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 deductible? | In-Network: $0<br>Out-of-Network: $750 Individual/ $1,875 Family | In-Network: See the Common Medical Events chart below for your costs for services this plan covers.<br>Out-of-Network: 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? | In-Network: Not Applicable<br>Out-of-Network: Yes. Emergency room care, home health care, and prescription drugs are covered before you meet your deductible. | In-Network: This plan does not have a deductible.<br>Out-of-Network: You will have to meet the deductible before the plan pays for any services. |
| Are there other deductibles for specific services? | No | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | In-Network: $1,750 Individual/ $4,375 Family;<br>Out-of-Network: $8,250 Individual/ $20,625 Family. | 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. |
| What is not included in the out-of-pocket limit? | Penalties for failure to obtain preauthorization for services, premiums, balance-billed charges, health care this plan doesn't cover, and optical and dental benefits. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| | | |
|---|---|---|
| Will you pay less if you use a network provider? | Yes. See www.empireblue.com or call 1-844-243-5566 for a list of In-Network providers. | This plan uses a provider network. You will usually pay less if you use a provider in the plan's network. You usually 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 for out-of-network providers 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 | $25 Copayment/Visit for exams, evaluations and consultations: all other services: 20% coinsurance | 40% Coinsurance | Hospital based clinic visits are not covered.<br><br>If you go to an out-of-network physician for an annual wellness exam, benefits are limited to $300.<br><br>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. |
| | Specialist visit | $50 Copayment/Visit for exams, evaluations and consultations: all other services: 20% coinsurance | 40% Coinsurance | |
| | Preventive care/screening/ immunization | No charge | 40% Coinsurance | |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% Coinsurance | 40% Coinsurance | Failure to obtain preauthorization for out-of-network providers may result in no coverage or reduced coverage. Failure to obtain preauthorization for x-rays and other imaging may result in no coverage or reduced benefits. |
| | Imaging (CT/PET scans, MRIs) | 20% Coinsurance | 40% 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 drugs to treat your illness or condition<br>More information about prescription drug coverage is available at www.iatsenbf.org | Generic drugs | Retail: $5 Copayment/Script<br>Mail Order: $10 Copayment/Script | Retail: $5 retail Copayment/Script;<br>Mail Order: Not covered. | Out-of-network deductible does not apply.<br>For out-of-network retail, you must pay the full charge and then file a claim for reimbursement with Caremark for the difference between the pharmacy's charge and the applicable copayment.<br>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 (which are only covered with a prescription).<br>No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate) and other ACA-required preventive medications. Certain drugs not in the formulary are excluded.<br>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 that the brand-name drug is medically necessary. |
| | Preferred Brand-name drugs | Retail: 20% Coinsurance, $40 minimum and $60 maximum;<br>Mail Order: 20% Coinsurance, $90 minimum and $140 maximum | Retail: 20% Coinsurance, $40 minimum and $60 maximum;<br>Mail Order: Not covered. | |
| | Non-preferred Brand-name drugs | Retail: 40% Coinsurance, $50 minimum and $70 maximum;<br>Mail Order: 40% Coinsurance, $115 minimum and $175 maximum | Retail: 40% Coinsurance, $50 minimum and $70 maximum;<br>Mail Order: Not covered. | |
| | Specialty drugs | Retail: Generic specialty drugs: $5 Copayment, Preferred Brand-name drugs: 20% Coinsurance, $40 minimum and $150 maximum; Non-preferred Brand-name drugs: 40% Coinsurance, $50 minimum and $150 maximum;<br><br>Mail Order: Generic specialty drugs: $10 Copayment, Preferred Brand-name drugs: 20% Coinsurance, $90 minimum and $300 maximum; Non-preferred Brand-name drugs: 40% Coinsurance, $115 minimum and $300 maximum | Retail: Generic specialty drugs: $5 Copayment, Preferred Brand-name drugs: 20% Coinsurance, $40 minimum and $150 maximum; Non-preferred Brand-name drugs: 40% Coinsurance, $50 minimum and $150 maximum<br><br>Mail Order: 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 have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance | 40% Coinsurance | Failure to obtain preauthorization may result in no coverage or reduced benefits. |
| | Physician/surgeon fees | 20% Coinsurance | 40% Coinsurance | |
| If you need immediate medical attention | Emergency room care | $100 Copayment/Visit | $100 Copayment/Visit; Out-of-Network; Deductible does not apply | If admitted within 24 hours, the ER copayment is waived. Physician/professional charges may be billed separately. |
| | Emergency medical transportation | 20% Coinsurance | $0 as long as the ambulance charge does not exceed the maximum allowed amount. You pay any difference between maximum allowed amount and actual charge. | Out-of-network providers are covered as in-network, subject to meeting "emergency" criteria. When services are delivered by an out-of-network land ambulance provider that is not licensed under the NY Public Health Law, you may be required to pay up to the difference between the reasonable and customary allowed amount and the provider's total charges. |
| | Urgent care | 20% Coinsurance | 40% Coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% Coinsurance | 40% Coinsurance | Failure to obtain preauthorization may result in no coverage or reduced benefits. |
| | Physician/surgeon fees | 20% Coinsurance | 40% Coinsurance | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office visits: $25 Copay/Visit for exams, evaluations and consultations; Other outpatient services: 20% Coinsurance | 40% Coinsurance | Failure to obtain preauthorization for outpatient facilities may result in no coverage or reduced benefits. |
| | Inpatient services | 20% Coinsurance | 40% Coinsurance | Failure to obtain preauthorization may result in no coverage or reduced benefits. |

