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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the plan document at www.32bjfunds.org or by calling 1-800-551-3225.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** participating. **$1,000** person/**$2,000** family non-participating.	See the chart starting on page 2 for your costs for services this Plan covers.
Are there other deductibles for specific services?	**No.**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Yes.** For participating providers **$6,850** person/ **$13,700** family; and, For non-participating providers **$2,500** person/ **$5,000** family.	The **out–of–pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	**No.**	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services such as office visits.
Does this plan use a network of providers?	**Yes.** For Participating hospitals and doctors see www.32bjfunds.org	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	**No.**	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	**Yes.**	Some of the services this plan doesn't cover are listed on page 5. See your plan document for additional information about **excluded services**.

Questions: Call 1-800-551-3552 or visit us at www.32bjfunds.org for more information, including a copy of your Plan's Summary Plan Description.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-551-3225 to request a copy.

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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a 5 Star Centers	Your cost if you use a Participating Providers	Your cost if you use a Non-Participating Providers	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 co-pay/visit	$40 co-pay/visit	50% co-insurance	-------none-------
	Specialist visit	$0 co-pay/visit	$40 co-pay/visit	50% co-insurance	
	Other practitioner office visit	$0 co-pay/visit chiropractor $0 co-pay/visit acupuncture $0 co-pay/visit occupational, vision, physical, speech therapy	$40 co-pay/visit chiropractor $40 co-pay/visit acupuncture $40 co-pay/visit occupational, vision, physical, speech therapy	50% co-insurance Not Covered Not Covered	Chiropractor 10 visits/year. Acupuncture 20 visits/year. 30 visits/year for occupational, vision and speech combined.30 separate visits/year for out-patient physical therapy. There is a $75 co-pay/visit for out-patient physical therapy provided in a hospital based facility. Pre-certification required.
	Preventive care/screening/ immunization	No Charge	No Charge	50% co-insurance	-------none-------

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Common Medical Event	Services You May Need	Your cost if you use a 5 Star Centers	Your cost if you use a Participating Providers	Your cost if you use a Non-Participating Providers	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	No Charge	50% co-insurance	If services are provided in a hospital based facility, there is a $75 facility co-pay/visit.
	Imaging (CT/PET scans, MRIs)	Not Applicable	$100 co-pay/scan	50% co-insurance	Pre-certification required. Failure to pre-certify 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 co-pay/ up to 30 day supply at retail $20 co-pay/ up to 90 day supply at CVS store or mail	Covered up to what the Fund would pay a participating retail pharmacy. Not Covered.	Value Option Formulary Only. Covers up to a 30-day supply (retail); up to a 90 day supply (CVS retail store 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 co-pay. Prescription drugs not on Value Option Formulary are NOT covered. Ask your doctor to call CVS/Caremark at 1-877-765-6294 for information on formulary alternatives. Certain drugs require prior approval and/or step therapy. Your doctor can call CVS/Caremark at 1-800-294-5979 for additional information. 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 co-pay/up to 30 day supply at retail $60 co-pay/up to 90 day supply at CVS store or mail	Covered up to what the Fund would pay a participating retail pharmacy. Not Covered.	
	Specialty drugs	Not Applicable	Same co-pays as generic and brand drugs above	Not Covered	

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Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		5 Star Centers	Participating Providers	Non-Participating Providers	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	No Charge	50% co-insurance	Outpatient services provided in a hospital based facility require pre-certification and there is a $75 facility co-pay/visit. Failure to pre-certify results in a $250 penalty.
	Physician/surgeon fees	No Charge	No Charge	50% co-insurance	
If you need immediate medical attention	Emergency room services	Not Applicable	$100 co-pay/visit	$100 co-pay/visit	The co-pay increases to $200 for all ER visits after the 2nd visit within the same calendar year.
	Emergency medical transportation	Not Applicable	No Charge	No Charge	-------none-------
	Urgent care	$0 co-pay/visit	$40 co-pay/visit	50% co-insurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Applicable	$100 co-pay/admission	50% co-insurance	Pre-certification required. Failure to pre-certify results in a $250 penalty.
	Physician/surgeon fee	Not Applicable	No Charge	50% co-insurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$0 co-pay/visit, if offered at the 5 Star Center	$40 co-pay/visit	50% co-insurance	Inpatient services require pre-certification. Failure to pre-certify results in a $250 penalty. Outpatient services provided in a hospital based facility require pre-certification and there is a $75 facility co-pay/episode of treatment.
	Mental/Behavioral health inpatient services	Not Applicable	$100 co-pay/admission	50% co-insurance	
	Substance use disorder outpatient services	$0 co-pay/visit, if offered at the 5 Star Center	$40 co-pay/visit	50% co-insurance	
	Substance use disorder inpatient services	Not Applicable	$100 co-pay/admission	50% co-insurance	
If you are pregnant	Prenatal and postnatal care	$0 co-pay	$40 co-pay/1st visit only	50% co-insurance	-------none-------

