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 1-212-343-1660. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, , deductible, provider, or other underlined terms see the Glossary .You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-633-5568 to request a copy. If you want more detail about your coverage and costs, you can get the complete terms in the Summary Plan Description or by calling the Fund office at 1-212-343-1660.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | $1,000 / individual or $2,000 / member/child(ren) | 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, the overall family deductible must be meet before the plan begins to pay. |
| Are there services covered before you meet your deductible? | Yes. Preventive care and primary care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet 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/. |
| Are there other deductibles for specific services? | No. There are no other specific deductibles | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | Yes, there are 2 separate out-of-pocket limits under this plan: medical and a separate one for the prescription benefit. Each benefit's out-of-pocket limit is $5,000 Individual, $10,000 member/child(ren). | 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, the overall family out-of-pocket limit must be met. |
| What is not included in the out-of-pocket limit? | Premiums and healthcare expenses that this plan does not 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 go to www.magnacare for providers. You may use any hospital or facility | 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 don't need a referral to see a specialist. | You can see the specialist you choose without permission from this plan provided that they are in the network. |

All 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 | $30 copayment after deductible / visit | Not Covered | Outpatient facility visits; $200 copayment plus 20% coinsurance after deductible |
| | Specialist visit | $30 copayment after deductible / visit | Not Covered | Outpatient facility visits; $200 copayment plus 20% coinsurance after deductible |
| | Preventive care/screening/ immunization | No Charge | Not Covered | ---------- none ---------- |
| If you have a test | Diagnostic test (x-ray, blood work) | $30 copayment after deductible / test freestanding facility | Not Covered | Outpatient facility - $200 copayment plus 20% coinsurance after deductible |
| | Imaging (CT/PET scans, MRIs) | $30 copayment after deductible / test freestanding facility | Not Covered | Outpatient facility - $200 copayment plus 20% coinsurance after deductible |
| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at www.Navitus.com | Generic drugs | $10 copayment | Covered up to the Navitus discount rate. | Up to 90 day retail supply available copayment $30 |
| | Preferred brand drugs | The greater of $30 copayment or 25% of the cost of the medication. | Covered up to the Navitus discount rate. | If there is a Generic equivalent available in addition to the copayment, the member will pay the difference in the cost between the Generic vs Preferred Brand cost. |
| | Non-preferred brand drugs | The greater of $50 copayment or 25% of the cost of the medication. | Covered up to the Navitus discount rate. | If there is a Generic equivalent available in addition to the copayment, the member will pay the difference in the cost between the Generic vs Non Preferred Brand cost. |
| | Specialty drugs | Same as above | Not Covered | Mandatory Specialty Program contact 1-855-847-3553 |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | $200 copayment plus 20% coinsurance after deductible | Not Covered | Outpatient hospital facility; $200 copayment plus 20% coinsurance after deductible |
| | Physician/surgeon fees | 20% coinsurance after deductible | Not Covered | Outpatient hospital facility 20% coinsurance after deductible |
| If you need immediate medical attention | Emergency room care | $300 copayment after deductible | $300 copayment after deductible | Waived if admitted. |
| | Emergency medical transportation | 20% coinsurance after deductible | 20% coinsurance after deductible | Maximum allowance ALS $1,290 BLS $704 plus $12 per mile transport. |
| | Urgent care | $50 copayment after deductible | Not Covered | ---------- none ---------- |

