**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, if applicable. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.nyccbf.org or call 1-800-529-FUND (3863) or 1-212-366-7373. 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 https://www.healthcare.gov/sbc-glossary/ or call the Fund Office to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | Not applicable. | This plan does not have a deductible. |
| **Are there other deductibles for specific services?** | Yes. Basic and major dental services are subject to a $100 annual deductible. 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?** | Not applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| **What is not included in the out-of-pocket limit?** | Not applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| **Will you pay less if you use a network provider?** | Not applicable. | This plan does not use a provider network. You can receive covered services from any provider. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

| 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 | Not Covered | Not Covered | There is no coverage for this type of medical event except for reimbursement of certain expenses related to these medical events. You must obtain benefits from other coverage or pay 100% of these expenses, even in-network.<br>The amount of $1,277 will be allocated to your health reimbursement account (HRA) at the start of the calendar year. You may apply for a distribution from your account for direct reimbursement of eligible "medical care expenses" not covered by your primary insurance. "Medical care expenses" mean expenses incurred by your or your covered dependents for medical care as defined in Internal Revenue Code (Code) §§ 105 and 213(d). A complete list of eligible medical care expenses is outlined in IRS publication 502. Reimbursable expenses include copayments, co-insurance, or deductibles paid under another health plan, post-tax premiums for prescription drug coverage, prescription drug costs, costs for certain over-the-counter drugs and medicines, costs for certain non-covered dental/optical expenses, and costs for menstrual care products.<br>You (and your dependents) must also be enrolled in a group health plan that meets the Affordable Care Act's (ACA) minimum value standard to be eligible for reimbursement. See the Summary of Benefits and Coverage (SBC) from your other group health plan to determine if it meets this standard. No reimbursement is allowed for individual coverage purchased through a Marketplace established by the ACA or Medicare. |
| | Specialist visit | Not Covered | Not Covered | |
| | Preventive care/screening/ immunization | Not Covered | Not Covered | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Not Covered | Not Covered | |
| | Imaging (CT/PET scans, MRIs) | Not Covered | Not Covered | |
| **If you need drugs to treat your illness or condition** | Generic drugs | Not Covered | Not Covered | |
| | Preferred brand drugs | Not Covered | Not Covered | |
| | Non-preferred brand drugs | Not Covered | Not Covered | |
| | Specialty drugs | Not Covered | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Not Covered | Not Covered | |
| | Physician/surgeon fees | Not Covered | Not Covered | |
| **If you need immediate medical attention** | Emergency room care | Not Covered | Not Covered | |
| | Emergency medical transportation | Not Covered | Not Covered | |
| | Urgent care | Not Covered | Not Covered | |

| 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) | |
| | | | | Any unused account balance will not be carried forward to the next plan year but instead will be forfeited. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Not Covered | Not Covered | There is no coverage for this type of medical event except for reimbursement of certain expenses related to these medical events. You must obtain benefits from other coverage or pay 100% of these expenses, even in-network.<br><br>The amount of $1,277 will be allocated to your HRA at the start of the calendar year. You may apply for a distribution from your account for direct reimbursement of eligible "medical care expenses" not covered by your primary insurance. "Medical care expenses" mean expenses incurred by your or your covered dependents for medical care as defined in Code §§ 105 and 213(d). A complete list of eligible medical care expenses is outlined in IRS publication 502. Reimbursable expenses include copayments, co-insurance, or deductibles paid under another health plan, post-tax premiums for prescription drug coverage, prescription drug costs, costs for certain over-the-counter drugs and medicines, costs for certain non-covered dental/optical expenses, and costs for menstrual care products.<br><br>You (and your dependents) must also be enrolled in a group health plan that meets the ACA's minimum value standard to be eligible for reimbursement. See the SBC from your other group health plan to determine if it meets this standard. No reimbursement is allowed for individual coverage purchased through a Marketplace established by the ACA or Medicare. |
| | Physician/surgeon fees | Not Covered | Not Covered | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Not Covered | Not Covered | |
| | Inpatient services | Not Covered | Not Covered | |
| **If you are pregnant** | Office visits | Not Covered | Not Covered | |
| | Childbirth/delivery professional services | Not Covered | Not Covered | |
| | Childbirth/delivery facility services | Not Covered | Not Covered | |
| **If you need help recovering or have other special health needs** | Home health care | Not Covered | Not Covered | |
| | Rehabilitation services | Not Covered | Not Covered | |
| | Habilitation services | Not Covered | Not Covered | |
| | Skilled nursing care | Not Covered | Not Covered | |
| | Durable medical equipment | Not Covered | Not Covered | |
| | Hospice services | Not Covered | Not Covered | |

| 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) | |
| | | | | Any unused account balance will not be carried forward to the next plan year but instead will be forfeited. |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | Amount over $25 Plan allowance (combined with glasses) | Vision benefits are separately administered by Comprehensive Professional Systems or General Vision Services. Eye exam and glasses or contact lenses are limited to once every 12 months (365 days). Selection of special lenses and coatings may require you to pay a portion of the cost, even in-network. |
| | Children's glasses | No Charge | Amount over $100 Plan allowance (combined with eye exam) | |
| | Children's dental check-up | No charge for preventive services. All services are limited by the schedule of covered allowances, frequency limits, and Plan maximums. | Amount over Plan allowance | Dental benefits are separately administered by Anthem BCBS. $100/Individual deductible (deductible will be waived for diagnostic and preventive services and orthodontic treatment) and $4,000 annual maximum per covered individual. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your Summary Plan Description ("SPD") for more information and a list of any other excluded services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs
- All Common Medical Events in the chart starting on page 2

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

- Dental care (Adult) (Subject to deductible of $100/per Individual excluding diagnostic, preventive, and orthodontic services)
- Hearing aids (Limited to $350/ear, not to exceed one every 4 years)
- Routine eye care (Adult) (Limited to one eye exam and pair of glasses or supply of contact lenses every 12 months)

**Your Rights to Continue Coverage:** There is an agency that can help if you want to continue your coverage after it ends. The contact information for this agency is: the U.S. Department of Labor's Employee Benefits Security Administration 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 SPD also provides 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 395 Hudson Street, New York, NY 10014; or Department of Labor's Employee Benefits Security Administration, 1-866-444-EBSA (3272), www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: Community Service Society of New York, Community Health Advocates, 105 East 22nd Street, 8th Floor, New York, NY 10010, (888) 614-5400, http://www.communityhealthadvocates.org.

**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?** **No**

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 1-212-366-7300 o 1-800-529-3863.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-529-3863.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-529-3863.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-529-3863.

*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 *cost sharing* | N/A |
| Hospital (facility) *cost sharing* | N/A |
| Other *cost sharing* | N/A |

**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 100% since this condition is not covered.**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $12,700 |
| **The total Peg would pay is** | **$12,700** |

### 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 *cost sharing* | N/A |
| Hospital (facility) *cost sharing* | N/A |
| Other *cost sharing* | N/A |

**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 100% since this condition is not covered.**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $5,600 |
| **The total Joe would pay is** | **$5,600** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist *cost sharing* | N/A |
| Hospital (facility) *cost sharing* | N/A |
| Other *cost sharing* | N/A |

**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 100% since this condition is not covered.**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $2,800 |
| **The total Mia would pay is** | **$2,800** |

This Plan provides an HRA benefit so these coverage examples are not applicable.

This Plan may pay benefits for some unreimbursed expenses.