



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](http://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 <https://www.healthcare.gov/sbc-glossary/> or call the Fund Office at (718) 939-1489 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<u>In-Network providers</u> : \$1,500/individual or \$3,750/family  <u>Out-of-Network providers</u> : \$4,500/individual or \$11,250/family	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 deductible?</b>	Yes. <u>In-Network providers</u> : Preventive care, <u>prescription drugs</u> , and dental and optical benefits are covered before you meet your <u>deductible</u> . <u>Out-of-Network providers</u> : Preventive care, x-ray, laboratory, imaging, surgeon fees, childbirth/delivery professional fees, <u>prescription drugs</u> , and dental and optical benefits are covered before you meet your <u>out-of-network deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other deductibles for specific services?</b>	Yes. \$50/individual or \$100/family for <u>Out-of-Network dental</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 out-of-pocket limit for this plan?</b>	Medical/Hospital <u>In-Network providers</u> : \$9,600/individual, \$19,200/family; Prescription drugs ( <u>in-network</u> ): \$1,000/individual, \$2,000/family; Medical/Hospital <u>Out-of-Network providers</u> : None	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 <u>plan</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. <u>Out-of-Network providers</u> : This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
<b>What is not included in the out-of-pocket limit?</b>	Dental and optical benefits, <u>premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> and health care this <u>plan</u> doesn't cover.	<u>In-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 use a network provider?</b>	Yes. See <a href="http://www.local14funds.org">www.local14funds.org</a> or call the Fund Office at (718) 939-1489 for a list of <u>in-network providers</u> .	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 charge</u> and what

Important Questions	Answers	Why This Matters:
		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
Do you need a <u>referral</u> to see a <u>specialist</u> ?	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)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	25% <u>coinsurance</u>	\$20 <u>copay</u> /visit plus 50% <u>coinsurance</u> plus balances above <u>allowed amount</u>	None.
	<u>Specialist</u> visit	25% <u>coinsurance</u>	\$30 <u>copay</u> /visit plus 50% <u>coinsurance</u> plus balances above <u>allowed amount</u>	None.
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	50% <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)	25% <u>coinsurance</u>	50% <u>coinsurance</u> plus balances above <u>allowed amount</u> ; <u>out-of-network deductible</u> does not apply	None.
	Imaging (CT/PET scans, MRIs)	25% <u>coinsurance</u>	\$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)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs	Retail: \$10 <u>copay</u> /prescription Mail order: \$20 <u>copay</u> /prescription	Retail only: \$10 <u>copay</u> /prescription plus balances over <u>allowed amount</u> Mail order: Not covered	<u>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 or \$2,000/family <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 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 unless as required by the ACA.
	Formulary brand drugs	Retail: \$25 <u>copay</u> /prescription Mail order: \$50 <u>copay</u> /prescription	Retail only: \$25 <u>copay</u> /prescription plus balances over <u>allowed amount</u> Mail order: Not covered	
	Non-formulary brand drugs	Retail: \$40 <u>copay</u> /prescription Mail order: \$80 <u>copay</u> /prescription	Retail only: \$40 <u>copay</u> /prescription plus balances over <u>allowed amount</u> Mail order: Not covered	
	<u>Specialty drugs</u>	Retail: 25% <u>coinsurance</u> with \$100 min per Rx and \$300 max per Rx Mail order: 25% <u>coinsurance</u> with \$200 min per Rx and \$600 max per Rx	Retail only: 25% <u>coinsurance</u> with \$100 min per Rx and \$300 max per Rx plus balances over <u>allowed amount</u> Mail order: Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>	50% <u>coinsurance</u> plus balances above <u>allowed amount</u>	Must pre-certify <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	25% <u>coinsurance</u>	50% <u>coinsurance</u> plus 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.
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	Professional/physician charges may be billed separately, except as provided by the No Surprises Act.
	<u>Emergency medical transportation</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u> plus balances above <u>allowed amount</u>	Emergency ambulance only.
	<u>Urgent care</u>	25% <u>coinsurance</u>	\$20 <u>copay</u> /visit plus 50% <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)	25% <u>coinsurance</u>	\$100 <u>copay</u> /admission plus 50% <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	25% <u>coinsurance</u>	50% <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: 25% <u>coinsurance</u> Outpatient Facility: 25% <u>coinsurance</u>	Office Visit: \$20 <u>copay</u> /visit plus 50% <u>coinsurance</u> plus balances above <u>allowed amount</u> ; Outpatient Facility: \$100 <u>copay</u> /course of treatment plus 50% <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	25% <u>coinsurance</u>	\$100 <u>copay</u> /admission plus 50% <u>coinsurance</u> plus balances above <u>allowed amount</u> for facility charges; 50% <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	25% <u>coinsurance</u>	50% <u>coinsurance</u> plus 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	25% <u>coinsurance</u>	50% <u>coinsurance</u> plus balances above <u>allowed amount</u> ; <u>out-of-network deductible</u> does not apply	Only semi-private room covered.
	Childbirth/delivery facility services	25% <u>coinsurance</u>	50% <u>coinsurance</u> plus balances above <u>allowed amount</u>	
If you need help recovering or have	<u>Home health care</u>	25% <u>coinsurance</u>	50% <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.

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>other special health needs</b>	<u>Rehabilitation services</u>	25% <u>coinsurance</u>	Inpatient facility: \$100 <u>copay</u> /admission plus 50% <u>coinsurance</u> plus balances above <u>allowed amount</u> ; Outpatient: \$30 <u>copay</u> /visit plus 50% <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: 25% <u>coinsurance</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>	25% <u>coinsurance</u>	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>	25% <u>coinsurance</u>	50% <u>coinsurance</u> plus balances above <u>allowed amount</u>	Limited to 210 days per lifetime.
<b>If your child needs dental or eye care</b>	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>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>	Benefits separately administered by Delta Dental. You may decline benefits by contacting the Fund Office. Limited to \$1,500 per person and \$4,500 per family per calendar year. <u>Deductible</u> does not apply. <u>Cost sharing</u> does not count toward medical/hospital <u>out-of-pocket limit</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](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 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](http://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](http://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.—————



## 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 <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> copayment	25%
■ Hospital (facility) <u>copayment</u>	25%
■ Other <u>copayment</u> (imaging)	25%

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>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$2,670
What isn't covered	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$4,240</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> copayment	25%
■ Hospital (facility) <u>copayment</u>	25%
■ Other <u>copayment</u> (imaging)	25%

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>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,150
<u>Copayments</u>	\$860
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,010</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> copayment	25%
■ Hospital (facility) <u>copayment</u>	25%
■ Other <u>copayment</u> (imaging)	25%

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>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$320
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,830</b>

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