

 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 (718) 274-5353. 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 (718) 274-5353 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<u>In-Network</u> Medical and Hospital: \$0 <u>Out-of-Network</u> Medical: \$250 Individual / \$750 Family. <u>Deductible</u> applies for period 1/1 – 12/31 of each year.	<u>In-Network</u> Medical and Hospital: See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. <u>Out-of-Network</u> Medical: 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>	<u>In-Network</u> Medical and Hospital: Not Applicable. <u>Out-of-Network</u> Medical: Yes. <u>Emergency services</u> and <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	<u>In-Network</u> Medical and Hospital: This <u>plan</u> does not have an <u>in-network deductible</u> . <u>Out-of-Network</u> Medical: 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.
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	<u>In-Network</u> Hospital: There is no <u>out-of-pocket limit</u> , but there is a \$5,000 Individual maximum on <u>coinsurance</u> . Applies for period 1/1 – 12/31 of each year; <u>In-Network</u> and <u>Out-of-Network</u> Medical: Not Applicable	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>	Not Applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
<b>Will you pay less if you use a network provider?</b>	Yes. For a list of <u>in-network</u> hospital <u>providers</u> see <a href="http://www.empireblue.com">www.empireblue.com</a> or call 1-800-553-9603. For a list of <u>in-network</u> medical <u>providers</u> see <a href="http://www.magnacare.com">www.magnacare.com</a> or call 1-800-235-7330.	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.
<b>Do you need a referral to see a specialist?</b>	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 **out-of-network** medical **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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit	30% <u>coinsurance</u>	Services not covered when furnished in a clinic. Limited to one <u>specialist</u> consultation per specialty every six months.  Acupuncture and Chiropractic care: Limited to 30 visits/calendar year.  Limited to one physical exam per calendar year. Fees for administration of vaccines and preventive injections not covered.
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit Acupuncture and Chiropractic care: \$30 <u>copay</u> /visit	30% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	Primary care: \$15 <u>copay</u> /visit; Specialist: \$30 <u>copay</u> /visit	30% <u>coinsurance</u>	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge at MagnaCare lab	30% <u>coinsurance</u>	<u>Diagnostic tests</u> and imaging must be furnished at a MagnaCare diagnostic lab to be covered <u>In-Network</u> . Services furnished elsewhere covered <u>Out-of-Network</u> .
	Imaging (CT/PET scans, MRIs)	No charge at MagnaCare lab	30% <u>coinsurance</u>	
<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.expressscripts.com">www.expressscripts.com</a>	Generic drugs	Retail: \$15 <u>copay</u> /prescription; Mail Order: \$30 <u>copay</u> /prescription	Retail: \$15 <u>copay</u> / prescription plus difference between <u>in-network</u> rate and <u>out-of-network</u> charges; Mail Order: Not covered	<u>Deductible</u> does not apply. Retail: Up to a 30-day supply; Mail Order: Up to a 60-day supply Drugs used to treat mental/behavioral health and substance use disorders: \$5 <u>copay</u> /prescription. If you purchase a brand drug when a generic alternative is available, you pay the applicable brand <u>copay</u> plus the difference in cost between the generic alternative and the brand name drug. Six-month limit for habit-forming analgesics. Not all <u>prescription drugs</u> are covered by the <u>Plan</u> . *See the <u>Prescription Drug</u> section of the SPD.
	Preferred brand drugs	Retail: \$25 <u>copay</u> /prescription; Mail Order: \$50 <u>copay</u> /prescription	Retail: \$25 <u>copay</u> / prescription plus difference between <u>in-network</u> rate and <u>out-of-network</u> charges; Mail Order: Not covered	
	Non-preferred brand drugs	Retail: \$50 <u>copay</u> /prescription; Mail Order: \$100 <u>copay</u> /prescription	Retail: \$50 <u>copay</u> / prescription plus difference between <u>in-network</u> rate and <u>out-of-network</u> charges; Mail Order: Not covered	
	<u>Specialty drugs</u>	Retail: \$50 <u>copay</u> /prescription; Mail Order: \$100 <u>copay</u> /prescription	Retail: \$50 <u>copay</u> / prescription plus difference between <u>in-network</u> rate and <u>out-of-network</u> charges; Mail Order: Not covered	

\* For more information about limitations and exceptions, see the plan or policy document

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$75 <u>copay</u> /procedure and 10% <u>coinsurance</u>	Not covered	<u>Out-of-Network</u> facility fees not covered.
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	None.
If you need immediate medical attention	<u>Emergency room care</u>	Facility fee: \$100 <u>copay</u> /visit and 10% <u>coinsurance</u> ; Physician fees: No charge	Facility fee: \$100 <u>copay</u> /visit and 10% <u>coinsurance</u> ; Physician fees: No Charge.	<u>Copay</u> waived if admitted to the hospital within 24 hours. If facility fee is not covered, professional fees are paid like an office visit.
	<u>Emergency medical transportation</u>	No charge	Amount over \$500/transport	None.
	<u>Urgent care</u>	\$30 <u>copay</u> /visit	30% <u>coinsurance</u>	Freestanding facility only. Services not covered when furnished at an outpatient hospital clinic.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copay</u> /admission and 10% <u>coinsurance</u>	Not covered	Failure to precertify services will result in a benefit reduction of \$100 per day up to \$300. <u>Out-of-Network</u> facility fees not covered.
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	Limited to one visit per day per specialty.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: \$30 <u>copay</u> /visit; Other outpatient services: \$75 <u>copay</u> /day and 10% <u>coinsurance</u> ; Substance abuse: No charge.	Office visit: 30% <u>coinsurance</u> ; Other outpatient services: Not covered; Substance abuse: 30% <u>coinsurance</u>	<u>Out-of-Network</u> facility fees not covered.
	Inpatient services	Facility fee: \$250 <u>copay</u> /admission and 10% <u>coinsurance</u> ; Physician: No charge	Facility fee: Not covered; Physician: 30% <u>coinsurance</u>	Failure to precertify services will result in a benefit reduction of \$100 per day up to \$300. <u>Out-of-Network</u> facility fees not covered.

