
 **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 (718) 939-1489 or visit www.local14funds.org. 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 call the Fund Office at (718) 939-1489 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<p><u>In-Network providers</u>: \$0</p> <p><u>Out-of-Network providers</u>: \$100/individual or \$200/family</p>	<p><u>In-Network providers</u>: See the Common Medical Events chart below for your costs for services this plan covers.</p> <p><u>Out-of-Network providers</u>: 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.</p>
Are there services covered before you meet your deductible?	<p>Yes. <u>In-Network providers</u>: Not applicable.</p> <p><u>Out-of-Network providers</u>: Preventive care, x-ray, laboratory, imaging, surgeon fees, childbirth/delivery professional fees, prescription drugs, and dental and optical benefits are covered before you meet your <u>out-of-network deductible</u>.</p>	<p><u>In-Network providers</u>: This plan does not have a deductible.</p> <p><u>Out-of-Network providers</u>: This plan covers some items and services even if you haven't yet met the deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.</p>
Are there other deductibles for specific services?	<p>Yes. \$50/individual or \$100/family for <u>Out-of-Network dental</u>. There are no other specific <u>deductibles</u>.</p>	<p>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.</p>
What is the out-of-pocket limit for this plan?	<p>Medical/Hospital <u>In-Network providers</u>: \$5,600/individual, \$11,200/family;</p> <p>Prescription drugs (<u>in-network</u>): \$1,000/individual, \$2,000/family;</p> <p>Medical/Hospital <u>Out-of-Network providers</u>: \$2,000/individual</p>	<p>Medical/Hospital <u>In-Network providers</u> and prescription drugs (<u>In-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 plan, 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.</p> <p><u>Out-of-Network providers</u>: The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.</p>
What is not included in the out-of-pocket limit?	<p><u>In-Network</u> and <u>Out-of-Network</u>: Dental and optical benefits, <u>premiums</u>, <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> and health care this plan doesn't cover. <u>Out-of-Network</u> also does not include <u>copayments</u>, <u>deductible</u> and <u>prescription drugs</u>.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>

Important Questions	Answers	Why This Matters:
<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>Yes. See www.local14funds.org or call the Fund Office at (718) 939-1489 for a list of <u>in-network providers</u>.</p>	<p>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>. 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</p>
<p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>

 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 <u>copay</u> /visit	\$20 <u>copay</u> /visit plus 10% <u>coinsurance</u> plus balances above <u>allowed amount</u>	None.
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit	\$30 <u>copay</u> /visit plus 10% <u>coinsurance</u> plus balances above <u>allowed amount</u>	None.
	<u>Preventive care/screening/immunization</u>	No charge	10% <u>coinsurance</u> plus balances above <u>allowed amount</u> for well child and well-woman care and annual physical exam; balances above <u>allowed amount</u> for <u>screenings</u> ; <u>out-of-network deductible</u> does not apply	Age and frequency limits apply. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. <u>Out-of-network</u> only covers: one annual physical exam, well child and well-woman care, <u>screenings</u> for cholesterol, diabetes (if pregnant or contemplating pregnancy), colorectal cancer and PSA.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Balances above <u>allowed amount</u> ; <u>out-of-network deductible</u> does not apply	None.
	Imaging (CT/PET scans, MRIs)	\$50 <u>copay</u> /test	\$50 <u>copay</u> /test plus balances above <u>allowed amount</u> ; <u>out-of-network deductible</u> does not apply	None.

