of the SPD.
	Inpatient services	No charge	40% coinsurance	Failure to obtain preauthorization will result in 20% reduction in benefits. Limited to semi-private room negotiated rate. *See the What is Covered under the Behavioral Health Program section of the SPD.
If you are pregnant	Office visits	$15 copay/first visit; No charge/subsequent visits; Deductible does not apply	40% coinsurance	Nurse midwives covered in-network only. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Depending on the service, a copayment, coinsurance or deductible may apply. *See the Maternity Care section of the SPD.
	Childbirth/delivery professional services	No charge	40% coinsurance	
	Childbirth/delivery facility services	No charge	40% coinsurance	Includes inpatient hospital and birthing center.

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	No charge	40% coinsurance	120-day maximum/calendar year. 4 hours = 1 visit. Failure to obtain preauthorization will result in 20% reduction in benefits.
	Rehabilitation services	Outpatient: $10 copay/visit; Inpatient skilled nursing facility (SNF), rehab and sub-acute facility: No charge	40% coinsurance	Short-term outpatient rehab limited to combined total of 60 visits/year. Inpatient SNF, rehab and sub-acute facility limited to combined total of 100 days/year. Failure to obtain preauthorization will result in 20% reduction in benefits. *See the Short-Term Rehabilitation (STR) section of the SPD.
	Habilitation services	Not covered	Not covered	You must pay 100% of these expenses even in-network.
	Skilled nursing care	No charge for inpatient skilled nursing facility (SNF) or sub-acute facility	40% coinsurance	Inpatient SNF, rehab and sub-acute facility limited to combined total of 100 days/year. Failure to obtain preauthorization will result in 20% reduction in benefits.
	Durable medical equipment	No charge	40% coinsurance	Limited to approved equipment.
	Hospice services	No charge	40% coinsurance	Failure to obtain preauthorization will result in 20% reduction in benefits. Maximum 180-days/lifetime.
If your child needs dental or eye care	Children's eye exam	$10 copay/exam	Balances over $30 Plan allowance	One exam/12 months (with dilation and refraction as necessary). Out-of-network maximum of $30 per exam. Frames - one/every 24 months; lenses - one/every 12 months. Out-of-network limit of $40 for frames and $25 for single vision lenses. Vision benefits separately administered by EyeMed.
	Children's glasses	$15 copay/frames and $10 copay/lenses plus 80% of balance over $100 Plan allowance	Frames: Balances over $40 Plan allowance; Lenses: Balances over $25 (single vision) Plan allowance	
	Children's dental check-up	No charge: separate dental deductible does not apply.	Balances over allowed amount	Dental benefits separately administered by Aetna. Limit 2/year. For out-of-network providers, you are responsible for difference between allowed amount and out-of-network dentist charges.

* For more information about limitations and exceptions, see the Summary Plan Description (SPD) at www.milamhctf.com.

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 (except for accidental injury or congenital abnormality of dependent child)
- Habilitation services
- Long-term care
- Weight loss programs (discounts available through Cigna Healthy Rewards Program)

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

- Acupuncture (all conditions incl. acupressure to max of $80/visit, in-network only)
- Bariatric surgery (if medically necessary)
- Chiropractic care (excludes massage therapy; maximum of 60 visits/year)
- Dental care (Adult & Child) ($2,500 max/year; separate $5,000 max/year for dental implants; lifetime maximum orthodontia $1,500)
- Hearing aids (Maximum $1,500/ear; once every 3 years to total of $3,000 every 3 years)
- Infertility treatment (Cigna Medical Centers of Excellence only; $30,000 max/lifetime medical; $10,000 max/lifetime drugs)
- Non-emergency care when traveling outside the U.S. (limited to residents of US)
- Private-duty nursing (outpatient, 70 visits/year; one visit = 4 hours; inpatient not covered))
- Routine eye care (Adult) (exams one/12 mos., frames one/24 mos., lenses one/12 mos.)
- Routine foot care (Only covered in connection with treatment for metabolic or peripheral vascular disease or neurological conditions.)

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (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 Plan at MILA Managed Healthcare Trust Fund, 111 Broadway, Suite 502, New York, NY 10006-1901; Phone (212) 766-5700. 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.

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 1-212-766-5700.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa -1-212-766-5700.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 -1-212-766-5700.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1--212-766-5700.

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 Summary Plan Description (SPD) at www.milamhctf.com.

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	**$0**
Primary care Visit copayment	**$15**
Hospital (facility) cost sharing	**None**
Other copayment (x-ray and lab)	**$10**

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	$0
Copayments	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$130**

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

The plan's overall deductible	**$0**
Specialist copayment	**$30**
Hospital (facility) cost sharing	**None**
Other copayment (x-ray and lab)	**$15**

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	$0
Copayments	$720
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$740**

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

The plan's overall deductible	$0
Specialist copayment	**$30**
Hospital (facility) cost sharing	**None**
Other copayment (x-ray and lab)	**$10**

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	$0
Copayments	$210
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$210**

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