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, please call the Fund at (212) 925-6033. 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 request a copy of the Glossary by calling the Fund at 212-925-6033.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0.00	You do not have to meet a deductible before this plan begins to pay for services rendered to you.
Are there services covered before you meet your deductible?	Not applicable.	You have no deductible.
Are there other deductibles for specific services?	Not applicable.	You have no deductible.
What is the out-of-pocket limit for this plan?	$6,500 Individual and $13,000 Family	Once you meet your out-of-pocket limit for the year, all your claims for the corresponding year will be paid at 100% (no co-payments).
What is not included in the out-of-pocket limit?	Dental or Optical Services	
Will you pay less if you use a network provider?	Yes. See www.emblemhealth.com	If you use an in-network doctor, this plan will pay up to 90% of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. You will be responsible all costs associated with services rendered by an out-of-network provider. Plans use the term in-network, preferred or participating for providers in their network. See the chart starting on page 2 for how this plan pays different providers
Do you need a referral to see a specialist?	No. You do not need a referral to see a specialist.	You can see a participating specialist you choose without permission from this plan.

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	$35 co-pay	Not covered	Hospital clinic visits are not covered
	Specialist visit	$35 co-pay	Not covered	Hospital clinic visits are not covered
	Preventive care/screening/ immunization	$0	Not covered	One visit per calendar year
If you have a test	Diagnostic test (x-ray, blood work)	$0	Not covered	Radiology services are covered in office settings and freestanding facilities. Not covered in hospitals **unless** part of pre-admission testing
	Imaging (CT/PET scans, MRIs)	$35 co-pay plus 10% coinsurance	Not covered	Radiology services are covered in freestanding facilities only; pre-certification required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welldynerx.com	Generic drugs	$35 co-pay	Not covered	
	Preferred brand drugs	$50 co-pay	Not covered	
	Non-preferred brand drugs	$50 co-pay	Not covered	
	Specialty drugs	$70 co-pay plus 10% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$35 co-pay plus 10% coinsurance	Not covered	Pre-certification required
	Physician/surgeon fees	$35 co-pay plus 10% coinsurance	Not covered	Pre-certification required
If you need immediate medical attention	Emergency room care	$150 co-pay plus10% coinsurance	$250 co-pay plus10% coinsurance	Co-pay waived if admitted.
	Emergency medical transportation	10% coinsurance	10% coinsurance	
	Urgent care	$50 co-pay plus 10% coinsurance	10% coinsurance	Paid at In-Network schedule
If you have a hospital stay	Facility fee (e.g., hospital room)	$700 plus 10% coinsurance	Not covered	Pre-certification required
	Physician/surgeon fees	$700 co-pay plus10% coinsurance	Not covered	Pre-certification required

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	$35 co-payment	Not covered	
	Inpatient services	$35 co-pay (mental health) and $700 co-pay plus 10% coinsurance (substance use disorder)	Not covered	Pre-certification required
If you are pregnant	Office visits	Covered in full	Not covered	
	Childbirth/delivery professional services	Covered in full	Not covered	Children of participants not covered for delivery services
	Childbirth/delivery facility services	Covered in full	Not covered	Children of participants not covered for delivery services
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	200 visits per year, pre-certification required
	Rehabilitation services	$700 co-pay plus 10% coinsurance (in-hospital) $35 co-pay for office & free-standing facilities	Not covered	$700 co-pay waived if follows a hospital stay
	Habilitation services	$700 co-pay plus 10% coinsurance (in-hospital) $35 co-pay for office & free-standing facilities	Not covered	$700 co-pay waived if follows a hospital stay
	Skilled nursing care	10% coinsurance	Not covered	45 days per calendar year limit. Pre-certification required
	Durable medical equipment	10% coinsurance	Not covered	
	Hospice services	10% coinsurance	Not covered	210 visits per year limitation
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	One visit every 24 months.
	Children's glasses	No charge	Not covered	One visit every 24 months.
	Children's dental check-up	No charge	Not covered	Covers up to $1,500 for member and $1,500 for dependents (combined).

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
- Private-duty nursing
- Air ambulance

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

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 Fund at (212) 925-6033.

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 212-925-6033.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 212-925-6033.
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 212-925-6033.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 212-925-6033.

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 normal hospital delivery)

The plan's overall deductible	$0
Specialist *[cost sharing]*	$0
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

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	**$15,000**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments (10 Office Visits Included)	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

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]*	$350
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	**$7,100**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments (10 Office Visits Included)	$350
Coinsurance	$675
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,025**

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$500
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	**$3,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments (10 Physical Therapy Visits Included)	$500
Coinsurance	$250
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$750**

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