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?	In-Network providers: $0 Out-of-Network providers: $100/individual or $200/family	In-Network providers: See the Common Medical Events chart below for your costs for services this plan covers. Out-of-Network providers: 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. In-Network providers: Not applicable. Out-of-Network providers: 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 out-of-network deductible.	In-Network providers: This plan does not have a deductible. Out-of-Network providers: 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?	Yes. $50/individual or $100/family for Out-of-Network dental. There are no other specific deductibles.	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.
What is the out-of-pocket limit for this plan?	Medical/Hospital In-Network providers: $5,600/individual, $11,200/family; Prescription drugs (in-network): $1,000/individual, $2,000/family; Medical/Hospital Out-of-Network providers: $2,000/individual	Medical/Hospital In-Network providers and prescription drugs (In-network): 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. Out-of-Network providers: The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	In-Network and Out-of-Network: Dental and optical benefits, premiums, balance-billing charges, penalties for failure to obtain preauthorization and health care this plan doesn't cover. Out-of-Network also does not include copayments, deductible and prescription drugs.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.local14funds.org or call the Fund Office at (718) 939-1489 for a list of in-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
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 copay/visit	$20 copay/visit plus 10% coinsurance plus balances above allowed amount	None.
	Specialist visit	$30 copay/visit	$30 copay/visit plus 10% coinsurance plus balances above allowed amount	None.
	Preventive care/screening/ immunization	No charge	10% coinsurance plus balances above allowed amount for well child and well-woman care and annual physical exam; balances above allowed amount for screenings; out-of-network deductible does not apply	Age and frequency limits apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Out-of-network 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	Diagnostic test (x-ray, blood work)	No charge	Balances above allowed amount; out-of-network deductible does not apply	None.
	Imaging (CT/PET scans, MRIs)	$50 copay/test	$50 copay/test plus balances above allowed amount; out-of-network deductible does not apply	Must precertify in-network 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 (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 copay/prescription Mail order: $10 copay/prescription	Retail only: $5 copay/prescription plus balances over allowed amount Mail order: Not covered	Out-of-network deductible does not apply. Cost sharing does not count toward medical/hospital out-of-pocket limit; in-network cost sharing counts toward separate $1,000/individual out-of-pocket limit for prescription drugs. Retail: 30-day supply. Mail order: 90-day supply. Certain drugs require prior authorization from OptumRx in order to be covered by the Plan. No copay for generic contraceptives for women and other generic ACA-required preventive care 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 copay/prescription Mail order: $40 copay/prescription	Retail only: $20 copay/prescription plus balances over allowed amount Mail order: Not covered	
	Non-formulary brand drugs	Retail: $35 copay/prescription Mail order: $70 copay/prescription	Retail only: $35 copay/prescription plus balances over allowed amount Mail order: Not covered	
	Specialty drugs	Applicable copay above	Applicable copay above	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay/visit	$100 copay/visit plus 20% coinsurance plus balances above allowed amount	Only one copay applies for radiation therapy and chemotherapy per covered person per year. Must precertify in-network 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; out-of-network deductible does not apply	Assistant surgeon paid at 25% of scheduled allowance for out-of-network surgeon.
If you need immediate medical attention	Emergency room care	$200 copay/visit	$200 copay/visit plus balances above allowed amount	Copay reduced to $100 if admitted to the same hospital within 24 hours. Professional/physician charges may be billed separately.
	Emergency medical transportation	No charge	10% coinsurance plus balances above allowed amount	Emergency ambulance only.
	Urgent care	$20 copay/visit	$20 copay/visit plus 10% coinsurance plus balances above allowed amount	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 copay/admission	$100 copay/admission plus 20% coinsurance plus balances above allowed amount	Only semi-private room covered. Must precertify in-network 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% coinsurance plus balances above allowed amount; out-of-network deductible does not apply	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $20 copay/visit; Outpatient Facility: $100 copay/course of treatment	Office Visit: $20 copay/visit plus 10% coinsurance plus balances above allowed amount; Outpatient Facility: $100 copay/course of treatment plus 20% coinsurance plus balances above allowed amount	Must precertify in-network outpatient facility benefits or benefits may be reduced by 50%, up to $5,000 for each admission, treatment or procedure.
	Inpatient services	$100 copay/admission for facility charges; No charge for professional fees	$100 copay/admission plus 20% coinsurance plus balances above allowed amount for facility charges; 10% coinsurance plus balances above allowed amount for professional fees; out-of-network deductible does not apply to professional charges	Only semi-private room covered. Must precertify in-network 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 allowed amount	Cost sharing does not apply for preventive care 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 copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	No charge	Balances above allowed amount; out-of-network deductible does not apply	Only semi-private room covered.
	Childbirth/delivery facility services	$100 copay/admission	$100 copay/admission plus 20% coinsurance plus balances above allowed amount	

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

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.

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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$240
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$260**

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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,090
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,090**

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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$450
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$450**

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