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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 are pregnant</b>	Office visits	\$15 <u>copay</u> for first visit, no charge for follow-up visits.	30% <u>coinsurance</u>	None
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$250 <u>copay/admission</u> and 10% <u>coinsurance</u>	Not covered	<u>Out-of-network</u> facility fees not covered.
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	10% <u>coinsurance</u>	Not covered	Failure to precertify services will result in a benefit reduction of \$100 per day up to \$300 or denial of claim. Limited to 200 visits per calendar year. Up to four hours of care is equal to one visit. <u>Out-of-Network</u> services not covered.
	<u>Rehabilitation services</u>	Office visit: \$30 <u>copay/visit</u> ; Outpatient facility: \$75 <u>copay/visit</u> and 10% <u>coinsurance</u> ; Inpatient facility: \$250 <u>copay/admission</u> and 10% <u>coinsurance</u>	Office visit: 30% <u>coinsurance</u> Outpatient facility: Not covered; Inpatient facility: Not covered	Failure to precertify outpatient occupational, speech, vision and respiratory therapies and cardiac rehab will result in a benefit reduction of \$100 per day up to \$300 or denial of claim. Outpatient occupational, speech and vision therapies limited to 30 visits per calendar. Outpatient kinetic and ophthalmic therapies limited to 18 visits per calendar year. Outpatient physical therapy not covered. Inpatient services must be precertified with hospital admission. Inpatient physical therapy limited to 30 days per calendar year.
	<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>	10% <u>coinsurance</u>	Not covered	Failure to precertify services will result in a benefit reduction of \$100 per day up to \$300. Limited to 60 days per calendar year. <u>Out-of-Network</u> services not covered.
	<u>Durable medical equipment</u>	After <u>hospitalization</u> : 10% <u>coinsurance</u> ; All other times: \$30 <u>copay/DME</u>	After <u>hospitalization</u> : Not covered; All other times: 30% <u>coinsurance</u>	Precertification required. Replacements not covered except for <u>medically necessary</u> prosthetic leg limited to 1 every 5 years with a \$100,000 lifetime maximum.

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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)	
	<u>Hospice services</u>	10% <u>coinsurance</u>	Not covered	Failure to precertify services will result in a benefit reduction of \$100 per day up to \$300. Limited to 210 days per lifetime. <u>Out-of-Network</u> services not covered.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Balances over \$25 <u>Plan</u> allowance	Limited to one eye exam and one pair of glasses once every 12-month period. Coverage can be declined by contacting Fund Office.
	Children's glasses	No charge	Balances over \$75 <u>Plan</u> allowance	
	Children's dental check-up	No charge	Balances over <u>Plan</u> allowance	Limited to 2 check-ups and \$2,500 per calendar year. Coverage can be declined by contacting Fund Office.

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## 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 (Except when medically necessary)
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

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

- Acupuncture (Limited to 30 visits/calendar year)
- Bariatric surgery (Precertification required)
- Chiropractic care (Limited to 30 visits/calendar year)
- Dental care (Adult) (Limited to \$2,500/calendar year)
- Hearing aids (Limited to \$500/ear/every 3 years)
- Infertility treatment (Limited to \$10,000/lifetime)
- Routine eye care (Adult) (Limited to one eye exam and one complete pair of glasses once every 12-month period)
- Routine foot care (Limited to 4 visits/calendar year; In-office surgery limited to \$1,000/calendar year)

**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. 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). 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 Administrator at (718) 274-5353. 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 1-718-274-5353.

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

\* For more information about limitations and exceptions, see the plan or policy document



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 \$0
- Specialist copay \$15
- Hospital (facility) coinsurance 10%
- Other cost sharing diagnostic test \$0

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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$290
<u>Coinsurance</u>	\$680
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,030</b>

**Managing Joe's Type 2 Diabetes**

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

- The plan's overall deductible \$0
- Specialist copay \$30
- Hospital (facility) coinsurance 10%
- Other cost sharing diagnostic test \$0

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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,110
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$120
<b>The total Joe would pay is</b>	<b>\$1,230</b>

**Mia's Simple Fracture**

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

- The plan's overall deductible \$0
- Specialist copay \$30
- Hospital (facility) coinsurance 10%
- Other cost sharing diagnostic test \$0

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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$530
<u>Coinsurance</u>	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$560</b>