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Common Medical Event	Services You May Need	Your cost if you use a 5 Star Centers	Your cost if you use a Participating Providers	Your cost if you use a Non-Participating Providers	Limitations & Exceptions
	Delivery and all inpatient services	Not Applicable	$100 co-pay/admission	50% co-insurance	Pre-certification required. Failure to pre-certify 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	200 visits/year.
	Rehabilitation services	Not Applicable	No Charge	Not Covered	Pre-certification required.
	Habilitation services	Not Covered	Not Covered	Not Covered	Excluded Service.
	Skilled nursing care	Not Applicable	No Charge	Not Covered	60 days/year. Pre-certification required.
	Durable medical equipment	Not Applicable	No Charge	Not Covered	Pre-certification required.
	Hospice service	Not Applicable	No Charge	Not Covered	
If your child needs dental or eye care More information about **vision coverage** is available at www.davisvision.com/32bj	Eye exam	Not Applicable	No Charge	Not covered under 19	Coverage once every 12 months, if you have family coverage through Davis Vision.
	Glasses	Not Applicable	No Charge	Not covered under 19	Coverage once every 24 months, if you have family coverage through Davis Vision.
	Dental check-up	Not Applicable	No Charge	Amount in excess of Participating Provider fee	Coverage once every 6 months, if you have family coverage through dental benefit.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan document for 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

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Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)

- 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 dental benefit
- Hearing Aids (In-network only/2 per lifetime)
- Routine eye care (Adult) through Davis Vision
- Routine foot care
- Weight loss programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-551-3225. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Member Services at 1-800-551-3225 or the U.S. Department of Labor, Employee Benefit Security Administration at 1-866-444-EBSA (3272) or 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 at 1-888-614-5400 or http://www.communityhealthadvocates.org/.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-551-3225. Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 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.

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

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,350
- **Patient pays** $1,190

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$140
Co-insurance	$0
Limits or exclusions	$1,050
Total	**$1,190**

This example assumes you have single coverage. If you had family coverage, your total cost would be $140 as the $1,050 in baby charges would be covered.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,980
- **Patient pays** $490

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$420
Co-insurance	$0
Limits or exclusions	$70
Total	**$490**

Note: If you use a 5 Star Center, your costs would be less. If you enroll in a chronic care program, your costs may be less. For more information about the chronic care program, please call Member Services at 1-800-551-3225.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Summary of Material Modifications

Tri-State Plan: 32BJ Health Fund Board of Trustees

Coverage Period: Beginning 1/1/17

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Single/Family** | **Plan Type: POS/PPO**

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The following is a list of changes to the Building Service 32BJ Health Fund's Summary of Benefits and Coverage (SBC) for the Empire Tri-State Plan issued for the Coverage Period beginning 7/1/16. All changes described below are effective January 1, 2017. **Please keep this document with your SBC.**

Page 1: The out of pocket limit for participating providers is increased from $6,850 per person to $7,150 and from $13,700 for a family to $14,300.

Pages 3 and 4: The co-pay for mental/behavioral health and substance abuse visits for participating providers is reduced from $40/visit to $20/visit and the Limitations & Exceptions column is modified for both of the Common Medical Events listed below. Specifically, the $75 facility co-pay for blood work is eliminated and certain non-participating substance abuse providers are excluded.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		5 Star Centers	Participating Providers	Non-Participating Providers	
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	No Charge	50% co-insurance	If services, excluding blood work, are provided in a hospital based facility, there is a $75 facility co-pay/visit.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$0 co-pay/visit, if offered at the 5 Star Center	$20 co-pay/visit	50% co-insurance	Inpatient services require pre-certification. Failure to pre-certify results in a $250 penalty. Outpatient services provided in a hospital based facility require pre-certification and there is a $75 facility co-pay/episode of treatment. *Non-participating NY 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.
	Mental/Behavioral health inpatient services	Not Applicable	$100 co-pay/admission	50% co-insurance	
	Substance use disorder outpatient services	$0 co-pay/visit, if offered at the 5 Star Center	$20 co-pay/visit	50% co-insurance*	
	Substance use disorder inpatient services	Not Applicable	$100 co-pay/admission	50% co-insurance*	

Questions: Call 1-800-551-3552 between the hours of 8:30AM and 5:00 PM Monday through Friday or visit us at www.32bjfunds.org for more information, including a copy of your Plan's Summary of Benefits and Coverage or Summary Plan Description.