



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, if applicable.**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.nycCBF.com or call 1-800-529-FUND (3863) or 1-212-366-7373. 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.com or call the Fund Office 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? | Yes. Basic and major dental services are subject to a \$100 annual <u>deductible</u> . There are no other specific <u>deductibles</u> . | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | Not applicable. | This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses. |
| What is not included in the <u>out-of-pocket limit</u>? | Not applicable. | This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses. |
| Will you pay less if you use a <u>network provider</u>? | Not applicable. | This <u>plan</u> does not use a <u>provider network</u> . You can receive covered services from any <u>provider</u> . |
| 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> . |

| 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 | Not Covered | Not Covered | <p>There is no coverage for this type of medical event except for reimbursement of certain expenses related to these medical events. You must obtain benefits from other coverage or pay 100% of these expenses, even <u>in-network</u>.</p> <p>The City of New York will contribute \$1,844 to your health reimbursement account (HRA) 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 you or your covered dependents for medical care as defined in Internal Revenue Code (Code) §§ 105 and 213(d). A complete list of eligible medical care expenses is outlined in IRS publication 502. Reimbursable expenses include <u>copayments</u>, <u>coinsurance</u>, or <u>deductibles</u> paid under another health <u>plan</u> or a <u>prescription drug</u> cost.</p> <p>You (and your dependents) must also be enrolled in a group health <u>plan</u> that meets the Affordable Care Act's (ACA) <u>minimum value standard</u> to be eligible for reimbursement. See the Summary of Benefits and Coverage (SBC) from your other group health <u>plan</u> to determine if it meets this standard. No reimbursement is allowed for individual coverage purchased through a <u>Marketplace</u> established by the ACA or Medicare.</p> <p>Any unused account balance will be not carried forward to the next <u>plan</u> year but instead will be forfeited.</p> |
| | <u>Specialist</u> visit | Not Covered | Not Covered | |
| | <u>Preventive care/screening/immunization</u> | Not Covered | Not Covered | |
| If you have a test | <u>Diagnostic test</u> (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 drugs | Not Covered | Not Covered | |
| | Non-preferred brand drugs | Not Covered | Not Covered | |
| | <u>Specialty drugs</u> | Not Covered | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Not Covered | Not Covered | |
| | Physician/surgeon fees | Not Covered | Not Covered | |
| If you need immediate medical attention | <u>Emergency room care</u> | Not Covered | Not Covered | |
| | <u>Emergency medical transportation</u> | Not Covered | Not Covered | |
| | <u>Urgent care</u> | Not Covered | Not Covered | |

| 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 a hospital stay | Facility fee (e.g., hospital room) | Not Covered | Not Covered | <p>There is no coverage for this type of medical event except for reimbursement of certain expenses related to these medical events. You must obtain benefits from other coverage or pay 100% of these expenses, even <u>in-network</u>.</p> <p>The City of New York will contribute \$1,844 to your HRA 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 you or your covered dependents for medical care as defined in Code §§ 105 and 213(d). A complete list of eligible medical care expenses is outlined in IRS publication 502. Reimbursable expenses include <u>copayments</u>, <u>co-insurance</u>, or <u>deductibles</u> paid under another health <u>plan</u> or a <u>prescription drug</u> cost.</p> <p>You (and your dependents) must also be enrolled in a group health <u>plan</u> that meets the ACA’s <u>minimum value standard</u> to be eligible for reimbursement. See the SBC from your other group health <u>plan</u> to determine if it meets this standard. No reimbursement is allowed for individual coverage purchased through a <u>Marketplace</u> established by the ACA or Medicare.</p> <p>Any unused account balance will not be carried forward to the next <u>plan</u> year but instead will be forfeited.</p> |
| | Physician/surgeon fees | Not Covered | Not Covered | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Not Covered | Not Covered | |
| | Inpatient services | Not Covered | Not Covered | |
| If you are pregnant | Office visits | Not Covered | Not Covered | |
| | Childbirth/delivery professional services | Not Covered | Not Covered | |
| | Childbirth/delivery facility services | Not Covered | Not Covered | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | Not Covered | Not Covered | |
| | <u>Rehabilitation services</u> | Not Covered | Not Covered | |
| | <u>Habilitation services</u> | Not Covered | Not Covered | |
| | <u>Skilled nursing care</u> | Not Covered | Not Covered | |
| | <u>Durable medical equipment</u> | Not Covered | Not Covered | |
| | <u>Hospice services</u> | Not Covered | Not Covered | |

| 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 your child needs dental or eye care | Children's eye exam | No Charge | Amount over \$125 <u>Plan</u> 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 (365 days). Selection of special lenses and coatings may require you to pay a portion of the cost, even <u>in-network</u> . |
| | Children's glasses | No Charge | Amount over \$125 <u>Plan</u> allowance (combined with eye exam) | |
| | Children's dental check-up | No charge for <u>preventive services</u> . Other services limited by schedule of covered allowances, frequency limits, and <u>Plan</u> maximums. | Amount over <u>Plan</u> allowance | Dental benefits are separately administered by ASO. \$100/Individual <u>deductible</u> (<u>deductible</u> will be waived for diagnostic, <u>preventive services</u> , and orthodontic treatment) and a \$1,500 annual maximum per covered individual. |

Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your Summary Plan Description (SPD) for more information and a list of any other <u>excluded services</u> .) | | |
|---|--|--|
| <ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Chiropractic care• Cosmetic surgery• Infertility treatment | <ul style="list-style-type: none">• Long-term care• Non-emergency care when traveling outside the U.S.• Private-duty nursing | <ul style="list-style-type: none">• Routine foot care• Weight loss programs• All Common Medical Events in the chart starting on page 2 |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your SPD.) | | |
| <ul style="list-style-type: none">• Dental care (Adult) (Subject to <u>deductible</u> of \$100/per Individual excluding diagnostic, preventive, and orthodontic services) | <ul style="list-style-type: none">• Hearing aids (Limited to \$350/ear, not to exceed one every 4 years) | <ul style="list-style-type: none">• 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: There is an agency that can help if you want to continue your coverage after it ends. The contact information for this agency is: the U.S. Department of Labor's Employee Benefits Security Administration 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 SPD also provides 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: the Fund Office at 395 Hudson Street, New York, NY 10014; or Department of Labor's Employee Benefits Security Administration, 1-866-444-EBSA (3272), www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: Community Service Society of New York, Community Health Advocates, 105 East 22nd Street, 8th Floor, New York, NY 10010, (888) 614-5400, <http://www.communityhealthadvocates.org>.

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? 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 1-212-366-7300 o 1-800-529-3863.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-529-3863.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-529-3863.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-529-3863.

—————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 \$0
- Hospital (facility) cost sharing N/A
- Other cost sharing N/A

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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay (This condition is not covered, so patient pays 100%.):

| <i>Cost Sharing</i> | |
|-----------------------------------|-----------------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$12,260 |
| The total Peg would pay is | \$12,260 |

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 \$0
- Hospital (facility) cost sharing N/A
- Other cost sharing N/A

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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay (This condition is not covered, so patient pays 100%.):

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$5,380 |
| The total Joe would pay is | \$5,380 |

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

- The plan's overall deductible \$0
- Specialist cost sharing \$0
- Hospital (facility) cost sharing N/A
- Other cost sharing N/A

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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay (This condition is not covered, so patient pays 100%.):

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$2,800 |
| The total Mia would pay is | \$2,800 |

This Plan provides an HRA benefit so these coverage examples are not applicable.
This Plan may pay benefits for some unreimbursed expenses.