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 the Fund Office at 1-212-366-7300 or 1-800-529-3863 or go to www.ibx.com or call 1-833-242-3330, or go to www.express-scripts.com or call 1-800-939-2091. 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?	In-Network providers: $200/Individual or $500/ Family Out-of-Network providers: $750/Individual or $1,875/Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If other family members are covered by the plan, each family member must meet their 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?	Yes. In-Network providers: Primary care visit, specialist visit, preventive care, outpatient rehab/habilitation services, outpatient behavioral health office visit, ER services, urgent care, prescription drugs, dental benefits (if elected), hearing aids and vision benefits (if elected) are covered before you meet your deductible. Out-of-Network providers: Only ER services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $100/Individual for the dental plan (if elected) (deductible will be waived for diagnostic and preventive services and orthodontic treatment). 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?	Medical In-Network providers: $1,900/Individual or $4,750/Family Medical Out-of-Network providers: $3,750/ Individual or $9,375/Family Prescription drugs (in-network): $3,000/Individual or $7,500/Family	The out-of-pocket limit is the most you could pay in a year for covered services. If other family members are covered by this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover. Also, certain specialty pharmacy drugs are considered non-essential health benefits, and the cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not count toward the out-of-pocket-limit.	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. Visit www.ibx.com or call 1-800-810-BLUE (2583) for a list of network providers.	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	$20 copay/visit. Deductible does not apply.	30% coinsurance	None
	Specialist visit	$25 copay/visit Deductible does not apply.	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge. Deductible does not apply.	30% coinsurance	Subject to age and frequency limitations. You may have to pay for services that aren't preventive. Ask your provider if the services are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	You must use a lab contracted with the local Blue plan for the provider/area that you are receiving services.

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)	
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Failure to pre-certify high tech radiology services may result in a benefit reduction up to 50% to a maximum of $2,500 or denial of claim if not medically necessary.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	Retail (30-day supply): $15 copay/Rx Mail Order and any participating CVS pharmacies (90-day supply): $25 copay/Rx	Reimbursement of up to the discounted amount the plan would have paid to a network pharmacy. You are responsible for any difference between the network discount price and what the pharmacy charged plus any applicable copay.	Medical deductible and out-of-pocket limits do not apply but separate prescription drug out-of-pocket limits apply. No charge for FDA-approved generic contraceptives (or brand name if generic is medically inappropriate) for women and other ACA-required preventive medications with prescription. Mandatory generic feature: Brand name drugs are only covered if no generic equivalent is available. If a brand name drug is selected, you must pay the applicable copay plus the difference in cost between the brand-name drug and the generic drug. Mandatory mail order program: Maintenance drugs for chronic conditions must be acquired by mail order. Specialty drugs: Must use Accredo specialty pharmacy (Mail Order only). Preauthorization required. To reach the specialty pharmacy, call 1-800-803-2523. Also, certain specialty pharmacy drugs are considered non-essential health benefits, and the cost of these drugs (though reimbursed by the manufacturer at no cost to you if you enroll in the program) will not count toward the plan's out-of-pocket limit. You pay the full cost for these certain specialty drugs if you do not enroll in the program.
	Preferred brand drugs	Retail (30-day supply): $25 copay/Rx Mail Order and any participating CVS pharmacies (90-day supply): $45 copay/Rx	Reimbursement of up to the discounted amount the plan would have paid to a network pharmacy. You are responsible for any difference between the network discount price and what the pharmacy charged plus any applicable copay.	
	Non-preferred brand drugs	Retail (30-day supply): $40 copay/Rx Mail Order and any participating CVS pharmacies (90-day supply): $75 copay/Rx	Reimbursement of up to the discounted amount the plan would have paid to a network pharmacy. You are responsible for any difference between the network discount price and what the pharmacy charged plus any applicable copay.	
	Specialty drugs	Mail Order only: Applicable copay above	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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Failure to pre-certify services may result in a benefit reduction up to 50% to a maximum of $2,500 or denial of claim if not medically necessary.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	$200 copay/visit Deductible does not apply.	$200 copay/visit. Deductible does not apply.	Professional/physician charges may be billed separately. Copay waived if admitted within 24 hours.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Transportation by air or land ambulance to nearest acute care hospital for emergency treatment.
	Urgent care	$25 copay/visit Deductible does not apply.	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Failure to pre-certify admissions may result in a benefit reduction up to 50% to a maximum of $2,500 or denial of claim if not medically necessary. This benefit reduction also applies to certain Same-Day Surgery and professional services rendered during an inpatient admission.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: $20 copay/visit. Deductible does not apply. Other outpatient services: 10% coinsurance	30% coinsurance	Failure to pre-certify partial hospital or intensive outpatient programs may result in a benefit reduction up to 50% to a maximum of $2,500 or denial of claim if not medically necessary.
	Inpatient services	10% coinsurance	30% coinsurance	Failure to pre-certify admissions may result in a benefit reduction up to 50% to a maximum of $2,500 or denial of claim if not medically necessary.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the types of services and provider, a copay, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).

