



**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, go to [www.nycCBF.com](http://www.nycCBF.com) or call the Fund Office at 1-212-366-7300 or 1-800-529-3863 or go to [www.empireblue.com](http://www.empireblue.com) or call Empire at 1-844-416-6387 or go to [www.express-scripts.com](http://www.express-scripts.com) or call Express Scripts at 1-800-939-2091. 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 1-212-366-7300 or 1-800-529-3863 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	<u>In-Network providers</u> : \$250/ Individual or \$625/ Family <u>Out-of-Network providers</u> : \$750/ Individual or \$1,875/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 other family members are covered by the <u>plan</u> , each family member must meet his/her 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 <u>deductible</u>?</b>	Yes. <u>In-Network providers</u> : Preventive and primary care, ER services, urgent care, prescription drugs, dental benefits, hearing aids and vision benefits are covered before you meet your deductible. <u>Out-of-Network providers</u> : Only ER services are covered before you meet your deductible.	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 <u>deductibles</u> for specific services?</b>	Yes. \$250/Individual for prescription drugs. \$50/Individual or \$150/Family for Comprehensive Dental program ("CDP") (only applies to those who live outside Aetna's DMO area). 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 <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	<u>Medical In-Network providers</u> : \$2,000/Individual or \$5,000/Family <u>Medical Out-of-network providers</u> : \$3,750/Individual or \$9,375/Family <u>Prescription drugs (in-network)</u> : \$3,250/Individual or \$8,125/Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If other family members are covered by 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	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 <u>network provider</u>?</b>	Yes. Visit <a href="http://www.empireblue.com">www.empireblue.com</a> or call 1-844-416-6387 for a list of <u>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</u> charge and what your <u>plan</u> pays (balance billing). 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 <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see a <u>specialist</u> 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)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	Subject to age and frequency limitations. 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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	When outside of Empire's service area, you must use a lab contracted with local Blue <u>plan</u> .

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)	
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Failure to pre-certify high tech radiology services may result in a benefit reduction up to 50% to a maximum of \$2,500 or denial of claim if not <u>medically necessary</u> .
<p><b>If you need drugs to treat your illness or condition</b> More information about <u><a href="http://www.express-scripts.com">prescription drug coverage</a></u> is available at <u><a href="http://www.express-scripts.com">www.express-scripts.com</a></u>.</p>	Generic drugs	Retail (30-day supply): \$15 <u>copay</u> /Rx Mail Order (90-day supply): \$25 <u>copay</u> /Rx. <u>Deductible</u> does not apply.	Reimbursement of up to the discounted amount the plan would have paid to a network pharmacy. You are responsible for any difference between the network discount price and what the pharmacy charged plus any applicable co-payment.	<p>No charge for FDA-approved generic contraceptives (or brand name if generic is medically inappropriate) for women and other ACA-required preventive medications with a prescription. Mandatory generic feature: Brand name drugs are only covered if no generic equivalent is available. If a brand name drug is selected, you must pay the applicable copay plus the difference in cost between the brand-name drug and the generic drug. Mandatory mail order program: Maintenance drugs for chronic conditions must be acquired by mail order. <u>Specialty drugs</u>: Must use Accredo specialty pharmacy (Mail Order only). <u>Preauthorization</u> required. To reach the specialty pharmacy, call 1-800-803-2523.</p>
	Preferred brand drugs	Retail (30-day supply): \$25 <u>copay</u> /Rx Mail Order (90-day supply): \$45 <u>copay</u> /Rx <u>Deductible</u> does not apply.	Reimbursement of up to the discounted amount the plan would have paid to a network pharmacy. You are responsible for any difference between the network discount price and what the pharmacy charged plus any applicable co-payment.	
	Non-preferred brand drugs	Retail (30-day supply): \$40 <u>copay</u> /Rx Mail Order (90-day supply): \$75 <u>copay</u> /Rx <u>Deductible</u> does not apply.	Reimbursement of up to the discounted amount the plan would have paid to a network pharmacy. You are responsible for any difference between the network discount price and what the pharmacy charged plus any applicable co-payment.	
	<u>Specialty drugs</u>	Mail Order only: Applicable <u>copay</u> above <u>Deductible</u> does not apply.	Not covered	

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 have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Failure to pre-certify services may result in a benefit reduction up to 50% to a maximum of \$2,500 or denial of claim if not <u>medically necessary</u> .
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$200 <u>copay</u> /visit <u>Deductible</u> does not apply.	\$200 <u>copay</u> /visit. <u>Deductible</u> does not apply.	<u>Copay</u> waived if admitted within 24 hours.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Transportation by air or land ambulance to nearest acute care hospital for emergency treatment.
	<u>Urgent care</u>	\$25 <u>copay</u> /visit <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Failure to pre-certify admissions may result in a benefit reduction up to 50% to a maximum of \$2,500 or denial of claim if not medically necessary. This benefit reduction also applies to certain Same-Day Surgery and professional services rendered during an inpatient admission.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u> a	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office visit: \$20 <u>copay</u> /visit. Other outpatient services: 10% <u>coinsurance</u>	40% <u>coinsurance</u>	Failure to pre-certify partial or hospital intensive outpatient programs may result in a benefit reduction up to 50% to a maximum of \$2,500 or denial of claim if not <u>medically necessary</u> .
	Inpatient services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Failure to pre-certify admissions may result in a benefit reduction up to 50% to a maximum of \$2,500 or denial of claim if not <u>medically necessary</u> .
<b>If you are pregnant</b>	Office visits	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Childbirth/delivery professional services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Out-of-network</u> birthing centers not covered.
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Out-of-network</u> birthing centers not covered.

