
 **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, call the Fund Office at 1-914-769-2440. 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](http://www.dol.gov/ebsa/healthreform) or call 1-914-769-2440 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	<u>In-Network</u> : \$0 <u>Out-of-Network</u> Medical: \$200/Person, \$600/Family; <u>Out-of-Network</u> Hospital: \$300/Person per admission	<u>In-Network</u> : See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. <u>Out-of-Network</u> : Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	<u>In-Network</u> : Not applicable. <u>Out-of-Network</u> : No.	<u>In-Network</u> : This <u>plan</u> does not have a <u>deductible</u> . <u>Out-of-Network</u> : You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.
<b>Are there other <u>deductibles</u> for specific services?</b>	\$50/person for Dental. This <u>deductible</u> does not apply to <u>preventive services</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	<u>In-Network</u> : Not applicable. <u>Out-of-Network</u> Medical: \$1,250/Person <u>Out-of-Network</u> Hospital: \$3,000/Person, \$7,500/Family.	<u>In-Network</u> : This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses. <u>Out-of-Network</u> : The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , and there is a family <u>out-of-pocket limit</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>In-Network</u> : Not applicable. <u>Out-of-Network</u> : <u>Copayments</u> on certain services, <u>deductibles</u> , premiums, <u>balance-billing</u> charges, penalties for failure to obtain pre-certification and health care this <u>plan</u> doesn't cover.	<u>In-Network</u> : This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses. <u>Out-of-Network</u> : Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you</b>	Yes. Hospital and Medical:	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> .

<b>use a <u>network provider</u>?</b>	<a href="http://www.empireblue.com">www.empireblue.com</a> or call 1-800-553-9603. Prescription drugs: <a href="http://www.express-scripts.com">www.express-scripts.com</a> or call 1-844-520-2679.	You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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)	
<b>If you visit a health care provider's office</b>	Primary care visit to treat an injury or illness	\$10 <u>copay</u> /visit	20% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$10 <u>copay</u> /visit	20% <u>coinsurance</u>	\$1,250 annual maximum for chiropractic & podiatry services
	<u>Preventive care/screening/immunization</u>	\$10 <u>copay</u> /visit	20% <u>coinsurance</u>	<u>Plan</u> allows one well visit/calendar year. Immunizations, except for a flu vaccination once per calendar year, are not covered for individuals 19 years of age or older.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Hospital:\$100 <u>copay</u> Other: no charge	Other: 20% <u>coinsurance</u> ; Hospital: 30% <u>coinsurance</u>	Pre-certification required for test > \$350. Failure to pre-certify may result in reduction of benefit or denial of claim.
	Imaging (CT/PET scans, MRIs)	Hospital:\$100 <u>copay</u> Other: no charge	Other: 20% <u>coinsurance</u> ; Hospital: 30% <u>coinsurance</u>	Precertification required for test > \$350. Failure to pre-certify may result in reduction of benefit or denial of claim.
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> call Express Scripts at 1-844-520-2679 or visit the website <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	No charge	No charge	90-day supply maximum/prescription. After applicable <u>copayment</u> , first \$3,000 of Rx drug charges for individual & \$5,000 for family will be paid 100% by <u>Plan</u> . Rx drug charges between \$3,000 & \$7,000 for Individual and \$5,000 & \$13,500 for Family are 100% participant <u>coinsurance</u> . Rx drug charges over \$7,000 for Individual & \$13,500 for Family are 80% participant <u>coinsurance</u> .
	Preferred brand drugs	\$25 <u>copay</u>	\$25 <u>copay</u>	
	Non-preferred brand drugs	\$25 <u>copay</u>	\$25 <u>copay</u>	
	<u>Specialty drugs</u>	Brand: \$25 <u>copay</u> Generic: No charge	Brand: \$25 <u>copay</u> Generic: No charge	After applicable <u>copayment</u> , first \$20,000 of IV Therapy drug charges will be paid 100% by <u>Plan</u> . IV Therapy drug charges between \$20,000 & \$30,000 are 100% participant <u>coinsurance</u> . IV Therapy drug charges over \$30,000 are 80% participant <u>coinsurance</u> . Must be FDA-approved for the condition for which it is being prescribed.

