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: Southern Tier Building Trades Benefit Plan Office at 202 W. Fourth Street, Jamestown, NY 14701 (Telephone No. (716) 664-4391). 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 (716) 664-4391 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300/individual or $600/family. In-patient hospital services, maternity care, surgery, routine physicals, & prescription drugs do not count toward this deductible. (Deductible may be eligible for payment from individual reimbursement account.)	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, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Prescription drugs, immunizations, routine physical exams, chiropractic visits, & preventive health screenings, surgeon fees, vision benefits & pre/post-natal maternity care (except diagnostic x-rays, lab tests & exams).	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes, for in-patient hospital services. $200/in-network stay, $500/out-of-network stay. There are no other specific deductible amounts. (Deductible may be eligible for payment from individual reimbursement account.)	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$2,500/individual or $5,000/family. (Out-of-pocket expense may be eligible for payment from individual reimbursement account.)	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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	*Premiums, co-payments, in-patient hospital charges, vision care expenses,* charges in excess of a plan dollar allowance or per visit limit, *balanced-billing charges and health care 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. See www.novahealthcare.com/Members/FindaProvider.com or call (716) 664-4391 for a list of hospital network 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 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 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% coinsurance.		Coinsurance may be eligible for payment from individual reimbursement account.
	Specialist visit	20% coinsurance.		Coinsurance may be eligible for payment from individual reimbursement account. $40 for up to 12 chiropractic visits visits/year with no deducible or coinsurance.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.		One screening & routine physical/ year. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Expenses not covered may be eligible for payment from individual reimbursement account.

*For more information about limitations and exceptions, see plan document.

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 have a test	Diagnostic test (x-ray, blood work)	20% coinsurance.		Coinsurance may be eligible for payment from individual reimbursement account. The fund will cover without cost sharing testing for detection and diagnosis of COVID-19
	Imaging (CT/PET scans, MRIs)	20% coinsurance.		
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at the Plan Office (Tel. No. (716) 664-4391)).	Generic drugs	$5/34-day copayment retail, $12.50/90-day supply copayment mail order. Deductible does not apply. Copayment not included in out-of-pocket limit.	20% coinsurance. Deductible does not apply. Coinsurance included in out-of-pocket limit.	Copayment and coinsurance may be eligible for payment from individual reimbursement account. In accordance with federal guidance, over the counter Home Covid-19 Testing kits will be covered under the plan at no copay if purchased at a network pharmacy using your current prescription card. Tests purchased outside of network pharmacies will be reimbursed at $12 per test.
	Preferred brand drugs	$15/34-day copayment retail, $37.50/90-day supply copayment mail order. Deductible does not apply. Copayment not included in out-of-pocket limit.	20% coinsurance. Deductible does not apply. Coinsurance included in out-of-pocket limit.	
	Non-preferred brand drugs	$30/34-day copayment retail, $75/90-day supply copayment mail order. Deductible does not apply. Copayment not included in out-of-pocket limit.	20% coinsurance. Deductible does not apply. Coinsurance included in out-of-pocket limit.	
	Specialty drugs	Same as non-preferred brand drugs		Same as non-preferred brand drugs

*For more information about limitations and exceptions, see plan document.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance.	Coinsurance may be eligible for payment from individual reimbursement account.
	Physician/surgeon fees	No charge, except 20% coinsurance for anesthesia services. Deductible does not apply to surgeon fees.	
If you need immediate medical attention	Emergency room care	20% coinsurance.	
	Emergency medical transportation	20% coinsurance.	
	Urgent care	20% coinsurance.	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge, but in-patient hospital deductible applies. In-patient hospital charges are not included in out-of-pocket limit.	None.
	Physician/surgeon fees	20% coinsurance. Deductible does not apply to surgeon fees.	Plan pays up to 20% of required assisting surgeon's fees. Coinsurance and remaining required assisting surgeon's fee may be eligible for payment from individual reimbursement account.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Expenses may be eligible for payment from individual reimbursement account.
	Inpatient services	Not covered	Expenses may be eligible for payment from individual reimbursement account.

*For more information about limitations and exceptions, see plan document.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	No charge. Deductible does not apply.	None.
	Childbirth/delivery professional services	No charge except 20% coinsurance for anesthesia services, but in-patient hospital deductible applies.	Coinsurance may be eligible for payment from individual reimbursement account.
	Childbirth/delivery facility services	No charge except 20% coinsurance for anesthesia services, but in-patient hospital deductible applies.	Maternity care may include tests or services described elsewhere in this SBC (e.g., ultrasound). Coinsurance may be eligible for payment from individual reimbursement account.
If you need help recovering or have other special health needs	Home health care	20% coinsurance.	Must be recommended by physician and provided by registered nurse. Coinsurance may be eligible for payment from individual reimbursement account.
	Rehabilitation services	20% coinsurance.	Coinsurance may be eligible for payment from individual reimbursement account.
	Habilitation services	Not covered	Expenses may be eligible for payment from individual reimbursement account.
	Skilled nursing care	Not covered	Expenses may be eligible for payment from individual reimbursement account.
	Durable medical equipment	20% coinsurance.	Items over $2,000 must be pre-authorized. Coinsurance and expenses for items not pre-authorized may be eligible for payment from individual reimbursement account.
	Hospice services	Not covered	Expenses may be eligible for payment from individual reimbursement account.

*For more information about limitations and exceptions, see plan document.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	No charge	Plan pays for one eye exam in 12 month period. Expenses not covered may be eligible for payment from individual reimbursement account.
	Children's glasses	90% of charges over $300 in 12 month period for frames, glass lenses and/or contact lenses. Deductible does not apply.	Expenses not covered may be eligible for payment from individual reimbursement account.
	Children's dental check-up	Not covered	Expenses may be eligible for payment from individual reimbursement account.

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.)

- Artificial Implants (except as noted below*)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Habilitation Services
- Hospice services
- Infertility treatment
- Long-term care
- Mental/behavioral services
- Private duty nursing
- Skilled nursing care
- Substance abuse disorder

* The plan covers artificial implants in connection with reconstructive surgery following a mastectomy, surgically implanted pacemakers to stimulate or regulate contractions of the heart muscle, stents, and hip and knee replacements)

Expenses for services shown above may be eligible for payment from individual reimbursement account.

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

- Bariatric surgery
- Chiropractic care (see limits on page 2)
- Hearing Aids (up to $5,000 in 5 year period)
- Non-emergency care when traveling outside U.S.
- Routine eye care (Adult) (same limits as for child – see page 4 of this SBC)
- Routine foot care
- Weight loss programs with counseling from supervised by health care professional. Expenses not covered may be eligible for payment from reimbursement accounts

*For more information about limitations and exceptions, see plan document.

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: 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. 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: Southern Tier Building Trades Benefit Plan Office at 202 W. Fourth Street, Jamestown, NY 14701 (Telephone No. (716) 664-4391), or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 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.

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

*For more information about limitations and exceptions, see plan document.

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** **$300**
- **The plan's inpatient hospital deductible** **$200**
- **Specialist 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	$500
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$770**

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

- **The plan's overall deductible** **$300**
- **Specialist 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	**$5,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

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

- **The plan's overall deductible** **$300**
- **Specialist coinsurance** **20%**
- **Hospital (facility) 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	**$2,700**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$10
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$810**

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