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.optumrx.com	Generic drugs	Retail: \$5 <u>copay</u> /prescription Mail order: \$10 <u>copay</u> /prescription	Retail only: \$5 <u>copay</u> /prescription plus balances over <u>allowed amount</u> Mail order: Not covered	<u>Out-of-network deductible</u> does not apply. <u>Cost sharing</u> does not count toward medical/hospital <u>out-of-pocket limit</u> ; <u>in-network cost sharing</u> counts toward separate \$1,000/individual <u>out-of-pocket limit</u> for <u>prescription drugs</u> . Retail: 30-day supply. Mail order: 90-day supply. Certain drugs require prior authorization from OptumRx in order to be covered by the <u>Plan</u> . No <u>copay</u> for generic contraceptives for women and other generic ACA-required <u>preventive care</u> prescriptions (brand name covered if a generic is medically inappropriate). Any over-the-counter drugs that are payable under this provision require a prescription to be covered.
	Formulary brand drugs	Retail: \$20 <u>copay</u> /prescription Mail order: \$40 <u>copay</u> /prescription	Retail only: \$20 <u>copay</u> /prescription plus balances over <u>allowed amount</u> Mail order: Not covered	
	Non-formulary brand drugs	Retail: \$35 <u>copay</u> /prescription Mail order: \$70 <u>copay</u> /prescription	Retail only: \$35 <u>copay</u> /prescription plus balances over <u>allowed amount</u> Mail order: Not covered	
	<u>Specialty drugs</u>	Applicable <u>copay</u> above	Applicable <u>copay</u> above	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 <u>copay</u> /visit	\$100 <u>copay</u> /visit plus 20% <u>coinsurance</u> plus balances above <u>allowed amount</u>	Only one <u>copay</u> applies for radiation therapy and chemotherapy per covered person per year. Must precertify <u>in-network</u> outpatient facility benefits or benefits may be reduced by 50%, up to \$5,000 for each admission, treatment or procedure.
	Physician/surgeon fees	No charge	Balances above <u>allowed amount</u> ; <u>out-of-network deductible</u> does not apply	Assistant surgeon paid at 25% of scheduled allowance for <u>out-of-network</u> surgeon.
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit	\$200 <u>copay</u> /visit	<u>Copay</u> reduced to \$100 if admitted to the same hospital within 24 hours. Professional/physician charges may be billed separately, except as provided by the No Surprises Act.
	<u>Emergency medical transportation</u>	No charge	10% <u>coinsurance</u> plus balances above <u>allowed amount</u>	Emergency ambulance only.
	<u>Urgent care</u>	\$20 <u>copay</u> /visit	\$20 <u>copay</u> /visit plus 10% <u>coinsurance</u> plus balances above <u>allowed amount</u>	Treated in same manner as office visit.

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 hospital stay	Facility fee (e.g., hospital room)	\$100 <u>copay</u> /admission	\$100 <u>copay</u> /admission plus 20% <u>coinsurance</u> plus balances above <u>allowed amount</u>	Only semi-private room covered. Must precertify <u>in-network</u> facility benefits or benefits may be reduced by 50%, up to \$5,000 for each admission, treatment or procedure.
	Physician/surgeon fees	No charge	10% <u>coinsurance</u> plus balances above <u>allowed amount</u> ; <u>out-of-network deductible</u> does not apply	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$20 <u>copay</u> /visit; Outpatient Facility: \$100 <u>copay</u> /course of treatment	Office Visit: \$20 <u>copay</u> /visit plus 10% <u>coinsurance</u> plus balances above <u>allowed amount</u> ; Outpatient Facility: \$100 <u>copay</u> /course of treatment plus 20% <u>coinsurance</u> plus balances above <u>allowed amount</u>	Must precertify <u>in-network</u> outpatient facility benefits or benefits may be reduced by 50%, up to \$5,000 for each admission, treatment or procedure.
	Inpatient services	\$100 <u>copay</u> /admission for facility charges; No charge for professional fees	\$100 <u>copay</u> /admission plus 20% <u>coinsurance</u> plus balances above <u>allowed amount</u> for facility charges; 10% <u>coinsurance</u> plus balances above <u>allowed amount</u> for professional fees; <u>out-of-network deductible</u> does not apply to professional charges	Only semi-private room covered. Must precertify <u>in-network</u> facility benefits or benefits may be reduced by 50%, up to \$5,000 for each admission, treatment or procedure.
If you are pregnant	Office visits	No charge	Balances above <u>allowed amount</u>	<u>Cost sharing</u> does not apply for <u>preventive care</u> services. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Depending on the type of service and provider, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery professional services	No charge	Balances above <u>allowed amount</u> ; <u>out-of-network deductible</u> does not apply	Only semi-private room covered.
	Childbirth/delivery facility services	\$100 <u>copay</u> /admission	\$100 <u>copay</u> /admission plus 20% <u>coinsurance</u> plus balances above <u>allowed amount</u>	

