**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, if applicable.**

**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 or call the Fund Office at 1-212-366-7300 or 1-800-529-3863, or go to www.empireblue.com or call Empire at 1-844-416-6387, or go to 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. www.dol.gov/ebsa/healthreform or call the Fund Office to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network providers: $200/Individual or $500/Family<br>Out-of-Network providers: $750/Individual or $1,875/ Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If other family members are covered by the plan, each family member must meet his/her 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: Primary care visit, specialist visit, outpatient rehab/habilitative services, preventive care, ER services, urgent care, prescription drugs, dental benefits, hearing aids and vision benefits are covered before you meet your deductible. Out-of-Network providers: Only ER services are covered before you meet your 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. $100/Individual for ASO dental benefit plan (deductible will be waived for diagnostic and preventive services and orthodontic treatment). 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 In-Network providers: $1,900/Individual or $4,750/Family<br>Medical Out-of-network providers: $3,750/Individual or $9,375/Family<br>Prescription drugs (in-network): $3,000/Individual or $7,500/Family | The out-of-pocket limit is the most you could pay in a year for covered services. If other family members are covered by this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, and health care this plan doesn't cover. Also, certain specialty pharmacy drugs are considered non-essential health benefits, and the cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not count towards the out-of-pocket limit. | 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. Visit www.empireblue.com or call 1-844-416-6387 for a list of 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 Deductible does not apply. | 30% coinsurance | None |
| | Specialist visit | $25 copay/visit Deductible does not apply. | 30% coinsurance | None |
| | Preventive care/screening/ immunization | No Charge Deductible does not apply. | 30% coinsurance | Subject to age and frequency limitations. 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. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance | 30% coinsurance | When outside of Empire's service area, you must use a lab contracted with local Blue plan. |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 30% coinsurance | 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 medically necessary. |

| 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.express-scripts.com. | Generic drugs | Retail (30-day supply): $15 copay/Rx Mail Order (90-day supply): $25 copay/Rx | 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 copay. | Medical deductible and out-of-pocket limits do not apply but separate prescription drug out-of-pocket limits apply. 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.<br><br>Specialty drugs: Must use Accredo specialty pharmacy (Mail Order only). Preauthorization required. To reach the specialty pharmacy, call 1-800-803-2523. Also, certain specialty pharmacy drugs are considered non-essential health benefits, and the cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not count toward the plan's out-of-pocket limit. |
| | Preferred brand drugs | Retail (30-day supply): $25 copay/Rx Mail Order (90-day supply): $45 copay/Rx | 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 copay. | |
| | Non-preferred brand drugs | Retail (30-day supply): $40 copay/Rx Mail Order (90-day supply): $75 copay/Rx | 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 copay. | |
| | Specialty drugs | Mail Order only: Applicable copay above | Not covered. | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance | 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 medically necessary. |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | |

| 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 immediate medical attention** | Emergency room care | $200 copay/visit Deductible does not apply. | $200 copay/visit Deductible does not apply. | Professional/physician charges may be billed separately. Copay waived if admitted within 24 hours. |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance | Transportation by air or land ambulance to nearest acute care hospital for emergency treatment. |
| | Urgent care | $25 copay/visit Deductible does not apply. | 30% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | 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% coinsurance | 30% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office visit: $20 copay/visit. Deductible does not apply. Other outpatient services: 10% coinsurance | 30% coinsurance | Failure to pre-certify partial hospital or intensive outpatient programs may result in a benefit reduction up to 50% to a maximum of $2,500 or denial of claim if not medically necessary. |
| | Inpatient services | 10% coinsurance | 30% coinsurance | 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. |
| **If you are pregnant** | Office visits | 10% coinsurance | 30% coinsurance | Cost sharing does not apply for preventive services. Depending on the types of services and provider, a copay, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | 10% coinsurance | 30% coinsurance | Out-of-network birthing centers not covered. |
| | Childbirth/delivery facility services | 10% coinsurance | 30% coinsurance | Out-of-network 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) | |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | Not Covered | 200 visits per calendar year (1 visit equals 4 hours of care). |
| | Rehabilitation services | Inpatient: 10% coinsurance<br>Outpatient office setting: $20 copay/visit<br>Outpatient hospital setting: $25 copay/visit<br>Deductible 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. Inpatient not covered for occupational or speech therapy. Physical therapy up to 45 visits combined in home, office or outpatient facility per calendar year. Inpatient physical therapy and rehabilitation up to 30 days per calendar year. |
| | Habilitation services | Inpatient: 10% coinsurance<br>Outpatient office setting: $20 copay/visit<br>Outpatient hospital setting: $25 copay/visit.<br>Deductible does not apply | Not Covered | All rehabilitation and habilitation visits count toward your rehabilitation visit limit. |
| | Skilled nursing care | 10% coinsurance | 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 medically necessary. |
| | Durable medical equipment | 10% coinsurance | 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 medically necessary. |
| | Hospice services | 10% coinsurance | 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 medically necessary. |

| 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 Deductible does not apply. | Amount over $25 Plan 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 (365 days). Selection of special lenses and coatings may require you to pay a portion of the cost, even in-network. |
| | Children's glasses | No Charge Deductible does not apply. | Amount over $100 Plan allowance | |
| | Children's dental check-up | No charge for preventive services. All other services limited by schedule of covered allowances, frequency limits, and Plan maximums. | Amount over Plan allowance | Dental benefits separately administered by ASO. Medical deductible does not apply but separate $100/Individual dental deductible applies (deductible will be waived for diagnostic and preventive care services and orthodontic treatment) and $2,500 annual maximum per covered individual. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check Summary Plan Description (SPD) for more information and a list of any other excluded services.)**

- Cosmetic surgery
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs (except as required by the ACA)

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

- Acupuncture
- Bariatric surgery
- Chiropractic care (45 visits/calendar year)
- Dental Care (Adult)
- Hearing aids (limited to $350/per ear, 1 every 4 years)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See www.BCBS.com/bluecardworldwide.
- Routine eye care (Adult)

**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's Employee Benefits Security Administration 1-866-444-EBSA (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 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. 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**

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 1-212-366-7300 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, kwiijigo holne' 1-800-529-3863.

*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 | $200 |
| Specialist copay | $25 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 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** | **$12,800** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $200 |
| Copayments | $90 |
| Coinsurance | $1,150 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| **The total Peg would pay is** | **$1,450** |

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

| | |
|---|---|
| The plan's overall deductible | $200 |
| Specialist copay | $25 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 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)*

| | |
|---|---|
| **Total Example Cost** | **$7,400** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $200 |
| Copayments | $910 |
| Coinsurance | $150 |
| *What isn't covered* | |
| Limits or exclusions | $70 |
| **The total Joe would pay is** | **$1,330** |

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

| | |
|---|---|
| The plan's overall deductible | $200 |
| Specialist copay | $25 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 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)*

| | |
|---|---|
| **Total Example Cost** | **$1,900** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $200 |
| Copayments | $300 |
| Coinsurance | $60 |
| *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.