

\*Participants living in New York City or its surrounding area counties in NY and NJ, or in CT have the POS network. Those living outside this area have the PPO network.



**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 your Summary Plan Description visit <http://health.32bjfunds.org/> or call 1-800-551-3225. 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 1-800-551-3225 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$0 for <a href="#">in-network providers</a> \$250 person/\$500 family for <a href="#">out-of-network providers</a> .	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your deductible?</b>	Yes, in-network because there is no <a href="#">deductible</a> .  No, when out-of-network.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .  You will have to meet the <a href="#">deductible</a> before the <a href="#">plan</a> pays for any services.
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet specific <a href="#">deductibles</a> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	For <a href="#">in-network providers</a> \$8,150 individual/\$16,300 family; for <a href="#">out-of-network providers</a> \$750 individual/\$1,500 family.	The in-network <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
<b>What is not included in the out-of-pocket limit?</b>	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, penalties for failure to obtain preauthorization, & health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.32bjfunds.org">www.32bjfunds.org</a> or call 1-800-551-3225 for a list of <a href="#">in-network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You pay the least if you use a 5 Star Center <a href="#">provider</a> . You pay more if you use a preferred <a href="#">provider</a> in the plan's <a href="#">network</a> . You pay even more if you use a non-preferred <a href="#">provider</a> in the plan's <a href="#">network</a> . You pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">in-network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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**
		5 Star Center Provider (You will pay the least)	In-network Preferred Provider*	In-network Non-Preferred Provider*	Out-of-network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	No charge	\$40 <a href="#">copay</a> /office visit		30% <a href="#">coinsurance</a>	None.
	<a href="#">Specialist</a> visit	No charge	\$40 <a href="#">copay</a> /office visit		30% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge		30% <a href="#">coinsurance</a>	\$75 <a href="#">copay</a> /visit for preventive procedures (e.g., mammogram, colonoscopy) at a preferred provider hospital or hospital based facility. \$250 <a href="#">copay</a> /visit for preventive procedures (e.g., mammogram, colonoscopy) at a non-preferred provider hospital or hospital based facility When utilizing an <a href="#">out-of-network provider</a> Plan pays 70% <a href="#">coinsurance</a> of the <a href="#">allowed amount</a> after the <a href="#">deductible</a> . You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
	Other practitioner office visit	No charge for chiropractic No charge for acupuncture No charge for occupational, vision, physical, speech therapy	\$40 <a href="#">copay</a> /visit chiropractic \$40 <a href="#">copay</a> /visit acupuncture \$40 <a href="#">copay</a> /visit occupational, vision, physical, speech therapy		30% <a href="#">coinsurance</a> for chiropractic care Not covered Not covered	Chiropractic care coverage is limited to 10 visits/year. Acupuncture coverage is limited to 20 visits/year. Occupational, vision and speech therapy combined coverage is limited to 30 visits/year. Outpatient physical therapy coverage is limited to 30 separate visits/year. Preauthorization required. \$75 facility <a href="#">copay</a> /visit for out-patient physical therapy services at a preferred hospital based facility; \$250 facility <a href="#">copay</a> /visit for out-patient physical therapy services at a non-preferred hospital based facility.

\* A list of preferred providers as well as a list of non-preferred providers is available on the plan's website at [www.32bjfunds.org](http://www.32bjfunds.org).

\*\* For more information about limitations and exceptions, see the plan or policy document at [www.32bjfunds.org](http://www.32bjfunds.org).