| 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) | $100 copayment; then 20% coinsurance after deductible | Not Covered | ---------- none ---------- |
| | Physician/surgeon fees | 20% coinsurance after deductible | Not Covered | Allowed one visit per day. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services office visit. | $30 copayment after deductible | Not Covered | Outpatient facility visit; $200 copayment plus 20% coinsurance after deductible |
| | Inpatient services | $100 copayment; 20% coinsurance after deductible | Not Covered | Precertification required |
| | Substance use disorder outpatient services office visit. | $30 copayment after deductible | Not Covered | Outpatient facility visit; $200 copayment plus 20% coinsurance |
| | Substance use disorder inpatient services | $100 copayment, 20% coinsurance after deductible | Not Covered | Residential Care Programs not covered. |
| If you are pregnant | Office visits | $30 copayment after deductible | Not Covered | Outpatient facility - $200 copayment plus 20% coinsurance after deductible |
| | Childbirth/delivery professional services | 20% coinsurance after deductible | Not Covered | |
| | Childbirth/delivery facility services | 20% coinsurance after deductible | Not Covered | Outpatient facility visit; $200 copayment plus 20% coinsurance after deductible |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance after deductible | Not Covered | Maximum 60 visits per year requires pre-authorization. |
| | Rehabilitation services | 20% coinsurance after deductible | Not Covered | Inpatient $100 copayment; Outpatient facility - $200 copayment plus 20% coinsurance after deductible |
| | Habilitation services | 20% coinsurance after deductible | Not Covered | Outpatient facility - $200 copayment plus 20% coinsurance after deductible |
| | Skilled nursing care | 20% coinsurance after deductible | Not Covered | Inpatient $100 copayment; Outpatient facility - $200 copayment plus 20% coinsurance after deductible |
| | Durable medical equipment | 20% coinsurance after deductible | Not Covered | Pre-cert required when amount is greater than $2,000. |
| | Hospice services | 20% coinsurance after deductible | Not Covered | Pre-cert required up to 210 days per lifetime. |
| If your child needs dental or eye care | Children's eye exam | Not Covered | Not Covered | ---------- none ---------- |
| | Children's glasses | Not Covered | Not Covered | ---------- none ---------- |
| | Children's dental check-up | Not Covered | Not Covered | If enrolled in Dental Benefit. |

For more information about limitations and exceptions, see the plan or policy document at www.DC1707L95WF.net by calling, DC 37 Local 95 HSEWF at 1-212-343-1660

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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 | • Motor vehicle related expenses | • Routine eye care (adult/child) |
| • Long-term Care | • Non-emergency care when traveling outside the U.S. | • Routine foot care (except for a specific diagnosis such as diabetes) |
| • Hearing aids | • Private-duty nursing | |
| **Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)** | | |
| • Acupuncture (for pain management or used for anesthesia) | • Dental care (adult/child) refer to standalone dental benefits) | • Routine wellcare |
| • Chiropractic care (limited) | • Dialysis (in-network only) | |
| • Chemotherapy | • Organ transplants | |

Your Rights to Continue Coverage:
** Individual health insurance sample –

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you or your employer pay the premium. There are exceptions, however, such as if:

- You commit fraud
- The Fund Stops offering services
- you move outside the coverage area

For more information on your rights to continue coverage, contact the Fund at 1-212-343-1660. You may also contact your state insurance department.

premium

Your Rights to Continue Coverage:

** Individual health insurance sample -

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.

Group health coverage -

For more information on your rights to continue coverage, contact the plan at 1-212-343-1660. You may also contact 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 x 61565 or www.cciio.cms.gov.

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: [insert applicable contact information from instructions].

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 1-800-225-1345
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 -800-225-1345
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa-800-225-1345
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne-800-225-1345

*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, s 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 | $1000 |
| Specialist copayment | $30 |
| Hospital (facility) coinsurance | $200 |
| Other coinsurance | 20% |

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:

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $230 |
| Coinsurance | $2,560 |
| *What isn't covered* | |
| Limits or exclusions | $100 |
| The total Peg would pay is | $3,890 |

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

| | |
|---|---|
| The plan's overall deductible | $1000 |
| Specialist copayment | $30 |
| Hospital (facility) coinsurance | $200 |
| Other coinsurance | 20% |

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:

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $230 |
| Coinsurance | $1,480 |
| *What isn't covered* | |
| Limits or exclusions | $100 |
| The total Joe would pay is | $2,810 |

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

| | |
|---|---|
| The plan's overall deductible | $1000 |
| Specialist copayment | $30 |
| Hospital (facility) coinsurance | $200 |
| Other coinsurance | 20% |

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:

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $230 |
| Coinsurance | $380 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $1,610 |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: DC 37 Local 95 HSEWF by calling 1-212-343-1660.