

\*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.32bifunds.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 <a href="#">deductible</a>?</b>	\$0 for <a href="#">in-network providers</a> \$1000 person/\$2000 family for <a href="#">out-of-network providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> 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 <a href="#">deductible</a>?</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 <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet specific <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">in-network providers</a> \$8,700 individual/\$17,400 family; for <a href="#">out-of-network providers</a> \$2500 individual/\$5,000 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 <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</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 <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.32bifunds.org">www.32bifunds.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 <a href="#">provider 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 <a href="#">provider's</a> 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 <a href="#">referral</a> to see a <a href="#">specialist</a>?</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</a> office or clinic	Primary care visit to treat an injury or illness	No charge	\$40 <a href="#">copay</a> +/office visit		+Participants working in Pennsylvania have a \$15 <a href="#">copay</a> /office visit.	
	<a href="#">Specialist</a> visit	No charge	\$40 <a href="#">copay</a> /office visit			
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge		50% <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 50% <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	\$40 <a href="#">copay</a> /visit chiropractic		50% <a href="#">coinsurance</a> for chiropractic care	Chiropractic care coverage is limited to 10 visits/year.
	No charge for acupuncture	\$40 <a href="#">copay</a> /visit acupuncture		Not covered	Acupuncture coverage is limited to 20 visits/year.	
	No charge for occupational, vision, physical, speech therapy	\$40 <a href="#">copay</a> /visit occupational, vision, physical, speech therapy		Not covered	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).

<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	No charge		50% <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)	\$100 <a href="#">copay</a> /scan	\$100 <a href="#">copay</a> /scan	\$250 <a href="#">copay</a> /scan	50% <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.optumrx.com">www.optumrx.com</a>	Generic drugs	Not applicable	\$10 <a href="#">copay</a> /up to 30 day supply		Covered up to what Fund would pay a participating retail pharmacy.	Formulary Only. Covers up to a 30-day supply retail and up to a 90 day supply of maintenance medications at CVS pharmacy or through OptumRx Home Delivery.
			\$20 <a href="#">copay</a> /up to 90 day supply		Not covered	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> .
	Brand drugs	Not applicable	\$30 <a href="#">copay</a> /up to 30 day supply		Covered up to what Fund would pay a participating retail pharmacy.	Ask your doctor to call OptumRx at 1-844-569-4148 for information on alternatives.
			\$60 <a href="#">copay</a> /up to 90 day supply		Not covered	Certain drugs are subject to prior authorization, step therapy and/or quantity limitations. Your doctor can call OptumRx at 1-844-569-4148 for additional information.
	<a href="#">Specialty drugs</a>	Not applicable	Same <a href="#">copays</a> as generic and brand drugs above		Not covered	<a href="#">Specialty drugs</a> only available through OptumRx Specialty Pharmacy Program by calling 1-877-838-2907. Participation in Variable Copay Program may reduce specialty drug <a href="#">copays</a> .
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	No charge		50% <a href="#">coinsurance</a>	
	Physician/surgeon fees	No charge	No charge		50% <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.

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<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	50% <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	50% <a href="#">coinsurance</a>	Private rooms not covered. \$100 <a href="#">copay</a> /emergency admission at preferred and non-preferred in-network facilities.
	Physician/surgeon fees	Not applicable	No charge	50% <a href="#">coinsurance</a>	<p>Preauthorization required. Failure to preauthorize out-of-network services results in a \$250 penalty.</p> <p>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.</p>	

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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 <u>copay</u> +/visit		50% <u>coinsurance</u> ***	+Participants working in Pennsylvania have a \$15 <u>copay</u> /office visit.  Inpatient, and some outpatient, services require preauthorization. Failure to preauthorize results in a \$250 penalty.  \$75 <u>copay</u> /episode of treatment for outpatient services at preferred provider hospital-based facilities. \$250 <u>copay</u> /episode of treatment for outpatient services at non-preferred provider hospital-based facilities.
	Inpatient services	Not applicable	\$100 <u>copay</u> /visit	\$1,000 <u>copay</u> /visit	50% <u>coinsurance</u> ***	\$100 <u>copay</u> /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 <u>copay</u> +/1 <sup>st</sup> visit only		50% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound.)  +Participants working in Pennsylvania have a \$15 <u>copay</u> /office visit.

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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)	
	Childbirth/delivery professional services	Not applicable	No charge		50% <a href="#">coinsurance</a>	None.
	Childbirth/delivery facility services	Not applicable	\$100 <a href="#">copay</a> /admission	\$1,000 <a href="#">copay</a> /admission	50% <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> .
<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		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.

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## 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 a 32BJ Health Fund Center of Excellence
- 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.**

[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:

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.*

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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>\$12,642</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0.00
<a href="#">Copayments</a>	\$190.00
<a href="#">Coinsurance</a>	\$0.00
What isn't covered	
Limits or exclusions	\$20.00
<b>The total Peg would pay is</b>	<b>\$210.00</b>

This example assumes you are not working in Pennsylvania, have single coverage, deliver at a preferred hospital but do not participate in the 32BJ Maternity Program.

**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](#) \$10.00

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>\$1,472</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0.00
<a href="#">Copayments</a>	\$950.00
<a href="#">Coinsurance</a>	\$0.00
What isn't covered	
Limits or exclusions	\$0.00
<b>The total Joe would pay is</b>	<b>\$950.00</b>

These numbers assume you are not working in Pennsylvania, 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>\$2,635</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0.00
<a href="#">Copayments</a>	\$310.00
<a href="#">Coinsurance</a>	\$0.00
What isn't covered	
Limits or exclusions	\$0.00
<b>The total Mia would pay is</b>	<b>\$310.00</b>