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**
		5 Star Center Provider (You will pay the least)	In-network Preferred Provider*	In-network Non-Preferred Provider*	Out-of-network Provider (You will pay the most)	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	No charge		30% <a href="#">coinsurance</a>	\$75 facility <a href="#">copay</a> /visit for diagnostic tests (excluding blood work) at a preferred hospital based facility. \$250 facility <a href="#">copay</a> /visit for diagnostic tests (excluding blood work) at a non-preferred hospital based facility.
	Imaging (CT/PET scans, MRIs)	\$75 <a href="#">copay</a> /scan	\$75 <a href="#">copay</a> /scan	\$250 <a href="#">copay</a> /scan	30% <a href="#">coinsurance</a>	Preauthorization required. Failure to preauthorize out-of-network services results in a \$250 penalty.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a> .	Generic drugs	Not applicable	\$10 <a href="#">copay</a> /up to 30 day supply at retail \$20 <a href="#">copay</a> /up to 90 day supply at CVS pharmacy or CVS mail order		Covered up to what Fund would pay a participating retail pharmacy. Not covered	Formulary Only. Covers up to a 30-day supply (retail); up to a 90 day supply (CVS retail pharmacy or mail order). If you require a brand name drug that has a generic equivalent, you pay the difference in cost between the brand and generic plus the <a href="#">copay</a> . Ask your doctor to call CVS Caremark at 1-877-765-6294 for information on alternatives. Certain drugs are subject to prior authorization, step therapy and/or quantity limitations. Your doctor can call CVS/Caremark at 1-800-294-5979 for additional information. <a href="#">Specialty drugs</a> are only available for purchase at a CVS pharmacy or through the CVS/Caremark Specialty Pharmacy Program by calling 1-800-237-2767.
	Brand drugs	Not applicable	\$30 <a href="#">copay</a> /up to 30 day supply at retail \$60 <a href="#">copay</a> /up to 90 day supply at CVS pharmacy or CVS mail order		Covered up to what Fund would pay a participating retail pharmacy. Not covered	
	<a href="#">Specialty drugs</a>	Not applicable	Same <a href="#">copays</a> as generic and brand drugs above		Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	No charge		30% <a href="#">coinsurance</a>	\$75 facility <a href="#">copay</a> /visit for outpatient services at a preferred hospital-based facility. \$250 facility <a href="#">copay</a> /visit for outpatient services at a non-preferred hospital-based facility.
	Physician/surgeon fees	No charge	No charge		30% <a href="#">coinsurance</a>	

\* A list of preferred providers as well as a list of non-preferred providers is available on the plan's website at [www.32bjfunds.org](http://www.32bjfunds.org).

\*\* For more information about limitations and exceptions, see the plan or policy document at [www.32bjfunds.org](http://www.32bjfunds.org).



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**
		5 Star Center Provider (You will pay the least)	In-network Preferred Provider*	In-network Non-Preferred Provider*	Out-of-network Provider (You will pay the most)	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Not applicable	\$100 <a href="#">copay</a> /visit		\$100 <a href="#">copay</a> /visit	The <a href="#">copay</a> increases to \$200 for all emergency room visits after the 2nd visit within the same calendar year.
	<a href="#">Emergency medical transportation</a>	Not applicable	No charge		No charge	Not covered if after transport you do not receive treating services.
	<a href="#">Urgent care</a>	No charge	\$40 <a href="#">copay</a> /office visit		30% <a href="#">coinsurance</a>	None.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not applicable	\$100 <a href="#">copay</a> /admission	\$1,000 <a href="#">copay</a> /admission	30% <a href="#">coinsurance</a>	Private rooms not covered. \$100 <a href="#">copay</a> /emergency admission at preferred and non-preferred facilities. Preauthorization required. Failure to preauthorize out-of-network services results in a \$250 penalty.
	Physician/surgeon fees	Not applicable	No charge		30% <a href="#">coinsurance</a>	Certain procedures are subject to higher <a href="#">copays</a> if not performed at certain hospitals. For more information see your SPD or call Member Services at 1-800-551-3225.

\* A list of preferred providers as well as a list of non-preferred providers is available on the plan's website at [www.32bjfunds.org](http://www.32bjfunds.org).

\*\* For more information about limitations and exceptions, see the plan or policy document at [www.32bjfunds.org](http://www.32bjfunds.org).