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 help recovering or have other special health needs	<u>Home health care</u>	No charge	20% <u>coinsurance</u> plus balances above <u>allowed amount</u>	Limited to 40 visits per calendar year; up to 4 hours of service are counted as one visit.
	<u>Rehabilitation services</u>	Inpatient facility: \$100 <u>copay/admission</u> Outpatient: \$30 <u>copay/visit</u>	Inpatient facility: \$100 <u>copay/admission</u> plus 20% <u>coinsurance</u> plus balances above <u>allowed amount</u> ; Outpatient: \$30 <u>copay/visit</u> plus 10% <u>coinsurance</u> plus amounts above <u>allowed amount</u>	Inpatient limited to 30 days per calendar year. Outpatient limited to 24 visits per diagnosis. Must precertify <u>in-network</u> benefits or benefits may be reduced by 50%, up to \$5,000 for each admission, treatment or procedure.
	<u>Habilitation services</u>	Not covered	Not covered	You must pay 100% of these expenses, even <u>in-network</u> .
	<u>Skilled nursing care</u>	Inpatient facility only: \$100 <u>copay/admission</u>	Not covered	Limited to 30 days per calendar year following <u>hospitalization</u> only. Must precertify <u>in-network</u> facility benefits or benefits may be reduced by 50%, up to \$5,000 for each admission, treatment or procedure. Not covered <u>out-of-network</u> .
	<u>Durable medical equipment</u>	No charge	Not covered	Covers purchase if cost exceeds rental. Not covered <u>out-of-network</u> . Must precertify <u>in-network</u> or benefits may be reduced by 50%, up to \$5,000 for each admission, treatment or procedure.
	<u>Hospice services</u>	No charge	20% <u>coinsurance</u> plus balances above <u>allowed amount</u>	Limited to 210 days per lifetime.
If your child needs dental or eye care	Children's eye exam	No charge	Balances over \$250 <u>plan</u> allowance (exam and glasses combined)	You may decline optical benefits by contacting the Fund Office. Limited to \$250 every 24 months for eye exams and glasses combined. <u>Out-of-network deductible</u> does not apply. <u>Cost sharing</u> does not count toward medical/hospital <u>out-of-pocket limit</u> .
	Children's glasses	No charge		
	Children's dental check-up	No charge	Balances over <u>allowed amount</u> after \$50/individual \$100/family dental <u>deductible</u>	

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.)

- Cosmetic surgery
- Habilitation services
- Hearing aids
- Long-term care
- Private-duty nursing
- Weight loss programs (except as required by the health reform law)

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

- Acupuncture (up to 12 visits per year)
- Bariatric surgery (to treat morbid obesity only)
- Chiropractic care (up to 40 visits per year Member & Spouse only)
- Dental care (Adult) (up to annual maximum of \$1,500 person/\$4,500 family per calendar year)
- Infertility treatment (one cycle per lifetime; prescription drugs not covered)
- Non-emergency care when traveling outside the U.S. (at BlueCard® Worldwide Program hospitals only)
- Routine eye care (up to \$250 per 24 months)
- Routine foot care (for Diabetics only)

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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 on how 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 Plan at 141-57 Northern Boulevard, Flushing, NY 11354; Telephone: (718) 939-1489; www.local14funds.org. 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.

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 Empire 1-877-267-2323/Fund Office (718) 939-1489.

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