| 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 are pregnant | Office visits | $25 for initial exam and evaluation; Other services: 20% Coinsurance | 40% Coinsurance | Cost sharing does not apply for preventive screening services. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Depending on the type of services, a copayment, coinsurance or deductible may apply. |
| | Childbirth/delivery professional services | 20% Coinsurance | 40% Coinsurance | |
| | Childbirth/delivery facility services | 20% Coinsurance | 40% Coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 20% Coinsurance | 40% Coinsurance; Out-of-Network Deductible does not apply | Coverage is limited to 200 visits per calendar year (a visit equals 4 hours of care). |
| | Rehabilitation services | $50 Copayment/Visit for examinations, evaluations and consultations; all other services require 20% coinsurance | 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 preauthorization may result in reduced or no coverage. |
| | Habilitation services | $50 Copayment/Visit for examinations, evaluations and consultations; all other services require 20% coinsurance | Not Covered | |
| | Skilled nursing care | 20% Coinsurance | Not Covered | Coverage is limited to 60 days per calendar year. Failure to obtain preauthorization may result in no coverage or reduced coverage. |
| | Durable medical equipment | 20% Coinsurance | Not Covered | Failure to obtain preauthorization may result in no coverage or reduced benefits. |
| | Hospice services | 20% Coinsurance | Not Covered | Coverage is limited to 365 days per lifetime. |
| If your child needs dental or eye care | Children's eye exam | No charges | Balances over network allowance | Children are covered for exams and lenses once per year up through the age of 18. Children are covered for frames once per 24 months through the age of 18. Benefits are separately administered by Davis Vision. |
| | Children's glasses | No charges | Balances over $100 network allowance | |
| | Children's dental check-up | No charge for up to two per calendar year | Balances over 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
- Long-term care
- Private-duty nursing
- 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
- Dental care (Adult) (Plan covers limited excepted/preventive services)
- Hearing aids (limited to $1,500 in a 36-month period for a hearing aid, batteries and/or repairs)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. (www.bcbs.com/bluecardworldwide)
- Routine eye care (Adult) (Plan covers limited/excepted benefits)

**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 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: IATSE National Health and Welfare Fund, 417 Fifth Avenue, Third Floor, 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 1-844-243-5566.

**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 1-844-243-5566.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-243-5566.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-243-5566.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-243-5566.

*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 | $0 |
| Specialist copay | $50 |
| Hospital (facility) coinsurance | 20% |
| Other copay (ER Visit) | $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 | $12,700 |

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $80 |
| Coinsurance | $430 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Peg would pay is | $570 |

### 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 | $50 |
| Hospital (facility) coinsurance | 20% |
| Other copay (ER Visit) | $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 | $5,800 |

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $290 |
| Coinsurance | $1,440 |
| *What isn't covered* | |
| Limits or exclusions | $250 |
| The total Joe would pay is | $1,680 |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copay | $50 |
| Hospital (facility) coinsurance | 20% |
| Other copay (ER Visit) | $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 | $2,800 |

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $500 |
| Coinsurance | $210 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $710 |

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