This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.local300csf.org or by calling 1-718-383-8945.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	**Not Applicable**	There is no deductible.
Are there other deductibles for specific services?	**No**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	**For 2018** **$7,350 Individual only coverage** **$14,700 family coverage**	There's a limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out-of-pocket limit?	Fees for non-covered services, such as specialty drugs and ancillary cost fees.	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. For a list of **participating pharmacies** call the Fund office at 718-383-8945.	If you use an in-network pharmacy, this plan will pay some or all of the costs of covered prescriptions. 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 kinds of **providers.**
Do you need a referral to see a specialist?	**Not Applicable**	This plan is limited to prescription drug coverage only.

Questions: Call 718-383-8945, or visit us at www.local300csf.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 718-38

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

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	Not covered	Not covered	This plan is limited to prescription drug coverage only.
	Specialist visit	Not covered	Not covered	This plan is limited to prescription drug coverage only.
	Preventive care/screening/ immunization	Not covered	Not covered	This plan is limited to prescription drug coverage only.
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	This plan is limited to prescription drug coverage only.
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	This plan is limited to prescription drug coverage only.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.local300csf.org	Generic drugs	At Retail at Preferred Pharmacies (up to 30 day supply - $20, up to 60 day supply - $40 and up to 90 day supply - $60) At Retail at Non-Preferred Pharmacies (up to 30 day supply - $30, up to 60 day supply - $60 and up to 90 day supply - $90) At Health Center Mail Order (up to 90 day supply - $0)	The applicable copayment plus the difference in the cost of the drug charged by the pharmacy and the plan's contracted rate with network pharmacies (calculated fee schedule).	Some of the prescriptions this plan doesn't cover are listed on page 4. See *the Fund's Benefit Book* for additional information about **excluded services.**
	Preferred brand drugs	At Retail at Preferred Pharmacies (up to 30 day supply – 30% or minimum of $80, up to 60 day supply – 30% or minimum of $160, up to 90 day supply – 30% or minimum of $240) At Retail at Non-Preferred Pharmacies (up to 30 day supply – 50% or a minimum of $90, up to 60 day supply – 50% or minimum of $180, up to 90 day supply – 50% or	The applicable copayment plus the difference in the cost of the drug charged by the pharmacy and the plan's contracted rate with network pharmacies (calculated fee schedule).	Some of the prescriptions this plan doesn't cover are listed on page 4. See *the Fund's Benefit Book* for additional information about **excluded services.**

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)	
		minimum of $270) At Health Center Mail Order (up to 90 day supply - $0)		
	Non-preferred brand drugs	At Retail at Preferred Pharmacies (up to 30 day supply – 30% or minimum of $80, up to 60 day supply – 30% or minimum of $160, up to 90 day supply – 30% or minimum of $240) At Retail at Non-Preferred Pharmacies (up to 30 day supply – 50% or a minimum of $90, up to 60 day supply – 50% or minimum of $180, up to 90 day supply – 50% or minimum of $270) At Health Center Mail Order (up to 90 day supply - $0)	The applicable copayment plus the difference in the cost of the drug charged by the pharmacy and the plan's contracted rate with network pharmacies (calculated fee schedule).	Some of the prescriptions this plan doesn't cover are listed on page 4. See *the Fund's Benefit Book* for additional information about **excluded services.**
	Specialty drugs	Not covered	Not covered	Some of the prescriptions this plan doesn't cover are listed on page 4. See *the Fund's Benefit Book* for additional information about **excluded services.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	Plan covers prescription drugs only.
	Physician/surgeon fees	Not covered	Not covered	Plan covers prescription drugs only.

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 immediate medical attention	Emergency room care	Not covered	Not covered	Plan covers prescription drugs only.
	Emergency medical transportation	Not covered	Not covered	Plan covers prescription drugs only.
	Urgent care	Not covered	Not covered	Plan covers prescription drugs only.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	Plan covers prescription drugs only.
	Physician/surgeon fees	Not covered	Not covered	Plan covers prescription drugs only.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	Plan covers prescription drugs only.
	Inpatient services	Not covered	Not covered	Plan covers prescription drugs only.
If you are pregnant	Office visits	Not covered	Not covered	Plan covers prescription drugs only.
	Childbirth/delivery professional services	Not covered	Not covered	Plan covers prescription drugs only.
	Childbirth/delivery facility services	Not covered	Not covered	Plan covers prescription drugs only.
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	Plan covers prescription drugs only.
	Rehabilitation services	Not covered	Not covered	Plan covers prescription drugs only.
	Habilitation services	Not covered	Not covered	Plan covers prescription drugs only.
	Skilled nursing care	Not covered	Not covered	Plan covers prescription drugs only.
	Durable medical equipment	Not covered	Not covered	Plan covers prescription drugs only.
	Hospice services	Not covered	Not covered	Plan covers prescription drugs only.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	This summary pertains to the prescription drug plan only.
	Children's glasses	Not covered	Not covered	This summary pertains to the prescription drug plan only.
	Children's dental check-up	Not covered	Not covered	This summary pertains to the prescription drug plan only.

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.)

- Specialty drugs
- Drugs used for cosmetic purposes
- Drugs purchased without a prescription
- Drugs covered under the NYC PICA program (Injectible and Chemotherapy medications for members with a NYC health plan.)
- Drugs used for the treatment of diabetes.

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

- This plan covers only prescription drug benefits.

Your Rights to Continue Coverage:

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 induration 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.

For more information on your rights to continue coverage, contact the plan at 718-383-8945. You may also contact your state insurance department, 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 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

In the event that your claim has been denied in whole or in part, and you do not agree with the denial, you may request in writing a review of the Fund's decision regarding your claim, within sixty (60) days of your receipt of written notification of the denial of your claim. This request must identify the patient, covered member, if different, the decision to be reviewed, and must also explain the reason you do not agree with the denial of benefits.

Please refer to the Fund's Benefits Book for a complete description of these rights.

Does this plan provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan covers prescription drugs only, and thus, by itself may not provide minimum essential coverage. You should check to see if your basic health plan provides minimum essential coverage.

Does this plan meet the Minimum Value Standards?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value is 60% (actuarial value). This plan covers prescription drugs only, and thus, by itself may not meet the minimum value standard. You should check to see if your basic health plan meets the minimum value standard.

Language Access Services:

Para obtener asistencia en Español, llame al 718-383-8945.

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.

Having a baby
(normal delivery)

- **Amount owed for prescriptions:** $200
- **Plan pays** $____*
- **Patient pays** $____**

Sample care costs:

Prescriptions	$200
Total	**$200**

Patient pays:

Deductibles	$0
Copays	$__
Coinsurance	$0
Limits or exclusions **	$0
Total	**$__**

***The Fund will pay the cost, less the applicable co-payment.**
****The patient pays the applicable co-payment.**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed for prescriptions:** $2,900
- **Plan pays** $0
- **Patient pays** $____*

Sample care costs:

Prescriptions	$2,900
Total	**$2,900**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions **	$0
Total	**$0**

*** Patient should consult basic health plan to determine how much of there costs would be covered.**
****The Fund does not cover diabetic drugs or supplies. Over the counter medications, such as aspirin, are also not covered by the plan.**