
 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 the complete terms of coverage, call the Fund Office at (718) 939-1489 or visit www.local14funds.org. 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 www.dol.gov/ebsa/healthreform or by calling the Fund Office at (718) 939-1489 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Not applicable.	This <u>plan</u> does not have a <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Medical/Hospital <u>In-Network providers</u> : \$5,600/individual, \$11,200/family; <u>Prescription drugs (in-network)</u> : \$1,000/individual, \$2,000/family; Medical/Hospital <u>Out-of-Network providers</u> : \$2,000/individual	Medical/Hospital <u>In-Network providers</u> and <u>prescription drugs (in-network)</u> : The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. <u>Out-of-Network providers</u> : The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u> ?	<u>In-Network</u> and <u>Out-of-Network</u> : Premiums, <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> and health care this <u>plan</u> doesn't cover. <u>Out-of-Network</u> also does not include <u>copayments</u> , <u>deductible</u> and <u>prescription drugs</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.local14funds.org or call the Fund Office at (718) 939-1489 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge	Amounts over Medicare allowance	<p><u>Plan</u> pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, no benefits are payable. <u>Plan</u> does not cover <u>providers</u> who have opted out of Medicare (you pay 100% of these charges).</p> <p><u>Plan</u> pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, no benefits are payable. <u>Plan</u> does not cover <u>providers</u> who have opted out of Medicare (you pay 100% of these charges).</p> <p>Age and frequency limits apply. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.</p>
	<u>Specialist</u> visit	No charge	Amounts over Medicare allowance	
	<u>Preventive care/screening/immunization</u>	No charge	Amounts over Medicare allowance	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Amounts over Medicare allowance	<p><u>Plan</u> pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, no benefits are payable. <u>Plan</u> does not cover <u>providers</u> who have opted out of Medicare (you pay 100% of these charges).</p>
	Imaging (CT/PET scans, MRIs)	No charge	Amounts over Medicare allowance	

* For more information about limitations and exceptions, see the plan or policy document at www.local14funds.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.optumrx.com</p>	Generic drugs	Retail: \$5 <u>copay</u> /prescription Mail order: \$10 <u>copay</u> /prescription	Retail only: \$5 <u>copay</u> /prescription plus balances over <u>allowed amount</u> Mail order: Not covered	<p>You have Creditable Coverage under the <u>Plan</u> and you do not have to enroll in Medicare Part D. If you are enrolled in a Medicare Part D Plan (PDP), you will lose your <u>prescription drug coverage</u> under the <u>Plan</u> (but will be allowed to keep your medical coverage). See the <u>Plan's</u> Notice of Creditable Coverage or contact the Fund Office for more information.</p> <p><u>Cost sharing</u> does not count toward medical/hospital <u>out-of-pocket limit</u>; counts toward separate \$1,000 <u>out-of-pocket limit</u> for <u>prescription drugs</u>.</p> <p>Retail: 30-day supply. Mail order: 90-day supply. Certain drugs require prior authorization from OptumRx in order to be covered by the <u>Plan</u>.</p> <p>No <u>copay</u> for generic contraceptives for women (or brand name contraceptives if a generic is medically inappropriate) and other ACA-required <u>preventive services</u> prescriptions. Any over-the-counter drugs that are payable under this provision require a prescription to be covered.</p>
	Formulary brand drugs	Retail: \$20 <u>copay</u> /prescription Mail order: \$40 <u>copay</u> /prescription	Retail only: \$20 <u>copay</u> /prescription plus balances over <u>allowed amount</u> Mail order: Not covered	
	Non-formulary brand drugs	Retail: \$35 <u>copay</u> /prescription Mail order: \$70 <u>copay</u> /prescription	Retail only: \$35 <u>copay</u> /prescription plus balances over <u>allowed amount</u> Mail order: Not covered	
	<u>Specialty drugs</u>	Applicable <u>copay</u> above	Applicable <u>copay</u> above	

* For more information about limitations and exceptions, see the plan or policy document at www.local14funds.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Amounts over Medicare Allowance	<p><u>Plan</u> pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, no benefits are payable. <u>Plan</u> does not cover <u>providers</u> who have opted out of Medicare (you pay 100% of these charges).</p>
	Physician/surgeon fees	No charge	Amounts over Medicare Allowance	
If you need immediate medical attention	<u>Emergency room care</u>	No charge	Amounts over Medicare Allowance	
	<u>Emergency medical transportation</u>	No charge	Amounts over Medicare Allowance	
	<u>Urgent care</u>	No charge	Amounts over Medicare Allowance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Amounts over Medicare Allowance	
	Physician/surgeon fees	No charge	Amounts over Medicare Allowance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Amounts over Medicare Allowance	
	Inpatient services	No charge	Amounts over Medicare Allowance	
If you are pregnant	Office visits	No charge	Amounts over Medicare Allowance	
	Childbirth/delivery professional services	No charge	Amounts over Medicare Allowance	
	Childbirth/delivery facility services	No charge	Amounts over Medicare Allowance	

* For more information about limitations and exceptions, see the plan or policy document at www.local14funds.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Amounts over Medicare Allowance	<u>Plan</u> pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, no benefits are payable. <u>Plan</u> does not cover <u>providers</u> who have opted out of Medicare (you pay 100% of these charges).
	<u>Rehabilitation services</u>	No charge	Amounts over Medicare Allowance	
	<u>Habilitation services</u>	No charge	Amounts over Medicare Allowance	
	<u>Skilled nursing care</u>	No charge	Amounts over Medicare Allowance	
	<u>Durable medical equipment</u>	No charge	Amounts over Medicare Allowance	
	<u>Hospice services</u>	No charge	Amounts over Medicare Allowance	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You pay 100% of these charges.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at www.local14funds.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.)

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|---|--|---|
| <ul style="list-style-type: none">• Acupuncture• Cosmetic surgery• Dental care (Adult & Child)• Hearing aids | <ul style="list-style-type: none">• Infertility treatment• Long-term care• Non-emergency care when traveling outside the U.S.• Private-duty nursing | <ul style="list-style-type: none">• Routine eye care (Adult & Child)• Routine foot care• Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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| <ul style="list-style-type: none">• Bariatric surgery (to extent Medicare covers such services, this <u>Plan</u> will pay benefits up to Medicare allowance) | <ul style="list-style-type: none">• Chiropractic care (to extent Medicare covers such services, this <u>Plan</u> will pay benefits up to Medicare allowance) |
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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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: the Plan at 141-57 Northern Boulevard, Flushing, NY 11354; Telephone: (718) 939-1489; www.local14funds.org. You may also contact 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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-267-2323.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-267-2323.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-267-2323.

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

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
- Specialist cost sharing None
- Hospital (facility) cost sharing None
- Other copay (generic drug) \$5

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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$40
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Peg would pay is	\$50

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

- The plan's overall deductible \$0
- Specialist cost sharing None
- Hospital (facility) cost sharing None
- Other copay (generic drug) \$5

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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$960
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$960

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

- The plan's overall deductible \$0
- Specialist cost sharing None
- Hospital (facility) cost sharing None
- Other copay (generic drug) \$5

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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$0