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)	
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	Out-of-network birthing centers not covered.
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	Out-of-network birthing centers not covered.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not Covered	200 visits per calendar year (1 visit equals 4 hours of care). To the extent home health care services are used in connection with treatment for mental health or substance use condition, services are covered both in and out-of-network. The out-of-network benefit for actives is 30% of the allowed amount after the deductible is satisfied.
	Rehabilitation services	Inpatient: 10% coinsurance Outpatient office setting: $20 copay/visit Outpatient hospital setting: $25 copay/visit Deductible does not apply to outpatient services.	Not Covered	Occupational and speech therapy up to 45 visits per person combined in home, office or outpatient facility per calendar year. Inpatient not covered for occupational or speech therapy. Physical therapy up to 45 visits combined in home, office or outpatient facility per calendar year. Inpatient physical therapy and rehabilitation up to 30 days per calendar year. To the extent home health care services are used in connection with treatment for mental health or substance use condition, services are covered both in and out-of-network. The out-of-network benefit for actives is 30% of the allowed amount after the deductible is satisfied.
	Habilitation services	Inpatient: 10% coinsurance Outpatient office setting: $20 copay/visit Outpatient hospital setting: $25 copay/visit Deductible does not apply to outpatient services.	Not Covered	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.

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)	
	Skilled nursing care	10% coinsurance	Not Covered	60 days per calendar year. Failure to pre-certify services may result in a benefit reduction up to 50% to a maximum of $2,500 or denial of claim if not medically necessary.
	Durable medical equipment	10% coinsurance	Not Covered	Failure to pre-certify services may result in a benefit reduction up to 50% to a maximum of $2,500 or denial of claim if not medically necessary.
	Hospice services	10% coinsurance	Not Covered	210 days per lifetime. Failure to pre-certify services may result in a benefit reduction up to 50% to a maximum of $2,500 or denial of claim if not medically necessary.
If your child needs dental or eye care	Children's eye exam	No Charge. Deductible does not apply.	Amount over $25 Plan allowance	Vision benefits are separately administered by Comprehensive Professional Systems or General Vision Services if elected by employer. Eye exam and glasses or contact lenses 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. Deductible does not apply.	Amount over $100 Plan allowance	
	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 if elected by employer. Medical deductible does not apply but a separate $100/Individual dental deductible applies (deductible will be waived for diagnostic and preventive care 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.)

- Cosmetic surgery
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs (except as required by the ACA)

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

- Acupuncture
- Bariatric surgery
- Chiropractic care (up to 45 visits per year)
- Dental care (Adult) **only available if employer has elected to provide dental coverage*
- Infertility treatment
- Emergency care when traveling outside the U.S. See www.bcbsglobalcore.com.
- Routine eye care (Adult) **only available if employer has elected to provide vision coverage*

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: Independence Administrators, Appeals Department, PO Box 21974, Eagan, MN 55121; or Express Scripts, 811 Royal Ridge Parkway, Irving, TX 75063, Attn: Administrative Reviews; or 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? **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 1-212-366-7300 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	$200
Specialist copay	$25
Hospital (facility) coinsurance	10%
Other coinsurance	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	$200
Copayments	$60
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,480**

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

The plan's overall deductible	$200
Specialist copay	$25
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$200
Copayments	$640
Coinsurance	$70
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$930**

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

The plan's overall deductible	$200
Specialist copay	$25
Hospital (facility) coinsurance	10%
Other coinsurance	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	$200
Copayments	$390
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$680**

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