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. $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. There is no deductible for in-network services. No, when out-of-network.	This plan covers some items and services even if you haven't 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/. 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 $9,200 individual / $18,400 family; for out-of-network providers $9,200 individual / $18,400 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 you use a preferred provider in the plan's network. You pay even more if you use a non-preferred provider in the plan's network. You 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 Preferred Provider*	In-network Non-Preferred Provider*	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.	$75 copay/visit for preventive procedures (e.g., mammogram, colonoscopy) at a preferred provider hospital or hospital based facility. $250 copay/visit for preventive procedures (e.g., mammogram, colonoscopy) at a non-preferred provider hospital or hospital based facility. When utilizing an out-of-network provider Plan pays 70% 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.

* 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.
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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)	
	Other practitioner office visit.	No charge for chiropractic. No charge for acupuncture.	$40 copay /visit chiropractic. $40 copay/visit acupuncture.		30% coinsurance for chiropractic care. Not covered.	Chiropractic care coverage is limited to10 visits/year. Acupuncture coverage is limited to 20 visits/year.
If you have a test	Diagnostic test (x-ray, blood work).	No charge.	No charge.		30% coinsurance.	$75 facility copay/visit for diagnostic tests (excluding blood work) at a preferred hospital based facility. $250 facility copay/visit for diagnostic tests (excluding blood work) at a non-preferred hospital based facility.
	Imaging (CT/PET scans, MRIs).	$75 copay/scan.	$75 copay/scan.	$250 copay/scan.	30% coinsurance.	Preauthorization required. Failure to preauthorize out-of-network services results in a $250 penalty.

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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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs.	Not applicable.	$10 copay/up to 30-day supply. $20 copay/up to 90-day supply.		Not covered.	Formulary Only. Covers up to a 30-day supply for retail pharmacy and up to a 90-day supply of maintenance medications. Maintenance medications require a 90-day supply fill (84-day for weekly dosage drugs) at CVS pharmacy or through OptumRx Home Delivery after a retail allowance (typically two fills) has been met. If you require a brand name drug that has a generic equivalent, you pay the difference in cost between the brand name drug and generic equivalent plus the copay. Ask your doctor to call OptumRx at 1-844-569-4148 for information on alternatives. 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. Specialty drugs are only available through OptumRx Specialty Pharmacy Program by calling 1-877-838-2907. Participation in Variable Copay Program may reduce specialty drug copays.
	Brand drugs.	Not applicable.	$30 copay/up to 30-day supply. $60 copay/up to 90-day supply.		Not covered.	
	Specialty drugs.	Not applicable.	Same copays as generic and brand drugs above.		Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center).	No charge.	Charges may apply.**		30% coinsurance.	$75 facility copay/visit for outpatient services at a preferred hospital-based facility. $250 facility copay/visit for outpatient services at a non-

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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)	
	Physician/surgeon fees.	No charge.	Charges may apply.**		30% coinsurance.	preferred hospital-based facility. $0 copay for certain surgeries when using a Lantern Surgery Care provider. Certain surgeries must be performed with a Lantern Surgery Care provider for coverage.
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.	$40 copay/urgent care visit at 5 Star Center Providers Westmed and Summit.
If you have a hospital stay	Facility fee (e.g., hospital room).	Not applicable.	$100 copay/ Admission.	$1,000 copay/ Admission.	30% coinsurance.	Private rooms not covered. $100 copay/ emergency admission at preferred and non-preferred facilities. Preauthorization required. Failure to preauthorize out-of-network services results in a $250 penalty. Certain procedures are subject to higher copays or are not covered if not performed at certain hospitals. For more information see your SPD or call Member Services at 1-800-551-3225.
	Physician/surgeon fees.	Not applicable.	No charge.		30% coinsurance.	

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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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services.	No charge.	$20 copay/visit.		30% coinsurance.***	Inpatient, and some outpatient, services require preauthorization. Failure to pre-authorize results in a $250 penalty. $75 copay/episode of treatment for outpatient services at preferred provider hospital-based facilities. $250 copay/episode of treatment for outpatient services at non-preferred provider hospital- based facilities. $100 copay/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.
	Inpatient services.	Not applicable.	$100 copay/visit.	$1,000 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 (e.g., ultrasound.)
	Childbirth/delivery professional services.	Not applicable.	No charge.		30% coinsurance.	None.
	Childbirth/delivery	Not	$100 copay/	$1,000	30% coinsurance.	

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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)	
	facility services.	applicable.	Admission.	copay/ admission.		If you are enrolled in the 32BJ Maternity Program and deliver at a hospital in this program, there will be no charge for the delivery.
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.	No charge for occupational, vision, physical, speech therapy.	$40 copay /visit occupational, vision, physical, speech therapy.		Not covered.	Preauthorization required. 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 copay/visit for out-patient physical therapy services at a preferred hospital based facility; $250 facility copay/visit for out-patient physical therapy services at a non-preferred hospital based facility. $0 copay for virtual physical therapy for 12 months when referred by a Lantern Surgery Care provider, to a designated virtual PT provider.
	Habilitation services.	Not covered.	Not covered.		Not covered.	Excluded services.
	Skilled nursing	Not	No charge.		Not covered.	Coverage is limited to 60 days/year.

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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)	
	care.	applicable.				Preauthorization required.
	Durable medical equipment.	Not applicable.	No charge.		Not covered.	Preauthorization required.
	Hospice services.	Not applicable.	No charge.		Not covered.	
If your child needs dental or eye care	Children's eye exam.	Not applicable.	No charge.		Not covered under 19 years old.	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 years old.	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 allowed amount plus the amount in excess of the allowed amount.***	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, Florida or New England, your cost is the amount in excess of the allowed amount.

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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
- 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, joint replacement, and spine surgery only at a 32BJ Health Fund Center of Excellence
- Chiropractic care up to 10 visits per year
- Dental care (Adult) through Delta Dental
- Fertility services through Progyny
- 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)

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 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: 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.
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, kwiijigo holne' 1-800-551-3225

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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

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 (initial visit)	**$40.00**
Preferred 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	**$12,642**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$150.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$00.00
The total Peg would pay is	**$150.00**

This example assumes you 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**
PCP/Specialist copay per visit (2x)	**$40.00**
Durable Medical Equipment copay	**$0.00**
Other Rx copay per 90-day refill (4x)	**$20.00**

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	**$1,472**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$160.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Joe would pay is	**$160.00**

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**
Rehabilitation services copay (5x)	**$40.00**
Preferred 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	**$2,635**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$310.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$310.00**

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