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, call the Fund Office at 1-914-769-2440. 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 call 1-914-769-2440 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $0 Out-of-Network Medical: $200/Person, $600/Family; Out-of-Network Hospital: $300/Person per admission	In-Network: 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 the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	In-Network: Not applicable. Out-of-Network: No.	In-Network: This plan does not have a deductible. Out-of-Network: You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	$50/person for Dental. This deductible does not apply to preventive services. 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: Not applicable. Out-of-Network Medical: $1,250/Person Out-of-Network Hospital: $3,000/Person, $7,500/Family.	In-Network: This plan does not have an out-of-pocket limit on your expenses. 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 this plan, and there is a family out-of-pocket limit, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	In-Network: Not applicable. Out-of-Network: Copayments on certain services, deductibles, premiums, balance-billing charges, penalties for failure to obtain pre-certification and health care this plan doesn't cover.	In-Network: This plan does not have an out-of-pocket limit on your expenses. Out-of-Network: Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. Hospital and Medical: www.empireblue.com or call 1-800-553-9603. Prescription drugs: www.express-scripts.com or call 1-844-520-2679.	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 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	$10 copay/visit	20% coinsurance	None
	Specialist visit	$10 copay/visit	20% coinsurance	$1,250 annual maximum for chiropractic & podiatry services
	Preventive care/screening/ immunization	$10 copay/visit	20% coinsurance	Plan allows one well visit/calendar year. Immunizations, except for a flu vaccination once per calendar year, are not covered for individuals 19 years of age or older.
If you have a test	Diagnostic test (x-ray, blood work)	Hospital:$100 copay Other: no charge	Other: 20% coinsurance; Hospital: 30% coinsurance	Pre-certification required for test > $350. Failure to pre-certify may result in reduction of benefit or denial of claim.
	Imaging (CT/PET scans, MRIs)	Hospital:$100 copay Other: no charge	Other: 20% coinsurance; Hospital: 30% coinsurance	Precertification required for test > $350. Failure to pre-certify may result in reduction of benefit or denial of claim.
If you need drugs to treat your illness or condition More information about prescription drug coverage call Express Scripts at 1-844-520-2679 or visit the website www.express-scripts.com	Generic drugs	No charge	No charge	90-day supply maximum/prescription. After applicable copayment, first $3,000 of Rx drug charges for individual & $5,000 for family will be paid 100% by Plan. Rx drug charges between $3,000 & $7,000 for Individual and $5,000 & $13,500 for Family are 100% participant coinsurance. Rx drug charges over $7,000 for Individual & $13,500 for Family are 80% participant coinsurance.
	Preferred brand drugs	$25 copay	$25 copay	
	Non-preferred brand drugs	$25 copay	$25 copay	
	Specialty drugs	Brand: $25 copay Generic: No charge	Brand: $25 copay Generic: No charge	After applicable copayment, first $20,000 of IV Therapy drug charges will be paid 100% by Plan. IV Therapy drug charges between $20,000 & $30,000 are 100% participant coinsurance. IV Therapy drug charges over $30,000 are 80% participant coinsurance. Must be FDA-approved for the condition for which it is being prescribed.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay	30% coinsurance	Pre-certification required. Failure to pre-certify may result in reduction of benefit or denial of claim.
	Physician/surgeon fees	No charge	20% coinsurance	Pre-certification required. Failure to pre-certify may result in reduction of benefit or denial of claim.
If you need immediate medical attention	Emergency room care	$100 copay	30% coinsurance	Waived if admitted to a hospital within 24 Hours. If emergency room care is for mental health, behavioral health, or substance abuse, the out-of-network charge is a $100 copay.
	Emergency medical transportation	Ambulance: No charge	Ambulance: 20% coinsurance	$3,000 limit for helicopter transport
	Urgent care	$15 copay	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay	30% coinsurance	Semi-private room, pre-cert required.
	Physician/surgeon fees	No charge	20% coinsurance	Surgery must be pre-certified.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $10 copay; out-patient hospital: $100 copay	Office: 20% coinsurance; outpatient hospital 30% coinsurance	Dependents are not covered for substance abuse disorder. Pre-cert required for in & out-patient substance use disorder benefits.
	Inpatient services	$100 copay	30% coinsurance	
If you are pregnant	Office visits	$10 copay	20% coinsurance	Not covered for dependent children.
	Childbirth/delivery professional services	$100 copay	20% coinsurance	Not covered for dependent children.
	Childbirth/delivery facility services	$100 copay	30% coinsurance	Not covered for dependent children.
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Pre-certification required. Failure to pre-certify may result in reduction of benefit or denial of claim. 200 visits/year, 4 hours equals one visit.
	Rehabilitation services	Office: $10 copay Hospital: $100 copay	20% coinsurance 30% coinsurance	Pre-certification required. Failure to pre-certify may result in reduction of benefit or

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)	
				denial of claim. Combined 26 visits/person per calendar year.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	Not covered	Not covered	Not covered
	Durable medical equipment	No charge	20% coinsurance	First $1,500 in allowed charges paid by Plan, between $1,500 & $11,500 is 100% participant coinsurance. DME charges over $11,500 are 80% participant coinsurance. Pre-certification & medical necessity required.
	Hospice services	Not covered	Not covered	Not covered
If your child needs dental or eye care	Children's eye exam	Charges over $50	Charges over $50	Plan allows one exam/yr. up to $50.00 Plan allows one pair of glasses/contacts per year up to $100.00
	Children's glasses	Charges over $100	Charges over $100	Plan allows one exam/yr. up to $50.00 Plan allows one pair of glasses/contacts per year up to $100.00
	Children's dental check-up	Amount over plan's schedule allowance	Amount over plan's schedule allowance	Annual dental max $1,800/person $50/person annual deductible applies to non-preventive covered dental services

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.)

- Acupuncture
- Bariatric surgery (unless medically necessary)
- Cosmetic surgery
- Habilitation services
- Immunizations age 19 years and older, except for a flu vaccination once per calendar year
- Hospice services
- Infertility treatments
- Long-term care services
- Non-emergency care when traveling outside the USA
- Clinic visits through a hospital
- Private-duty nursing
- Skilled nursing care
- Weight loss programs
- Substance Abuse Disorder for Dependents
- Childbirth/delivery for Dependent Children
- Genetic testing and gene therapy

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

- Chiropractic care (2 x-rays & $1,250/person annual individual maximum)
- Dental care (Adult) (Annual $1,800 annual individual maximum)
- Hearing aids (up to $850/member & $350/dependent, every 24 months).
- Routine eye care (Adult) ($50/exam & $100 for lenses/frames/contacts per calendar year).
- Routine foot care (Podiatry services: $1,250 annual maximum/person/calendar year).

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
	• Physical, speech, and occupational therapy (26 combined visits/person per year. Precertification required).

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 Department of Labor's 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 Fund Office at 1-914-769-2440. 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 1-914-769-2440.

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

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**
Specialist copay	**$10**
Hospital (facility) copay	**$100**
Other copay	**$100**

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	$790
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$850**

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 copay	**$10**
Hospital (facility) copay	**$100**
Other copay	**$100**

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	$560
Coinsurance	$0
What isn't covered	
Limits or exclusions	$420
The total Joe would pay is	**$980**

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

The plan's overall deductible	**$0**
Specialist copay	**$10**
Hospital (facility) copay	**$100**
Other copay	**$100**

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	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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