**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: |
|---|---|---|
| **What is the overall deductible?** | $0 for in-network providers<br>$250 person/$500 family for out-of-network providers. | 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?** | Yes, when in-network. Preventive care and primary care services are covered before you meet your $0 deductible.<br><br>No, when out-of-network. | 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/.<br><br>You will have to meet the deductible before the plan pays for any services. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet specific deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | For in-network providers $7,350 individual/$14,700 family; for out-of-network providers $750 individual/$1,500 family. | 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, 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?** | Premiums, balance billing charges, penalties for failure to obtain preauthorization, & health care this plan doesn't cover. | 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. See www.32bjfunds.org or call 1-800-551-3225 for a list of in-network providers. | This plan uses a provider network. You pay the least if you use a 5 Star Center provider. You pay more if your 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 in-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* |
|---|---|---|---|---|---|
| | | 5 Star Center Provider (You will pay the least) | In-network Provider (You will pay more, but not the most) | 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 | No charge | $40 copay/office visit | 30% coinsurance | None. |
| | Specialist visit | No charge | $40 copay/office visit | 30% coinsurance | |
| | Preventive care/screening/ immunization | No charge | No charge | 30% coinsurance | When utilizing an out-of-network provider Plan pays 30% coinsurance of the allowed amount after the deductible. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| | Other practitioner office visit | No charge for chiropractic<br>No charge for acupuncture<br>No charge for occupational, vision, physical, speech therapy | $40 copay /visit chiropractic<br>$40 copay/visit acupuncture<br>$40 copay /visit occupational, vision, physical, speech therapy | 30% coinsurance for chiropractic care<br>Not covered<br>Not covered | Chiropractic care coverage is limited to10 visits/year.<br>Acupuncture coverage is limited to 20 visits/year.<br>Occupational, vision and speech therapy combined coverage is limited to 30 visits/year. Outpatient physical therapy coverage is limited to 30 separate visits/year. $75 facility co-pay/visit for out-patient physical therapy services provided in a hospital based facility. Pre-certification required. |

* For more information about limitations and exceptions, see the plan or policy document at www.32bjfunds.org.

| 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 Provider (You will pay more, but not the most) | Out-of-network Provider (You will pay the most) | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | No charge | 30% coinsurance | If services, excluding blood work, are provided in a hospital based facility, there is a $75 facility copay/visit. |
| | Imaging (CT/PET scans, MRIs) | $75 copay/scan | $75 copay/scan | 30% coinsurance | Pre-certification required. Failure to pre-certify out-of-network services results in a $250 penalty. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.caremark.com. | Generic drugs | Not applicable | $10 copay/up to 30 day supply at retail<br>$20 copay/up to 90 day supply at CVS pharmacy or CVS mail order | Covered up to what Fund would pay a participating retail pharmacy.<br>Not covered | Formulary Only. Covers up to a 30-day supply (retail); up to a 90 day supply (CVS retail pharmacy or mail order).<br>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 copay.<br>Ask your doctor to call CVS Caremark at 1-877-765-6294 for information on alternatives.<br>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.<br>Specialty drugs 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 copay/up to 30 day supply at retail<br>$60 copay/up to 90 day supply at CVS pharmacy or CVS mail order | Covered up to what Fund would pay a participating retail pharmacy.<br>Not covered | |
| | Specialty drugs | Not applicable | Same copays as generic and brand drugs above | Not covered | |

* For more information about limitations and exceptions, see the plan or policy document at www.32bjfunds.org.

| 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 Provider (You will pay more, but not the most) | Out-of-network Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | No charge | 30% coinsurance | $75 facility copay/visit for outpatient services provided in a hospital-based facility. |
| | Physician/surgeon fees | No charge | No charge | 30% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | Not applicable | $100 copay/visit | $100 copay/visit | The copay increases to $200 for all emergency room visits after the 2nd visit within the same calendar year. |
| | Emergency medical transportation | Not applicable | No charge | No charge | Not covered if after transport you do not receive treating services. |
| | Urgent care | No charge | $40 copay/office visit | 30% coinsurance | None. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Not applicable | $100 copay/admission | 30% coinsurance | Pre-certification required. Failure to pre-certify out-of-network services results in a $250 penalty. |
| | Physician/surgeon fees | Not applicable | No charge | 30% coinsurance | |

* For more information about limitations and exceptions, see the plan or policy document at 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 Provider (You will pay more, but not the most) | Out-of-network Provider (You will pay the most) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge | $20 copay/visit | 30% coinsurance** | Inpatient services require pre-certification. Failure to pre-certify results in a $250 penalty.<br>Outpatient services provided in a hospital based facility require pre-certification and there is a $75 facility copay/episode of treatment.<br>**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. |
| | Inpatient services | Not applicable | $100 copay/visit | 30% coinsurance** | |
| **If you are pregnant** | Office visits | No charge | $40 copay/1st visit only | 30% coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery professional services | Not applicable | No charge | 30% coinsurance | None. |

* For more information about limitations and exceptions, see the plan or policy document at 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 Provider (You will pay more, but not the most) | Out-of-network Provider (You will pay the most) | |
| | Childbirth/delivery facility services | Not applicable | $100 copay/admission | 30% coinsurance | Pre-certification required. Failure to pre-certify out-of-network services results in a $250 penalty. |
| **If you need help recovering or have other special health needs** | Home health care | Not applicable | No charge | Not covered | Coverage is limited to 200 visits/year. |
| | Rehabilitation services | Not applicable | No charge | Not covered | Precertification required. |
| | Habilitation services | Not covered | Not covered | Not covered | Excluded services. |
| | Skilled nursing care | Not applicable | No charge | Not covered | Coverage is limited to 60 days/year. Pre-certification required. |
| | Durable medical equipment | Not applicable | No charge | Not covered | Precertification required. |
| | Hospice services | Not applicable | No charge | Not covered | |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | Not covered | Vision coverage is provided under Massachusetts Employers/SEIU 888 Health and Welfare Fund. |
| | Children's glasses | Not covered | Not covered | Not covered | |
| | Children's dental check-up | Not covered | Not covered | Not covered | Dental coverage is provided under the Massachusetts Employers/SEIU 888 Health and Welfare Fund. |

* For more information about limitations and exceptions, see the plan or policy document at 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
- Dental Care (Pediatric and Adult)
- 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
- Routine eye care (Pediatric and Adult)

**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
- Hearing aids (in-network only/2 per lifetime)
- Chiropractic care up to 10 visits per year
- 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. 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 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.

**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, kwiijigo holne' 1-800-551-3225

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

* For more information about limitations and exceptions, see the plan or policy document at 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)*

| | |
|---|---|
| **Total Example Cost** | **$12,371** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0.00 |
| Copayments | $200.00 |
| Coinsurance | $0.00 |
| *What isn't covered* | |
| Limits or exclusions | $200.00 |
| **The total Peg would pay is** | **$400.00** |

This example assumes you have single coverage. 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)*

| | |
|---|---|
| **Total Example Cost** | **$7,389** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0.00 |
| Copayments | $1,200.00 |
| Coinsurance | $0.00 |
| *What isn't covered* | |
| Limits or exclusions | $60.00 |
| **The total Joe would pay is** | **$1,260.00** |

These numbers assume you 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)*

| | |
|---|---|
| **Total Example Cost** | **$1,925** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0.00 |
| Copayments | $400.00 |
| Coinsurance | $0.00 |
| *What isn't covered* | |
| Limits or exclusions | $0.00 |
| **The total Mia would pay is** | **$400.00** |

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