**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 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: |
|---|---|---|
| **What is the overall deductible?** | In-Network providers: $300/individual or $900/family<br><br>Out-of-Network providers: $900/individual or $1,800/family | 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: Preventive care, prescription drugs, and dental and optical benefits are covered before you meet your deductible.<br>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. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| **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: $6,000/individual, $12,000/family;<br>Prescription drugs (in-network): $1,000/individual, $2,000/family;<br>Medical/Hospital Out-of-Network providers: None | 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.<br>Out-of-Network providers: This plan does not have an out-of-pocket limit on your expenses. |
| **What is not included in the out-of-pocket** | Dental and optical benefits, premiums, balance-billing charges, penalties for failure to obtain preauthorization and health care this plan doesn't cover. | In-Network: Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **limit?** | | |
| **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 | 10% coinsurance | $20 copay/visit plus 50% coinsurance plus balances above allowed amount | None. |
| | Specialist visit | 10% coinsurance | $30 copay/visit plus 50% coinsurance plus balances above allowed amount | None. |
| | Preventive care/screening/ immunization | No charge. Deductible does not apply. | 50% 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.<br><br>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) | 10% coinsurance | 50% coinsurance plus balances above allowed amount | None. |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 50% coinsurance plus balances above allowed amount; out-of-network deductible 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.caremark.com | Generic drugs | Retail: $10 copay/prescription Mail order: $20 copay/prescription | Retail only: $10 copay/prescription plus balances over allowed amount Mail order: Not covered | 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.<br>Retail: 30-day supply. Mail order: 90-day supply. Certain drugs require prior authorization in order to be covered by the Plan.<br>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 unless as required by the ACA. |
| | Formulary brand drugs | Retail: $25 copay/prescription Mail order: $50 copay/prescription | Retail only: $25 copay/prescription plus balances over allowed amount Mail order: Not covered | |
| | Non-formulary brand drugs | Retail: $40 copay/prescription Mail order: $80 copay/prescription | Retail only: $40 copay/prescription plus balances over allowed amount Mail order: Not covered | |
| | Specialty drugs | Applicable copay above | Applicable copay above Mail order: Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 50% coinsurance plus balances above allowed amount | Must pre-certify 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 | 10% coinsurance | 50% coinsurance plus 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 | 10% coinsurance | 10% coinsurance | Professional/physician charges may be billed separately, except as provided by the No Surprises Act. |
| | Emergency medical transportation | 10% coinsurance | 50% coinsurance plus balances above allowed amount | Emergency ambulance only. |
| | Urgent care | 10% coinsurance | $20 copay/visit plus 50% 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) | 10% coinsurance | $100 copay/admission plus 50% 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 | 10% coinsurance | 50% 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: 10% coinsurance; Outpatient Facility: 10% coinsurance | Office Visit: $20 copay/visit plus 50% coinsurance plus balances above allowed amount; Outpatient Facility: $100 copay/course of treatment plus 50% 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 | 10% coinsurance | $100 copay/admission plus 50% coinsurance plus balances above allowed amount for facility charges; 50% 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 | 10% coinsurance | 50% coinsurance plus 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 | 10% coinsurance | 50% coinsurance plus balances above allowed amount | Only semi-private room covered. |
| | Childbirth/delivery facility services | 10% coinsurance | 50% 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 | 10% coinsurance | 50% 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 | 10% coinsurance | Inpatient facility: $100 copay/admission plus 50% coinsurance plus balances above allowed amount; Outpatient: $30 copay/visit plus 50% 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: 10% coinsurance | 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 | 10% coinsurance | 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 | 10% coinsurance | 50% 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. 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. 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** $300
- **Specialist copayment** 10%
- **Hospital (facility) copayment** 10%
- **Other copayment (imaging)** 10%

**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 | $300 |
| Copayments | $50 |
| Coinsurance | $1,190 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Peg would pay is** | **$1,560** |

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

- **The plan's overall deductible** $300
- **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 | $300 |
| Copayments | $860 |
| Coinsurance | $90 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,250** |

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

- **The plan's overall deductible** $300
- **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 | $300 |
| Copayments | $10 |
| Coinsurance | $250 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$560** |

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