This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the Summary Plan Description (SPD) and Summaries of Material Modifications ("SMMs") either at www.nyccbf.com or by calling 1-800-529-FUND (3863) or 1-212-366-7373.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0.**	Not applicable because there is no deductible.
Are there other deductibles for specific services?	No.	Not applicable because there is no deductible.
Is there an out–of–pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This plan has no out-of-pocket limit.	Not applicable because there is no out-of-pocket limit on your expenses.
Is there an overall annual limit on what the plan pays?	Yes. The limit is equal to the contributions in your health reimbursement account. The plan will contribute **$869** to your account at the start of the calendar year. This amount is subject to change from year to year. Any unused account balance will not be carried forward to the next plan year but instead will be forfeited.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit.
Does this plan use a network of providers?	No.	This plan treats **providers** the same in determining payment for the same services.
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 SPD and SMMs for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if a plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** 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**.)
- A plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered	Not covered	There is no coverage for this type of medical event. You must obtain benefits from other coverage or pay 100% of these expenses, even in-network. This Plan will contribute $869 to your health reimbursement account at the start of the calendar year. You may apply for a distribution from your account for direct reimbursement of eligible "medical care expenses" not covered by your primary insurance. "Medical care expenses" means expenses incurred by your or your covered dependents for medical care as defined in Internal Revenue Code §§ 105 and 213(d). A complete listing of eligible medical care expenses is outlined in IRS publication 502. You (and your dependents) must also be enrolled in a group health plan that meets the Affordable Care Act's (ACA) minimum value standard to be eligible for reimbursement. See the Summary of Benefits and Coverage from your other group health plan to determine if it meets this standard. No reimbursement is allowed for individual coverage purchased through a Marketplace established by the ACA or Medicare. Any unused account balance will be forfeited at the end of the calendar year.
	Specialist visit	Not covered	Not covered	
	Other practitioner office visit	Not covered	Not covered	
	Preventive care/ screening/ immunization	Not covered	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	
If you need drugs to treat your illness or condition	Generic drugs	Not covered	Not covered	
	Preferred Brand name drugs	Not covered	Not covered	
	Non-Preferred Brand name drugs	Not covered	Not covered	
	Specialty drugs	Not covered	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	There is no coverage for this type of medical event. You must obtain benefits from other coverage or pay 100% of these expenses, even in-network. This plan will contribute $869 to your health reimbursement account at the start of the calendar year. You may apply for a distribution from your account for direct reimbursement of eligible "medical care expenses" not covered by your primary insurance. "Medical care expenses" means expenses incurred by your or your covered dependents for medical care as defined in Internal Revenue Code §§ 105 and 213(d). A complete listing of eligible medical care expenses is outlined in IRS publication 502. You (and your dependents) must also be enrolled in a group health plan that meets the Affordable Care Act's (ACA) minimum value standard to be eligible for reimbursement. See the Summary of Benefits and Coverage from your other group health plan to determine if it meets this standard. No reimbursement is allowed for individual coverage purchased through a Marketplace established by the ACA or Medicare. Any unused account balance will be forfeited at the end of the calendar year.
	Physician/surgeon fees	Not covered	Not covered	
If you need immediate medical attention	Emergency room services	Not covered	Not covered	
	Emergency medical transportation	Not covered	Not covered	
	Urgent care	Not covered	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	
	Physician/surgeon fee	Not covered	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	Not covered	
	Mental/Behavioral health inpatient services	Not covered	Not covered	
	Substance use disorder outpatient services	Not covered	Not covered	
	Substance use disorder inpatient services	Not covered	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	Not covered	Not covered	There is no coverage for this type of medical event. You must obtain benefits from other coverage or pay 100% of these expenses, even in-network. This plan will contribute $869 to your health reimbursement account at the start of the plan year. You may apply for a distribution from your account for direct reimbursement of eligible "medical care expenses" not covered by your primary insurance. "Medical care expenses" means expenses incurred by your or your covered dependents for medical care as defined in Internal Revenue Code §§ 105 and 213(d). A complete listing of eligible medical care expenses is outlined in IRS publication 502. You (and your dependents) must also be enrolled in a group health plan that meets the Affordable Care Act's (ACA) minimum value standard to be eligible for reimbursement. See the Summary of Benefits and Coverage from your other group health plan to determine if it meets this standard. No reimbursement is allowed for individual coverage purchased through a Marketplace established by the ACA or Medicare. Any unused account balance will be forfeited at the end of the calendar year.
	Delivery and all inpatient services	Not covered	Not covered	
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	
	Rehabilitation services	Not Covered	Not Covered	
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	Not Covered	Not Covered	
	Durable medical equipment	Not Covered	Not Covered	
	Hospice service	Not Covered	Not Covered	
If your child needs dental or eye care	Eye exam	No Charge	Amount over $125 Plan allowance (combined with glasses)	Vision benefits separately administered by Comprehensive Professional Systems or General Vision Services. Eye exam and glasses or contact lenses limited to once every 12 months. Selection of special lenses and coatings may require you to pay a portion of the cost, even in-network.
	Glasses	No Charge	Amount over $125 Plan allowance (combined with eye exam)	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Dental check-up	None	Reimbursed according to Plan's schedule of allowances	Services are subject to a maximum Fund payment of $1,500 per person per calendar year; Children orthodontia covered up to $1,950 per lifetime.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your SPD and SMMs for other excluded services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs (except as required by the ACA)
- All Common Medical Events in the chart starting on page 2

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

- Dental care (Adult) (Subject to $100 per individual deductible excluding diagnostic, preventive, and orthodontic services
- Hearing aids (Limited to $350/ear, not to exceed one every 4 years)
- Routine eye care (Adult) (Limited to one eye exam and pair of glasses or supply of contact lenses every 12 months)

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 1-800-529-FUND (3863) or 1-212-366-7373. 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 the Fund Office at 395 Hudson Street, 9th Floor, New York, NY 10014 or call the Fund Office at 1-800-529-FUND (3863) or 1-212-366-7373. 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 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 or policy 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 not meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-529-FUND (3863) o 1-212-366-7373.

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

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** $0
- **Patient pays** $7,540

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
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$7,540**

Under this Plan, you may apply for a distribution of a portion of your health reimbursement account to be reimbursed for out-of-pocket eligible medical care expenses not covered by your primary insurance.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $0
- **Patient pays** $5,400

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
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$5,400**

Under this Plan, you may apply for a distribution of a portion of your health reimbursement account to be reimbursed for out-of-pocket eligible medical expenses not covered by your primary insurance.

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.