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information**
		5 Star Center (You will pay the least)	In-network Preferred Provider*	In-network Non-Preferred Provider*	Out-of-network Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No charge	\$20 <a href="#">copay</a> /visit		30% <a href="#">coinsurance</a> ***	Inpatient, and some outpatient, services require preauthorization. Failure to preauthorize results in a \$250 penalty.  \$75 <a href="#">copay</a> /episode of treatment for outpatient services at preferred provider hospital-based facilities. \$250 <a href="#">copay</a> /episode of treatment for outpatient services at non-preferred provider hospital-based facilities.
	Inpatient services	Not applicable	\$100 <a href="#">copay</a> /visit	\$1,000 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a> ***	\$100 <a href="#">copay</a> /emergency admission at preferred and non-preferred facilities.  ***Non-participating NY inpatient and outpatient substance abuse providers that are not certified and/or licensed by the Office of Alcoholism and Substance Abuse Services and non-participating providers in all other states that are not certified by a similar state agency and which are not accredited by The Joint Commission are not covered.
<b>If you are pregnant</b>	Office visits	No charge	\$40 <a href="#">copay</a> /1 <sup>st</sup> visit only		30% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound.)
	Childbirth/delivery professional services	Not applicable	No charge		30% <a href="#">coinsurance</a>	None.
	Childbirth/delivery facility services	Not applicable	\$100 <a href="#">copay</a> /admission	\$1,000 <a href="#">copay</a> /admission	30% <a href="#">coinsurance</a>	Preauthorization required. Failure to preauthorize out-of-network services results in a \$250 penalty.

\* A list of preferred providers as well as a list of non-preferred providers is available on the plan's website at [www.32bjfunds.org](http://www.32bjfunds.org).

\*\* For more information about limitations and exceptions, see the plan or policy document at [www.32bjfunds.org](http://www.32bjfunds.org).

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information**
		5 Star Center (You will pay the least)	In-network Preferred Provider*	In-network Non-Preferred Provider*	Out-of-network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Not applicable	No charge		Not covered	Coverage is limited to 200 visits/year.
	<a href="#">Rehabilitation services</a>	Not applicable	No charge		Not covered	Preauthorization required.
	<a href="#">Habilitation services</a>	Not covered	Not covered		Not covered	<a href="#">Excluded services</a> .
	<a href="#">Skilled nursing care</a>	Not applicable	No charge		Not covered	Coverage is limited to 60 days/year. Preauthorization required.
	<a href="#">Durable medical equipment</a>	Not applicable	No charge		Not covered	Preauthorization required.
	<a href="#">Hospice services</a>	Not applicable	No charge		Not covered	
<b>If your child needs dental or eye care</b>	Children's eye exam	Not applicable	No charge		Not covered under 19	Coverage limited to 1 exam/12 months, if you have family coverage, through Davis Vision.
	Children's glasses	Not applicable	No charge		Not covered under 19	Coverage is limited to 1 pair/24 months, if you have family coverage, through Davis Vision.
	Children's dental check-up	Not applicable	No charge		50% of <a href="#">allowed amount</a> plus the amount in excess of the <a href="#">allowed amount</a> ***	Coverage is limited to 2 visits in a calendar year, if you have family coverage, through Delta Dental.

\*\*\*Participants working outside the NY metropolitan area such as CT, PA, MD, VA, Washington DC or Florida, your cost is the amount in excess of the [allowed amount](#).

\* A list of preferred providers as well as a list of non-preferred providers is available on the plan's website at [www.32bjfunds.org](http://www.32bjfunds.org).

\*\* For more information about limitations and exceptions, see the plan or policy document at [www.32bjfunds.org](http://www.32bjfunds.org).

## 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
- Habilitation Services
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-preferred brand and specialty drugs
- Private-duty nursing

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

- Acupuncture up to 20 visits per year
- Bariatric surgery only at Blue Distinction hospitals within the Empire network
- Chiropractic care up to 10 visits per year
- Dental care (Adult) through Delta Dental
- Hearing aids ([in-network](#) only/2 per lifetime)
- Routine eye care (Adult) through Davis Vision
- Routine foot care
- Weight loss programs (excluding commercial programs, e.g., Weight Watchers, Jenny Craig)

**Your Rights to Continue Coverage:** For more information on your rights to continue your coverage, contact the [plan](#) at 1-800-551-3225. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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 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: Member Services at 1-800-551-3225 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? **Yes.**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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:

Para obtener asistencia en Español, llame al 1-800-551-3225

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-551-3225

如果需要中文的帮助, 请拨打这个号码 1-800-551-3225

Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-551-3225

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

\* A list of preferred providers as well as a list of non-preferred providers is available on the plan's website at [www.32bjfunds.org](http://www.32bjfunds.org).

