



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.iatsenbf.org or call 1-800-456-3863. 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 1-800-456-3863 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$1,000 Individual/\$2,500 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 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> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> and primary care services, exams, evaluations and consultations, home health care, <u>prescription drug</u> , emergency room, dental and optical benefits are covered before you meet your <u>deductible</u> .	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 https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$4,000 Individual/\$10,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in 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.
What is not included in the <u>out-of-pocket limit</u>?	Penalties for failure to obtain <u>preauthorization</u> for services, <u>premiums</u> , and health care this <u>plan</u> doesn't cover, and optical and dental benefits.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.empireblue.com or call 1-800-553-9603 for a list of <u>In-Network</u> providers.	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 full cost if you use an <u>out-of-network provider</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.
Do you need a <u>referral</u> to see a <u>specialist</u>?	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 **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	\$30 <u>Copayment</u> /Visit for exams, evaluations and consultations; 20% <u>coinsurance</u> for all other services	Not covered	Hospital based clinic visits are not covered.
	<u>Specialist</u> visit	\$60 <u>Copayment</u> /Visit for exams, evaluations and consultations; 20% <u>coinsurance</u> for all other services	Not covered	
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	Hospital based clinic visits are not covered. 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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	Not covered	Failure to obtain <u>preauthorization</u> for x-rays and other imaging may result in no coverage or reduced coverage.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	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)	
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.iatsenbf.org</p>	Generic drugs	Retail: \$5 <u>Copayment/Script</u> Mail Order: \$10 <u>Copayment/Script</u>	Not covered	<p>Deductible does not apply. Certain drugs are subject to prior authorization, coverage limits, clinical programs, safety monitoring and quantity limits. Medications that can be obtained without a prescription (over-the-counter medications) are not covered except for ACA-required preventive medications.</p> <p>No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate) and other ACA-required preventive medications. Over-the-counter medications are only covered with a prescription.</p> <p>Certain drugs not in the <u>formulary</u> are excluded.</p> <p>If you choose to obtain a brand-name drug when a generic equivalent is available, you will be charged the generic drug copayment and the full difference in cost between the generic drug and the brand-name drug. There is an appeals process that allows your doctor to provide information showing the medical necessity for the brand-name drug.</p>
	Brand-name drugs with no generic equivalent	Retail: 20% <u>coinsurance</u> , \$40 minimum and \$60 maximum; Mail Order: 20% <u>coinsurance</u> , \$90 minimum and \$140 maximum	Not covered	
	Brand-name drugs with a generic equivalent available	Retail: 40% <u>coinsurance</u> , \$50 minimum and \$70 maximum; Mail Order: 40% <u>coinsurance</u> \$115 minimum and \$175 maximum	Not covered	
	<u>Specialty drugs</u>	Retail: Generic specialty drugs: \$5 <u>Copayment</u> , Brand-name drugs with no generic equivalent: 20% <u>coinsurance</u> , \$40 minimum and \$150 maximum; Brand-name drugs with a generic equivalent: 40% <u>coinsurance</u> , \$50 minimum and \$150 maximum; Mail Order: Generic drugs: \$10 <u>Copayment</u> , Brand-name drugs with no generic equivalent:	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)	
		20% <u>coinsurance</u> , \$90 minimum and \$300 maximum; Brand-name drugs with a generic equivalent: 40% <u>coinsurance</u> , \$115 minimum and \$300 maximum		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	Failure to obtain <u>preauthorization</u> may result in no coverage or reduced benefits.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>Copayment/Visit</u> ; <u>Deductible</u> does not apply	\$100 <u>Copayment/Visit</u>	If admitted within 24 hours, the ER <u>copayment</u> is waived.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	Not covered	None
	<u>Urgent care</u>	\$60 <u>Copayment/Visit</u> for exams, evaluations and consultations; 20% <u>coinsurance</u> for all other services	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	Failure to obtain <u>preauthorization</u> may result in no coverage or reduced benefits.
	Physician/surgeon fees	20% <u>coinsurance</u>	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 mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: \$30 <u>Copayment</u> /Visit for office visits, examinations, evaluations and consultations; Other outpatient: 20% <u>coinsurance</u>	Not covered	Failure to obtain <u>preauthorization</u> for outpatient facilities may result in no coverage or reduced benefits.
	Inpatient services	20% <u>coinsurance</u>	Not covered	Failure to obtain <u>preauthorization</u> may result in no coverage or reduced benefits.
If you are pregnant	Office visits	\$30 <u>copayment</u> for initial exam and evaluation; 20% <u>coinsurance</u> for all other services:	Not covered	<u>Cost sharing</u> does not apply for preventive <u>screening</u> services. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	Not Covered	Coverage is limited to 200 visits per calendar year (a visit equals four hours of care).
	<u>Rehabilitation services</u>	\$60 <u>Copayment</u> /Visit for examinations, evaluations and consultations; 20% <u>coinsurance</u> for all other services	Not Covered	Coverage is limited to 50 visits per calendar year for Occupational, Speech and Vision therapy combined, with a separate 50 visits per calendar year limit for outpatient Physical Therapy and Rehabilitation. Failure to obtain <u>preauthorization</u> may result in reduced or no coverage.
	<u>Habilitation services</u>	\$60 <u>Copayment</u> /Visit for examinations, evaluations and consultations; 20% <u>coinsurance</u> for all other services	Not Covered	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not Covered	Coverage is limited to 60 days per calendar year. Failure to obtain <u>preauthorization</u> for <u>In Network</u> providers may result in no coverage or reduced coverage.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not Covered	Failure to obtain <u>preauthorization</u> may result in

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)	
				no coverage or reduced benefits.
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not Covered	Coverage is limited to 210 days per lifetime.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of this service.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	No charges for up to two per calendar year	Covered up to network allowance	Children are fully covered for two exams per year up through the age of 18. Benefits are separately administered by Delta Dental.

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
- Dental care (Adult) (basic preventive care for oral exams and cleanings/2 per year and x-rays/once per year are covered)
- Hearing aids
- Long term care
- Private duty nursing
- Routine eye care (Child & Adult)
- Routine foot care
- Weight loss program (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
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the United States (See www.bcbs.com/bluecardworldwide)

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 Department of Labor's Employee Benefits Security Administration at 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 plan documents also provide 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: IATSE National Health and Welfare Fund, 417 Fifth Avenue, New York, NY 10016-2204 or call 1-800-456-FUND (3863) or Empire Blue Cross and Blue Shield, P.O. Box 1407, Church Street Station, New York, NY 10008-1407 or call 1-800-553-9603.

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 1-800-553-9603.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-553-9603.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-553-9603.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-553-9603.

—————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 \$1,000
- Specialist copay \$60
- Hospital (facility) coinsurance 20%
- Other copay (ER Visits) \$100

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$20
Coinsurance	\$2,280
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,360

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

- The plan's overall deductible \$1,000
- Specialist copay \$60
- Hospital (facility) coinsurance 20%
- Other copay (ER Visits) \$100

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$410
Copayments	\$260
Coinsurance	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$410
The total Joe would pay is	\$2,780

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

- The plan's overall deductible \$1,000
- Specialist copay \$60
- Hospital (facility) coinsurance 20%
- Other copay (ER Visits) \$100

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$250
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,250