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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$100 <u>copay</u>	30% <u>coinsurance</u>	Pre-certification required. Failure to pre-certify may result in reduction of benefit or denial of claim.
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	Pre-certification required. Failure to pre-certify may result in reduction of benefit or denial of claim.
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$100 <u>copay</u>	30% <u>coinsurance</u>	Waived if admitted to a hospital within 24 hours
	<u>Emergency medical transportation</u>	Ambulance: No charge	Ambulance: 20% <u>coinsurance</u>	\$3,000 limit for helicopter transport
	<u>Urgent care</u>	\$15 <u>copay</u>	20% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$100 <u>copay</u>	30% <u>coinsurance</u>	Semi-private room, pre-cert required.
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	Surgery must be pre-certified.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office: \$10 <u>copay</u> ; out-patient hospital:\$100 <u>copay</u>	Office: 20% <u>coinsurance</u> ; outpatient hospital 30% <u>coinsurance</u>	Dependents are not covered for substance abuse disorder. Pre-cert required for in & outpatient substance use disorder benefits. If hospital stay exceeds 120 days, you pay 20% co-insurance after meeting major med deductible.
	Inpatient services	\$100 <u>copay</u>	30% <u>coinsurance</u>	
<b>If you are pregnant</b>	Office visits	\$10 <u>copay</u>	20% <u>coinsurance</u>	Not covered for dependent children.
	Childbirth/delivery professional services	\$100 <u>copay</u>	20% <u>coinsurance</u>	Not covered for dependent children.
	Childbirth/delivery facility services	\$100 <u>copay</u>	30% <u>coinsurance</u>	Not covered for dependent children.

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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	20% <u>coinsurance</u>	Pre-certification required. Failure to pre-certify may result in reduction of benefit or denial of claim. 200 visits/year, 4 hours equals one visit.
	<u>Rehabilitation services</u>	Office: \$10 <u>copay</u> Hospital: \$100 <u>copay</u>	20% <u>coinsurance</u> 30% <u>coinsurance</u>	Pre-certification required. Failure to pre-certify may result in reduction of benefit or denial of claim. Combined 26 visits/person per calendar year.
	<u>Habilitation services</u>	Not covered	Not covered	Not covered
	<u>Skilled nursing care</u>	Not covered	Not covered	Not covered
	<u>Durable medical equipment</u>	No charge	20% <u>coinsurance</u>	First \$1,500 in allowed charges paid by Plan, between \$1,500 & \$11,500 is 100% participant <u>coinsurance</u> . DME charges over \$11,500 are 80% participant <u>coinsurance</u> . Pre-certification & medical necessity required.
	<u>Hospice services</u>	Not covered	Not covered	Not covered
<b>If your child needs dental or eye care</b>	Children's eye exam	Charges over \$50	Charges over \$50	<u>Plan</u> allows one exam/yr. up to \$50.00 <u>Plan</u> allows one pair of glasses/contacts per year up to \$100.00
	Children's glasses	Charges over \$100	Charges over \$100	<u>Plan</u> allows one exam/yr. up to \$50.00 <u>Plan</u> allows one pair of glasses/contacts per year up to \$100.00
	Children's dental check-up	Amount over <u>plan's</u> schedule allowance	Amount over <u>plan's</u> schedule allowance	Annual dental max \$1,800/person \$50/person annual <u>deductible</u> applies to non-preventive covered dental services

## 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 (unless medically necessary)
- Cosmetic surgery
- Habilitation services
- Immunizations age 19 years and older, except for a flu vaccination once per calendar year
- Hospice services
- Infertility treatments
- Long-term care services
- Non-emergency care when traveling outside the USA
- Clinic visits through a hospital
- Genetic testing
- Private-duty nursing
- Skilled nursing care
- Weight loss programs
- Substance Abuse Disorder for Dependents
- Childbirth/delivery for Dependent Children

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

- Chiropractic care (2 x-rays & \$1,250/person annual individual maximum)
- Dental care (Adult) (Annual \$1,800 annual individual maximum)
- Hearing aids (up to \$850/member & \$350/dependent, every 24 months).
- Physical, speech, and occupational therapy (26 combined visits/person per year. Precertification required).
- Routine eye care (Adult) (\$50/exam & \$100 for lenses/frames/contacts per calendar year).
- Routine foot care (Podiatry services: \$1,250 annual maximum/person/calendar year).

**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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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 Office at 1-914-769-2440. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### 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 1-914-769-2440.

—————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 copay \$10
- Hospital (facility) copay \$100
- Other copay \$100

**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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$790
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$850</b>

**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 copay \$10
- Hospital (facility) copay \$100
- Other copay \$100

**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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$560
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$420
<b>The total Joe would pay is</b>	<b>\$980</b>

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

- The plan's overall deductible \$0
- Specialist copay \$10
- Hospital (facility) copay \$100
- Other copay \$100

**This EXAMPLE event includes services like:**  
 Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$200</b>