A General Overview of Your Plan
for Participants of

Bronze Plus Plan

The Health & Welfare Plan of the Amalgamated National Health Fund

On the following pages you will find a chart providing an overview of your coverage.

This Overview of Coverage is to provide you with a very general, basic description of your Health & Welfare Plan. This Note is not intended to replace any of the Plan documents or your summary plan description booklet. To obtain detailed information about the Plan, you should read your summary plan description booklet or contact the Fund Office at 333 Westchester Avenue, White Plains, N Y 10604, telephone number (914) 367-5100.

Your Plan At A Glance

Health Care Coverage

By using the Network of Hospitals, doctors and other health care providers, you will be entitled to maximum healthcare coverage for yourself and your family. The chart below summarizes your full managed care coverage and is included here as a "quick reference."

	Coverage When A Network Provider Is Used	Coverage When A Network Provider Is NOT Used[1]
Annual Maximum	None.	None.
Annual Deductible	$500 per person, $1,000 per family.	$1,000 per person, $2,000 per family.
Out of Pocket Maximum	$6,350 per person, $12,700 per family.	Unlimited.
Hospital Coverage		
Hospital Inpatient Room, Board and Ancillary, Skilled Nursing or Acute Rehabilitation Facility, Birthing Center	60% of the network rate for up to 120 days per calendar year. Includes coverage for mental health and substance abuse admissions.	50% of reasonable billed charges for up to 120 days per calendar year. Includes coverage for mental health and substance abuse admissions.[2]
Hospice	60% of the network rate for up to a maximum period of six months and three bereavement counseling sessions per calendar year.	50% of reasonable billed charges for up to a maximum period of six months and three bereavement counseling sessions per calendar year.[2]
Hospital Outpatient		
Emergency Accident, Emergency Illness	60% of the network rate.	60% of reasonable billed charges.[2]

[1] For services where you have no control in selecting an in network provider (e.g. you used an in network provider but there were professional components that may have resulted in billing by non-network professionals such as an emergency room physician, anesthesiology, assistant surgeon, diagnostic interpretations such as radiology & pathology and ambulance) coverage will be provided at the in-network level of coinsurance based on usual and customary charges for the service provided.

[2] The reasonable billed charges are either the usual and customary charges for the service provided, the network rate, or the Fund's schedule.

	Coverage When A Network Provider Is Used	Coverage When A Network Provider Is NOT Used
Hospital Coverage (continued)		
Hospital Outpatient (continued)		
Non-emergency hospital, clinic, urgent care, or diagnostic only facility services	60% of the network rate. $35 co-payment per urgent care facility visit.	50% of reasonable billed charges.[1]
Ambulatory or Outpatient Surgery, Chemotherapy, Radio-therapy, and Pre-admission testing (within 7 days from admission)	60% of the network rate.	50% of reasonable billed charges.[1]
Major Medical Coverage		
Surgery **Maternity, Assistant Surgeon, Second Surgical Opinion**	60% of the network rate.	50% of reasonable billed charges.[1]
Organ Transplants	60% of the network rate.	Not covered.
Anesthesiology	60% of the network rate.	50% of reasonable billed charges.[1]
Physician Hospital Inpatient Visits	60% of the network rate.	50% of reasonable billed charges.[1]
Physician Office Visits	100% of the network rate, after a $25 primary care physician co-payment per visit and a $35 specialist co-payment per visit.	50% of reasonable billed charges.[1]
Home Health Care	60% of the network rate.	50% of reasonable billed charges.[1]
Diagnostic Imaging, X-Ray and Laboratory Testing (includes MRI, CT Scans, etc.)	60% of the network rate.	50% of reasonable billed charges.[1]

[1] The reasonable billed charges are either the usual and customary charges for the service provided, the network rate, or the Fund's schedule.