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 help recovering or have other special health needs</b>	<u>Home health care</u>	10% <u>coinsurance</u>	Not Covered	200 visits/per calendar year (1 visit equals 4 hours of care).
	<u>Rehabilitation services</u>	Inpatient: 10% <u>coinsurance</u> Outpatient office setting: \$20 <u>copay</u> /visit Outpatient hospital setting: \$25 <u>copay</u> /visit. <u>Deductible</u> does not apply.	Not Covered	Occupational and speech therapy up to 45 visits per person combined in home, office or outpatient facility per calendar year. Physical therapy up to 45 visits combined in home, office or outpatient facility per calendar year.
	<u>Habilitation services</u>	Inpatient: 10% <u>coinsurance</u> Outpatient office setting: \$20 <u>copay</u> /visit. Outpatient hospital setting: \$25 <u>copay</u> /visit <u>Deductible</u> does not apply in outpatient settings.	Not Covered	All <u>rehabilitation and habilitation</u> visits count toward your rehabilitation visit limit.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	Not Covered	60 days/per calendar year. Failure to pre-certify services may result in a benefit reduction up to 50% to a maximum of \$2,500 or denial of claim if not <u>medically necessary</u> .
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	Not Covered	Failure to pre-certify services may result in a benefit reduction up to 50% to a maximum of \$2,500 or denial of claim if not <u>medically necessary</u> .
	<u>Hospice services</u>	10% <u>coinsurance</u>	Not Covered	210 days/per lifetime. Failure to pre-certify services may result in a benefit reduction up to 50% to a maximum of \$2,500 or denial of claim if not <u>medically necessary</u> .

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 your child needs dental or eye care	Children's eye exam	No Charge. <u>Deductible</u> does not apply.	Amount over \$25 <u>Plan</u> allowance	Vision benefits separately administered by Comprehensive Professional Systems or General Vision Services. Eye exam and glasses or contact lenses limited to once every 12 months. Selection of special lenses and coatings may require you to pay a portion of the cost, even <u>in-network</u> .
	Children's glasses	No Charge. <u>Deductible</u> does not apply.	Amount over \$100 <u>Plan</u> allowance	
	Children's dental check-up	Aetna DMO: No Charge Aetna CDP: Amount over <u>Plan</u> allowance	Aetna DMO: Not Covered Aetna CDP: Amount over <u>Plan</u> allowance	Dental benefits separately administered by Aetna. If you are enrolled in the CDP, services subject to a <u>deductible</u> of \$50 individual / \$150 family. Frequency limits apply.

#### Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your Summary Plan Description (SPD) for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>Birthing centers (out-of-network)</li> <li>Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>Long-term care</li> <li>Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care</li> <li>Weight loss programs (except as required by the ACA)</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your SPD.)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Chiropractic care (up to 45 visits per year)</li> <li>Dental care (Adult)</li> <li>Hearing aids (limited to \$350/ear, 1 every 4 years)</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Non-emergency care when traveling outside the U.S. See <a href="http://www.BCBS.com/bluecardworldwide">www.BCBS.com/bluecardworldwide</a></li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> </ul>

**Your Rights to Continue Coverage:** There is an agency that can help if you want to continue your coverage after it ends. The contact information for this agency is: the U.S. Department of Labor, Employee Benefits Security Administration 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 SPD also provides 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:

Empire Appeal and Grievance Dept., P.O. Box 1407, Church Street Station, New York, NY 10008-1407, or Express Scripts, 811 Royal Ridge Parkway, Irving, TX 75063, Attn: Administrative Reviews; or the Fund Office at 395 Hudson Street, New York, NY 10014; or Department of Labor's Employee Benefits Security Administration, 1-866-444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact: Community Service Society of New York, Community Health Advocates, 105 East 22nd Street, 8th Floor, New York, NY 10010, (888) 614-5400, <http://www.communityhealthadvocates.org>.

### **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 1-212-366-7300 o 1-800-529-3863.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-529-3863.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-529-3863.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-529-3863.

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

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## 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 <u>deductible</u>	\$250
■ <u>Specialist copay</u>	\$25
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$340
Copayments	\$0
Coinsurance	\$1,150
What isn't covered	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$1,500</b>

### Managing Joe's type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$250
■ <u>Specialist copay</u>	\$25
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

#### 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>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$890
Coinsurance	\$150
What isn't covered	
Limits or exclusions	\$70
<b>The total Joe would pay is</b>	<b>\$1,610</b>

### Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$250
■ <u>Specialist copay</u>	\$25
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

#### 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>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$300
Coinsurance	\$60
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$610</b>