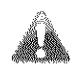

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.MyPOMCO.com or 1-800-905-0904 or 1-716-828-0488. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-905-0904 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network and Out-of-Network: **$250**/Individual or **$500**/family Applies to Major Medical benefits only.	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. Preventive care and primary care services, services paid at 100%, and other services as described in your plan document 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.
Are there other deductibles for specific services?	No.	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	Network and Out-of-Network $1,000 per person. Applies to Major Medical benefits only.	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?	Dental, vision, and basic benefits, prescription drugs, deductibles, penalties for failure to follow pre-authorization, premiums, balance-billing charges, and health care this plan doesn't 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.MyPOMCO.com or call 1-800-898-9713 or 1-716-828-0488 for a list of 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. services from any provider.
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 after deductible		None
	Specialist visit	20% coinsurance after deductible		None
	Preventive care/screening/ immunization	Routine Child up to age 26: 20% coinsurance after deductible. Routine adult physical and Well Woman: No charge. Adult Immunizations: 20% coinsurance after deductible.		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.
If you have a test	Diagnostic test (x-ray, blood work)	First $300 no charge then 20% coinsurance after deductible		None
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ProAct.com	Generic drugs	$15 copay/prescription (retail). $30 copay/prescription (mail order)		Covers up to a 30-day supply (retail subscription); 90 day supply (mail order prescription).
	Preferred brand drugs	$30 copay/prescription (retail). $60 copay/prescription (mail order)		
	Non-preferred brand drugs	See Preferred brand drugs		
	Specialty drugs	See www.ProAct.com for details		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible		None
	Surgeon fees	First $1,000 no charge then 20% coinsurance after deductible		None
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible		If medically necessary (life threatening).
	Emergency medical transportation	20% coinsurance after deductible		Limit $100 maximum for mileage.
	Urgent care	20% coinsurance after deductible		None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge		Limit 70 days.
	Physician	First $15 no charge then 20% coinsurance after deductible		Limit 70 days.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible		None
	Inpatient services	No charge		Limit 70 days. Substance Abuse Services not covered if court ordered.
If you are pregnant	Office visits	No charge		None
	Childbirth/delivery professional services	No charge		Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	No charge		None
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible		Precertify.
	Rehabilitation services	20% coinsurance after deductible		None
	Habilitation services	20% coinsurance after deductible		None
	Skilled nursing care	20% coinsurance after deductible		None
	Durable medical equipment	20% coinsurance after deductible		Precertify.
	Hospice services	No charge		Precertify. Limit 16 days.
If your child needs dental or eye care	Children's eye exam	First $150 no charge then 100% member responsibility		Eye exam and glasses are combined.
	Children's glasses	First $150 no charge then 100% member responsibility		
	Children's dental check-up	20% coinsurance		Limit $1,000 maximum per calendar year. Limit one every six months.

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.)		
• Bariatric Surgery • Cosmetic Surgery	• Long Term Care • Private Duty Nursing	• Routine Foot Care • Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Chiropractic Care • Dental Care (Adult, Child)	• Hearing Aids • Infertility Treatment (diagnostic only)	• Non-emergency care when traveling outside the U.S. unless travel is for the sole purpose of obtaining medical services • Routine eye care (Adult Child)

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: Department of Labor's Employee Benefits Security Administration at 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact NY Department of Financial Services, One State Street, New York, NY 10004-1511,1 (800) 342-3736, http://www.dfs.ny.gov/consumer/chealth.htm.

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.

———————*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** **$250**
- **Specialist** **20%**
- **Hospital (facility)** **20%**
- **Other** **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	**$12,755**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$60
Coinsurance	$249
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$619**

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

- **The plan's overall deductible** **$250**
- **Specialist** **20%**
- **Hospital (facility)** **20%**
- **Other** **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	**$7,435**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$534
Coinsurance	$216
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,055**

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

- **The plan's overall deductible** **$250**
- **Specialist** **20%**
- **Hospital (facility)** **20%**
- **Other** **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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$378
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$628**

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

The Roofers Local No. 74 / Local No 203 Welfare Fund believes our Plan is a "grandfathered health plan" under the Patient Protections and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at Roofers Local No 74 / Local No 203 Welfare Fund, 2800 Clinton Street, West Seneca, NY 14224. You may also contact the Employee Benefits Security Administration, US Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.