

 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> ?	\$3,000 Individual/\$7,500 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 first three primary care visits, <u>prescription drugs</u> , and <u>emergency room care</u> 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> ?	\$7,000 Individual/\$14,000 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.	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 1-844-243-5566 for a list of <u>In-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 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	First 3 visits covered at 100%, <u>deductible</u> does not apply; 4th and subsequent visits subject to the <u>deductible</u> and 50% <u>coinsurance</u>	Not covered	Hospital-based clinic visits are not covered Chiropractor services 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.
	<u>Specialist</u> visit	50% <u>coinsurance</u>	Not covered	
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	Not covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	50% <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)	50% <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 <u>prescription drug coverage</u> is available at www.iatsenbf.org</p>	Generic drugs	50% <u>coinsurance</u>	Not covered	<p><u>Deductible</u> 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 (which are only covered with a prescription). 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 <u>formulary</u> are excluded. If you choose to obtain a brand-name drug when a generic equivalent is available, you will be charged the generic drug <u>copayment</u> 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 <u>medically necessary</u>.</p>
	Preferred Brand-name drugs	50% <u>coinsurance</u>	Not covered	
	Non-preferred Brand-name drugs	50% <u>coinsurance</u>	Not covered	
	<u>Specialty drugs</u>	<p>Retail: 50% <u>coinsurance</u>. There is a maximum <u>copayment</u> of \$200 per script for <u>specialty drugs</u></p> <p>Mail Order: 50% <u>coinsurance</u></p>	Not covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	50% <u>coinsurance</u>	Not covered	<p>Failure to obtain <u>preauthorization</u> may result in no coverage or reduced benefits.</p>
	Physician/surgeon fees	50% <u>coinsurance</u>	Not covered	
<p>If you need immediate medical attention</p>	<u>Emergency room care</u>	\$250 <u>copayment</u> /visit; <u>deductible</u> does not apply	\$250 <u>copayment</u> /visit; <u>deductible</u> does not apply	<p>If admitted within 24 hours, the ER <u>copayment</u> is waived. Physician/professional charges may be billed separately</p> <p>None.</p>
	<u>Emergency medical transportation</u>	50% <u>coinsurance</u>	Not covered	
	<u>Urgent care</u>	50% <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 have a hospital stay	Facility fee (e.g., hospital room)	\$200 <u>copayment</u> per day for ten days, then no charge	Not covered	Failure to obtain <u>preauthorization</u> may result in no coverage or reduced benefits. Skilled nursing facilities are not covered.
	Physician/surgeon fees	50% <u>coinsurance</u>	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	First 3 visits covered at 100%, <u>deductible</u> does not apply; 4th and subsequent visits subject to the <u>deductible</u> and 50% <u>coinsurance</u>	Not covered	Failure to obtain <u>preauthorization</u> for outpatient facilities may result in no coverage or reduced benefits.
	Inpatient services	\$200 <u>copayment</u> per day for ten days, then no charge	Not covered	Failure to obtain <u>preauthorization</u> may result in no coverage or reduced benefits.
If you are pregnant	Office visits	50% <u>coinsurance</u>	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). Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply.
	Childbirth/delivery professional services	50% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	50% <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 help recovering or have other special health needs	<u>Home health care</u>	50% <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>	Inpatient <u>copayment</u> of \$200 per day for ten days, then no charge	Not covered	Inpatient physical therapy or rehabilitation stays are limited to 30 days per year. Outpatient Occupational, Physical, Speech and Vision Rehabilitation therapy is not covered.
	<u>Habilitation services</u>	Inpatient <u>copayment</u> of \$200 per day for ten days, then no charge	Not covered	
	<u>Skilled nursing care</u>	Not covered	Not covered	
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	Not covered	Failure to obtain <u>preauthorization</u> may result in no coverage or reduced benefits.
	<u>Hospice services</u>	50% <u>coinsurance</u>	Not covered	Coverage is limited to 365 days per lifetime.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of these services.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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.)

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|--|---|---|
| <ul style="list-style-type: none">• Chiropractic care• Cosmetic surgery• Dental care (Adult & Child) | <ul style="list-style-type: none">• Hearing aids• Long-term care• Private-duty nursing• Routine eye care (Adult & Child) | <ul style="list-style-type: none">• Routine foot care• <u>Skilled nursing care</u>• Weight loss program (expect as required by the health law reform) |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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|---|---|--|
| <ul style="list-style-type: none">• Bariatric surgery• Acupuncture | <ul style="list-style-type: none">• Infertility treatment | <ul style="list-style-type: none">• Non-emergency care when traveling outside the United States (See www.bcbs.com/bluecardworldwide) |
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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, kwijigo 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 \$3,000
- Specialist coinsurance 50%
- Hospital (facility) copay \$200
- Other coinsurance 50%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$3,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$4,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$7,060

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

- The plan's overall deductible \$3,000
- Specialist coinsurance 50%
- Hospital (facility) copay \$200
- Other coinsurance 50%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$420
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,110
<i>What isn't covered</i>	
Limits or exclusions	\$250
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 \$3,000
- Specialist coinsurance 50%
- Hospital (facility) copay \$200
- Other coinsurance 50%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,070
<u>Copayments</u>	\$250
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$360
The total Mia would pay is	\$2,680