
 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 [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call the Fund Office at (718) 939-1489 to request a copy.

| Important Questions   | Answers   | Why This Matters:  |
|---|---|--|
| <p><b>What is the overall deductible?</b></p>                             | <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 <u>plan</u> covers.</p> <p><u>Out-of-Network providers</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>.</p> |
| <p><b>Are there services covered before you meet your deductible?</b></p> | <p>Yes. <u>In-Network providers</u>: Not applicable.</p> <p><u>Out-of-Network providers</u>: <u>Preventive care</u>, 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>.</p>                   | <p><u>In-Network providers</u>: This <u>plan</u> does not have a <u>deductible</u>.</p> <p><u>Out-of-Network providers</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.</p>  |
| <p><b>Are there other deductibles for specific services?</b></p>          | <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 <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.</p>  |
| <p><b>What is the out-of-pocket limit for this plan?</b></p>              | <p>Medical/Hospital <u>In-Network providers</u>: \$5,600/individual, \$11,200/family;</p> <p><u>Prescription drugs (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 <u>prescription drugs (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.</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>  |
| <p><b>What is not included in the out-of-pocket limit?</b></p>            | <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 <u>plan</u> 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 <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>.</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>  |

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 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<br>(You will pay the least) | Out-of-Network Provider<br>(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 | \$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.<br><br><u>Out-of-network</u> only covers: one annual physical exam, well child and well-woman care, screenings 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  | Must precertify <u>in-network</u> benefits or benefits may be reduced by 50%, up to \$5,000 for each treatment or procedure.  |

| Common Medical Event  | Services You May Need                          | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information  |
|---|--|--|---|---|
|   |  | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)  |   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a> | Generic drugs                                  | Retail: \$5 <a href="#">copay/prescription</a><br>Mail order: \$10 <a href="#">copay/prescription</a>  | Retail only: \$5 <a href="#">copay/prescription</a> plus balances over <a href="#">allowed amount</a><br>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> .<br><br>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> .<br><br>No <u>copay</u> for generic contraceptives for women (or brand name contraceptives if a generic is medically inappropriate) and other ACA-required <u>preventive care</u> prescriptions. Any over-the-counter drugs that are payable under this provision require a prescription to be covered. |
|   | Formulary brand drugs                          | Retail: \$20 <a href="#">copay/prescription</a><br>Mail order: \$40 <a href="#">copay/prescription</a> | Retail only: \$20 <a href="#">copay/prescription</a> plus balances over <a href="#">allowed amount</a><br>Mail order: Not covered |   |
|   | Non-formulary brand drugs                      | Retail: \$35 <a href="#">copay/prescription</a><br>Mail order: \$70 <a href="#">copay/prescription</a> | Retail only: \$35 <a href="#">copay/prescription</a> plus balances over <a href="#">allowed amount</a><br>Mail order: Not covered |   |
|   | <u>Specialty drugs</u>                         | Applicable <a href="#">copay</a> above   | Applicable <a href="#">copay</a> above  |   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center) | \$100 <a href="#">copay/visit</a>  | \$100 <a href="#">copay/visit</a> plus 20% <a href="#">coinsurance</a> plus balances above <a href="#">allowed amount</a>         | Only one <a href="#">copay</a> 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 allowed amount; <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>                     | \$200 <a href="#">copay/visit</a>  | \$200 <a href="#">copay/visit</a> plus balances above <a href="#">allowed amount</a>  | <a href="#">Copay</a> reduced to \$100 if admitted to the same hospital within 24 hours. Professional/physician charges may be billed separately.   |
|   | <u>Emergency medical transportation</u>        | No charge  | 10% <a href="#">coinsurance</a> plus balances above <a href="#">allowed amount</a>  | Emergency ambulance only.   |
|   | <u>Urgent care</u>                             | \$20 <a href="#">copay/visit</a>   | \$20 <a href="#">copay/visit</a> plus 10% <a href="#">coinsurance</a> plus balances above <a href="#">allowed amount</a>          | 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<br>(You will pay the least)   | Out-of-Network Provider<br>(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 allowed amount; <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<br>(You will pay the least)  | Out-of-Network Provider<br>(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><br>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> ;<br>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](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 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

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 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 plan's overall deductible None
- Specialist copayment \$30
- Hospital (facility) copayment \$100
- Other copayment (imaging) \$50

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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$0          |
| Copayments                        | \$240        |
| Coinsurance                       | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$10         |
| <b>The total Peg would pay is</b> | <b>\$250</b> |

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

- The plan's overall deductible None
- Specialist copayment \$30
- Hospital (facility) copayment \$100
- Other copayment (imaging) \$50

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> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$0            |
| Copayments                        | \$1,330        |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$1,330</b> |

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

- The plan's overall deductible None
- Specialist copayment \$30
- Hospital (facility) copayment \$100
- Other copayment (imaging) \$50

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> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$0          |
| Copayments                        | \$410        |
| Coinsurance                       | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$410</b> |

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