	Coverage When A Network Provider Is Used	Coverage When A Network Provider Is NOT Used
Major Medical Coverage (continued)		
Therapeutic Professional Services (chemotherapy, radiation therapy, infusion therapy, dialysis, electroshock therapy)	60% of the network rate.	50% of reasonable billed charges.[1]
Physical Therapy	100% of the network rate, after a $35 co-payment, for up to 30 visits per calendar year.	50% of reasonable billed charges, for up to 30 visits per calendar year.[1]
Speech Therapy	100% of the network rate, after a $35 co-payment, for up to 30 visits per calendar year.	50% of reasonable billed charges, for up to 30 visits per calendar year.[1]
Occupational Therapy	100% of the network rate, after a $35 co-payment, for up to 30 visits per calendar year.	50% of reasonable billed charges, for up to 30 visits per calendar year.[1]
Respiratory Therapy	60% of the network rate for up to 30 visits per calendar year.	50% of reasonable billed charges, for up to 30 visits per calendar year.[1]
Cardiac Rehabilitation	60% of the network rate for up to 30 visits per calendar year.	50% of reasonable billed charges, for up to 30 visits per calendar year.[1]
Allergy Testing and Treatment	60% of the network rate.	50% of reasonable billed charges.[1]
Injections/Immunizations	60% of the network rate (some immunizations may be covered at 100% of the network rate).	50% of reasonable billed charges.[1]
Accidental Injury To Sound Natural Teeth	60% of the network rate.	50% of reasonable billed charges.[1]
Durable Medical Equipment, Prosthetics, & Orthotics (includes medical supplies essential to DME, e.g. oxygen)	60% of the network rate. Shoe inserts are covered for up to a maximum payment of $500 every 2 years.	50% of reasonable billed charges.[1] Shoe inserts are covered for up to a maximum payment of $500 every 2 years.
Ambulance	60% of the network rate.	50% of reasonable billed charges.[1]

[1] The reasonable billed charges are either the usual and customary charges for the service provided, the network rate, or the Fund's schedule.

	Coverage When A Network Provider Is Used	Coverage When A Network Provider Is NOT Used
Major Medical Coverage (continued)		
Blood	60% of the network rate.	50% of reasonable billed charges.[1]
Outpatient Psychotherapy	100% of the network rate, after a $35 co-payment per visit.	50% of reasonable billed charges.[1]
Outpatient Substance Abuse Therapy	100% of the network rate, after a $35 co-payment per visit.	50% of reasonable billed charges.[1]
Chiropractic Visits	100% of the network rate, after a $35 co-payment, for up to 30 visits per calendar year.	50% of reasonable billed charges, for up to 30 visits per calendar year.[1]
Preventive Services	Certain preventive services are covered in full. Refer to your Summary Plan Description for details. When a network provider is not used, preventive services are covered at 50% of reasonable billed charges.[1]	

Medical Certification Program — The Medical Certification Program requires that you call Alicare Medical Management at 1-800-332-5426 to obtain the Fund's certification before you or one of your covered dependents use any of the following services or procedures:

- If you are going into the hospital.
- If you are having any surgery.
- If you are having any high cost diagnostic or therapeutic treatment (over $500) such as Magnetic Resonance Imaging (MRI), CAT Scans, Dialysis or Infusion Therapy.
- If your doctor is planning to admit you to a skilled nursing facility, an acute rehabilitation facility or order home health care services.
- If you are going to have hospice care.
- If you are pregnant, you must call Alicare Medical Management if your physician or midwife has recommended a hospital length of stay for more than 48 hours following a normal vaginal delivery or more than 96 hours following a Caesarean Section. In addition, when you are in the hospital at the time of delivery, you must call Alicare Medical Management if it is determined that your stay will be longer than what is outlined above. Additional days that are not precertified may not be covered.
- If you are planning to participate in an approved experimental and/or clinical trial with respect to the treatment of cancer or another life-threatening disease or condition.

If you do not notify Alicare Medical Management when required, your claims for those services will not be covered, or will not be covered in full. The toll free telephone number to call Alicare Medical Management is 1-800-332-5426.

The 24-Hour Nurse HelpLine

The 24-Hour Nurse HelpLine is a service that allows you and your family to call registered nurses, toll free, 24 hours a day, who will assist you with your health questions. This is a completely voluntary program of health education, support and counseling. In addition to speaking with a nurse, callers may choose to listen to any of over 1000 pre-recorded tapes dealing with a wide range of medical topics such as allergies, diet, children's health and development, HIV/AIDS, cancer, exercise, dental health, drug abuse, and many other topics. Close to 600 of these tapes are also available in Spanish. Call the Nurse HelpLine at **1-888-557-6796**.

[1] The reasonable billed charges are either the usual and customary charges for the service provided, the network rate, or the Fund's schedule.

Prescription Drug Coverage

Covered through a card program for up to a 34 day supply, after a $15 co-payment for generic drugs, a $30 co-payment for formulary brand name drugs, and a $45 co-payment for non-formulary brand name drugs.

Also covered through a maintenance mail order program for up to a 90 day supply after a $30 co-payment for generic drugs, and a $60 co-payment for formulary brand name drugs, and an $90 co-payment for non-formulary brand name drugs.

Vision Care Coverage

Covered up to $200 per person each 24 months for eyeglasses or contact lenses and/or an eye examination.

Affordable Care Act

The benefits summarized in this Summary Plan Description are intended to comply with the Patient Protection and Affordable Care Act (the Affordable Care Act). Any further modifications required by the Affordable Care Act will be made as necessary at the appropriate time.