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, contact the Fund office by calling 1-212-366-7880 Option 5. 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 www.cciio.cms.gov or call 1-212-366-7880 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?	Yes. Preventive care.	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.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Preferred providers, **$6,000** for single / **$12,000** for family (no limit Non-Preferred providers). For prescriptions, **$600** for single / **$1,200** for family.	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, and preauthorization penalties.	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.ibxtpa.com or call 833-242-3330 for a list of Preferred 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 providers 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.

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	$20 copay	$20 copay plus balance billing	None.
	Specialist visit	$40 copay	$40 copay plus balance billing	None.
	Other practitioner office visit	$40 copay	$40 copay plus balance billing	Limit to 30 chiropractor visits per year.
	Preventive care/screening/ immunization	No charge.	Out-of-network claims are paid at the allowed amount. Balance is the members responsibility.	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)	20% coinsurance	20% coinsurance plus balance billing	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance plus balance billing	Precertification is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by contacting Express Scripts at www.express-scripts.com.	Generic drugs	$10 copay per prescription (retail) $20 copay per prescription (mail order)	Not covered.	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Brand name drugs	Not covered.		

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance plus balance billing	None.
	Physician/surgeon fees	20% coinsurance	20% coinsurance plus balance billing	None.
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance plus balance billing	None.
	Emergency medical transportation	20% coinsurance	20% coinsurance plus balance billing	None.
	Urgent care	20% coinsurance	20% coinsurance plus balance billing	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance plus balance billing	Precertification is required.
	Physician/surgeon fees	20% coinsurance	20% coinsurance plus balance billing	Precertification is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance plus balance billing	None.
	Inpatient services			
If you are pregnant	Office visits	20% coinsurance	20% coinsurance plus balance billing	None.
	Childbirth /delivery professional services			Precertification is required.
	Childbirth /delivery facility services			
	Home health care	20% coinsurance	20% coinsurance plus balance billing	Limited to 200 visits per year.

If you need help recovering or have other special health needs	Rehabilitation services	20% coinsurance	20% coinsurance plus balance billing	Limited to 30 visits per year.
	Habilitation services	Not covered	Not covered	None.
	Skilled nursing care	20% coinsurance	20% coinsurance plus balance billing	Limited to 60 visits per year.
	Durable medical equipment	20% coinsurance	20% coinsurance plus balance billing	Precertification is required.
	Hospice services	20% coinsurance	20% coinsurance plus balance billing	Limited to 210 days per lifetime.
If your child needs dental or eye care	Children's eye exam	No charge.	Out-of-network claims are reimbursed up to $100 per year. Balance is the member's responsibility.	Limited to one exam and one pair of glasses per child per year. For a list of in-network vision providers, call us at 1-800-999-5431 or go to davisvision.com and log in.
	Children's glasses			
	Children's dental check-up		Out-of-network claims are paid at the allowed amount. Balance is the member's responsibility.	There is a $1,500 annual limit for all dental benefits. For a list of in-network dental providers, visit www.mycigna.com or www.cigna.com.

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
- Bariatric surgery
- Cosmetic surgery
- Habilitation services
- Infertility treatment
- Long-term care
- Private-duty nursing
- Weight loss programs (except as required by the ACA)

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

- Chiropractic care (limited to 30 visits annually)
- Dental Care (Adult) ($1,500 annual limit)
- Hearing aids
- Most emergency coverage provided outside the United States.
- Routine Eye Care (Adult) limited to one exam and one pair of glasses per year
- Routine foot care (if medically necessary)

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 the U.S. Department of Labor's Employee Benefits Security Administration is 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 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: 833-242-3330 or www.ibxtpa.com. You may also contact the Department of Labor's Employee Benefits Security Administration, 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Hollow Metal Trust Fund, 1-212-366-7880, 395 Hudson Street, New York, NY 10014. 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 htpp://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? 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 1-212-366-7880 Opción 5.

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 copayment	$40
Hospital (facility) coinsurance	20%
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	$0
Copayments	$50
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,310**

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 copayment	$40
Hospital (facility) coinsurance	20%
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	$0
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$3,100
The total Joe would pay is	**$3,700**

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

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) coinsurance	20%
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	$0
Copayments	$100
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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