\*\* For more information about limitations and exceptions, see the plan or policy document at [www.32bjfunds.org](http://www.32bjfunds.org).

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](#) \$0.00
- [Specialist copay](#) \$40.00
- [Hospital \(facility\) copay](#) \$100.00
- [Other Rx copay](#) \$10.00

**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*)

<b>Total Example Cost</b>	<b>\$12,371</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$200.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$200.00
<b>The total Peg would pay is</b>	<b>\$400.00</b>

This example assumes you have single coverage and you delivered at a preferred hospital. If you had dependent coverage, your total cost would be \$200 as the \$200 in baby charges would be covered.

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

- The [plan's overall deductible](#) \$0.00
- [Specialist copay](#) \$40.00
- [Hospital \(facility\) copay](#) \$100.00
- [Other Rx copay](#) \$30.00

**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*)

<b>Total Example Cost</b>	<b>\$7,389</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$1,200.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$60.00
<b>The total Joe would pay is</b>	<b>\$1,260.00</b>

These numbers assume you use a preferred hospital but don't use a 5 Star Center Provider or participate in the [plan's](#) 5 Star Wellness Program. If you use a 5 Star Center Provider and participate in the [plan's](#) 5 Star Wellness Program, you may be able to reduce your costs. For more information about 5 Star Center Providers and the 5 Star Wellness Program, please call Member Services at 1-800-551-3225.

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

- The [plan's overall deductible](#) \$0.00
- [Specialist copay](#) \$40.00
- [Hospital \(facility\) copay](#) \$100.00
- [Other Rx copay](#) \$10.00

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$400.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$0.00
<b>The total Mia would pay is</b>	<b>\$400.00</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



## Summary of Modifications

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services  
**Metropolitan/Suburban Plan: Board of Trustees**

**Coverage Period: 01/01/2020-12/31/2020**  
**Coverage for: Single/Family | Plan Type: POS/PPO\***

*\*Participants living in New York City or its surrounding area counties in NY and NJ, or in CT have the POS network. Those living outside this area have the PPO network.*

Following is a list of changes to the Building Service 32BJ Health Fund’s Summary of Benefits and Coverage (SBC) for the Metropolitan/Suburban Plan issued for the Coverage Period 1/1/2020-12/31/2020. **Please keep this document with your SBC.**

Effective April 1, 2020 the following changes are made to the SBC:

**Page 5:** The Common Medical Event “If you are pregnant” section is deleted in its entirety and replaced with the following:

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information**
		5 Star Center (You will pay the least)	In-network Preferred Provider*	In-network Non-Preferred Provider*	Out-of-network Provider (You will pay the most)	
<b>If you are pregnant</b>	Office visits	No charge	\$40 <a href="#">copay</a> /1 <sup>st</sup> visit only		30% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound.)
	Childbirth/delivery professional services	Not applicable	No charge		30% <a href="#">coinsurance</a>	None.
	Childbirth/delivery facility services	Not applicable	\$100 <a href="#">copay</a> */admission	\$1,000 <a href="#">copay</a> /admission	30% <a href="#">coinsurance</a>	Preauthorization required. Failure to preauthorize out-of-network services results in a \$250 penalty.  *If you are enrolled in the 32BJ Maternity Program and deliver at a hospital in this program, you may be reimbursed for your \$100 <a href="#">copay</a> .

**Page 8:** The text box under the example “Peg is Having a Baby” is deleted in its entirety and is replaced with the following:

This example assumes you have single coverage, deliver at a preferred hospital but do not participate in the 32BJ Maternity Program. If you had dependent coverage, your total cost would be \$200 as the \$200 in baby charges would be covered.