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 deductible? | $0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible? | Not applicable. | This plan does not have a deductible. |
| Are there other deductibles for specific services? | Yes. $50/individual or $100/family for Out-of-Network dental. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan? | Medical/Hospital In-Network providers: $5,600/individual, $11,200/family;<br>Prescription drugs (in-network): $1,000/individual, $2,000/family;<br>Medical/Hospital Out-of-Network providers: $2,000/individual | Medical/Hospital In-Network providers and prescription drugs (in-network): 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.<br>Out-of-Network providers: The out-of-pocket limit is the most you could pay in a year for covered services. |
| What is not included in the out-of-pocket limit? | In-Network and Out-of-Network: Premiums, balance-billing charges, penalties for failure to obtain preauthorization and health care this plan doesn't cover. Out-of-Network also does not include copayments, deductible and prescription drugs. | 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.local14funds.org or call the Fund Office at (718) 939-1489 for a list of in-network providers. | This plan uses a provider network. You will pay less if you 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 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. |

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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 |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | 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 | Amounts over Medicare allowance | Plan pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, no benefits are payable. Plan does not cover providers who have opted out of Medicare (you pay 100% of these charges). |
| | Specialist visit | No charge | Amounts over Medicare allowance | |
| | Preventive care/screening/ immunization | No charge | Amounts over Medicare allowance | Plan pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, no benefits are payable. Plan does not cover providers who have opted out of Medicare (you pay 100% of these charges).<br><br>Age and frequency limits apply. 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. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | Amounts over Medicare allowance | Plan pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, no benefits are payable. Plan does not cover providers who have opted out of Medicare (you pay 100% of these charges). |
| | Imaging (CT/PET scans, MRIs) | No charge | Amounts over Medicare allowance | |

| 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 drugs to treat your illness or condition<br>More information about prescription drug coverage is available at www.[insert].com | Generic drugs | Retail: $5 copay/prescription<br>Mail order: $10 copay/prescription | Retail only: $5 copay/prescription plus balances over allowed amount<br>Mail order: Not covered | Cost sharing does not count toward medical/hospital out-of-pocket limit; counts toward separate $1,000 out-of-pocket limit for prescription drugs.<br>Retail: 30-day supply. Mail order: 90-day supply. Certain drugs require prior authorization from CVS Health in order to be covered by the Plan.<br>No copay for generic contraceptives for women (or brand name contraceptives if a generic is medically inappropriate) and other ACA-required preventive services prescriptions. Any over-the-counter drugs that are payable under this provision require a prescription to be covered. |
| | Formulary brand drugs | Retail: $20 copay/prescription<br>Mail order: $40 copay/prescription | Retail only: $20 copay/prescription plus balances over allowed amount<br>Mail order: Not covered | |
| | Non-formulary brand drugs | Retail: $35 copay/prescription<br>Mail order: $70 copay/prescription | Retail only: $35 copay/prescription plus balances over allowed amount<br>Mail order: Not covered | |
| | Specialty drugs | Applicable copay above | Applicable copay above | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | Amounts over Medicare Allowance | Plan pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, no benefits are payable. Plan does not cover providers who have opted out of Medicare (you pay 100% of these charges). |
| | Physician/surgeon fees | No charge | Amounts over Medicare Allowance | |
| If you need immediate medical attention | Emergency room care | No charge | Amounts over Medicare Allowance | Plan pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, no benefits are payable. Plan does not cover providers who have opted out of Medicare (you pay 100% of these charges). |
| | Emergency medical transportation | No charge | Amounts over Medicare Allowance | |
| | Urgent care | No charge | Amounts over Medicare Allowance | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | Amounts over Medicare Allowance | Plan pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, no benefits are payable. Plan does not cover providers who have opted out of Medicare (you pay 100% of these charges). |
| | Physician/surgeon fees | No charge | Amounts over Medicare Allowance | |

| 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 mental health, behavioral health, or substance abuse services | Outpatient services | No charge | Amounts over Medicare Allowance | Plan pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, no benefits are payable. Plan does not cover providers who have opted out of Medicare (you pay 100% of these charges). |
| | Inpatient services | No charge | Amounts over Medicare Allowance | |
| If you are pregnant | Office visits | No charge | Amounts over Medicare Allowance | Plan pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, no benefits are payable. Plan does not cover providers who have opted out of Medicare (you pay 100% of these charges). |
| | Childbirth/delivery professional services | No charge | Amounts over Medicare Allowance | |
| | Childbirth/delivery facility services | No charge | Amounts over Medicare Allowance | |
| If you need help recovering or have other special health needs | Home health care | No charge | Amounts over Medicare Allowance | Plan pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, no benefits are payable. Plan does not cover providers who have opted out of Medicare (you pay 100% of these charges). |
| | Rehabilitation services | No charge | Amounts over Medicare Allowance | |
| | Habilitation services | No charge | Amounts over Medicare Allowance | |
| | Skilled nursing care | No charge | Amounts over Medicare Allowance | |
| | Durable medical equipment | No charge | Amounts over Medicare Allowance | |
| | Hospice services | 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 | You pay 100% of these charges. |
| | Children's dental check-up | Not covered | Not covered | You pay 100% of these charges. |

## 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.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Bariatric surgery (to extent Medicare covers such services, this Plan will pay benefits up to Medicare allowance)
- Chiropractic care (to extent Medicare covers such services, this Plan will pay benefits up to Medicare allowance)

**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?** No

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.*

* For more information about limitations and exceptions, see the plan or policy document at www.local14funds.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 $
- Specialist *[cost sharing]* $
- Hospital (facility) *[cost sharing]* %
- Other *[cost sharing]* %

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 |
|---|---|

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $40 |
| Coinsurance | $0 |
| *What isn't covered* | |
| 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 $
- Specialist *[cost sharing]* $
- Hospital (facility) *[cost sharing]* %
- Other *[cost sharing]* %

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 |
|---|---|

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $960 |
| Coinsurance | $0 |
| *What isn't covered* | |
| 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 $
- Specialist *[cost sharing]* $
- Hospital (facility) *[cost sharing]* %
- Other *[cost sharing]* %

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 |
|---|---|

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $0 |

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