**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, call 1-212-465-8888. 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 1-212-465-8888 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$0** | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | Not applicable. | This plan does not have a deductible. |
| **Are there other deductibles for specific services?** | Yes. Out-of-network dental: $250/individual and $500/family. 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 plan network providers: $5,300/individual or $10,500/family<br>Prescription drugs (in-network): $4,150/individual or $8,400/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?** | Premiums, balance-billing charges, dental and vision plan expenses, health care this plan doesn't cover, your cost sharing for certain non-essential specialty drugs, and costs paid by drug manufacturers for those non-essential specialty drugs. | 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. For a list of network providers for medical see www.empireblue.com or call 1-800-553-9603. For a list of network providers for dental see www.metlife.com/dental or call 1-800-942-0854. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the full cost if you use an out-of-network provider. 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. |

| 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 | $50 copay/visit | Not covered | None |
| | Specialist visit | $50 copay/visit | Not covered | None |
| | Preventive care/screening/ immunization | No charge | Not covered | Age and frequency limits apply. You may have to pay for services that aren't preventive care. 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) | 20% coinsurance | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | Not covered | Failure to obtain preauthorization may result in non-coverage or reduced coverage. |

| 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 1-212-465-8888 | Generic drugs | Retail: $10 copay/fill (21-day supply); Mail Order: $40 copay/fill (90-day supply); | Not covered | Medication needed on an on-going basis must be filled through the Mail Order Program. If brand name is purchased when generic is available, you are responsible for any difference between brand and generic cost. No charge for ACA-required generic preventive drugs (such as contraceptives) (or brand drug if generic is not medically appropriate).<br><br>Controlled Substances are limited to a 30-day fill or less under applicable laws.<br><br>Out-of-network retail is not covered. However, one direct reimbursement is available per lifetime; reimbursement is made at the in-network cost.<br><br>The SaveOnSP Specialty Drug List is available at 1-800-683-1074. Your cost sharing for these "non-essential" specialty drugs, as well as any amount paid by the drug manufacturer through its copay assistance program, do not count toward your out-of-pocket limit. |
| | Preferred brand drugs | Retail: $30 copay/fill (21-day supply); Mail Order: $40 copay/fill (90-day supply) | Not covered | |
| | Non-preferred brand drugs | Retail: $30 copay/fill (21-day supply); Mail Order: $40 copay/fill (90-day supply) | Not covered | |
| | Specialty drugs | Retail: $10 copay/fill (21-day supply); Mail Order: $40/fill (90-day supply)<br><br>No cost for specialty drugs on the SaveOnSP Specialty Drug List if you enroll in that program. You pay the full copay indicated on that list if you do not enroll in that program. | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | Not covered | Failure to obtain preauthorization may result in non-coverage or reduced coverage. |
| | Physician/surgeon fees | 20% coinsurance | Not covered | None |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | 20% coinsurance | Copay waived if admitted. |
| | Emergency medical transportation | 20% coinsurance | Not covered | Local transport to nearest hospital. |
| | Urgent care | $50 copay/office visit | 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) | 20% coinsurance | Not covered | Failure to obtain preauthorization may result in non-coverage or reduced coverage. |
| | Physician/surgeon fees | 20% coinsurance | Not covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office visit: $50 copay/visit<br>Other outpatient services: 20% coinsurance | Not covered | Failure to obtain preauthorization for partial hospitalization, psychological testing, or intensive outpatient treatment may result in non-coverage or reduced coverage. |
| | Inpatient services | 20% coinsurance | Not covered | Failure to obtain preauthorization may result in non-coverage or reduced coverage. |
| **If you are pregnant** | Office visits | 20% coinsurance | Not covered | Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | 20% coinsurance | Not covered | None |
| | Childbirth/delivery facility services | 20% coinsurance | Not covered | None |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | Not covered | Failure to obtain preauthorization may result in non-coverage or reduced coverage. Limited to 200 visits per calendar year. |
| | Rehabilitation services | $50 copay/visit | Not covered | Physical therapy and rehabilitation are limited to 60 visits per calendar year combined in home, office or outpatient facility, and 30 days per year for inpatient services. All rehabilitation and habilitation visits count toward these visit limits. Occupational, speech, and vision therapy limited to 30 outpatient visits per year. |
| | Habilitation services | $50 copay/visit | Not covered | |
| | Skilled nursing care | 20% coinsurance | Not covered | Limited to 120 days per lifetime. Failure to obtain preauthorization may result in non-coverage or reduced coverage. |
| | Durable medical equipment | 20% coinsurance | Not covered | Failure to obtain preauthorization may result in non-coverage or reduced coverage. |
| | Hospice services | 20% coinsurance | Not covered | Limited to 210 days per lifetime. Failure to obtain preauthorization may result in non-coverage or reduced coverage. |

| 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 | Amount over $300 | Amount over $300 | Limited to $300 per person per calendar year for eye exam, frames, and/or lenses, including contact lenses. Non-prescription sunglasses not covered. Participants may opt out of vision coverage. |
| | Children's glasses | Amount over $300 | Amount over $300 | |
| | Children's dental check-up | No charge | 20% coinsurance after dental deductible | Limited to two oral exams per year. Separately insured by Metlife. |

## 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.)**

- Acupuncture
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs (except as required by health reform law)

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

- Bariatric surgery
- Chiropractic care
- Dental care (Adult) (Up to $4,000 per year)
- Hearing Aid purchase (Limited to $2,000 per year)
- Non-emergency care when traveling outside the U.S. (See www.BCBS.com/bluecardworldwide)
- Routine Eye Care (Adult) (Limited to $300 per person per calendar year for eye exam, frames, and/or lenses, including contact lenses.)

**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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 the Fund Office at: Steamfitters' Industry Welfare Fund, 27-08 40th Avenue, Long Island City, New York 11101-3725 or 1-212-465-8888. You may also contact Empire Blue Cross and Blue Shield, P.O. Box 11825, Appeals Department Mail Drop 6/0, Albany, NY 12211-0825 or New York State Department of Financial Services, 1-(800) 342-3736.

**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 1-212-465-8888.

*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 *copayment* | $50 |
| Hospital (facility) *coinsurance* | 20% |
| Other *coinsurance* | 20% |

**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 | $10 |
| Coinsurance | $2,440 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Peg would pay is** | **$2,470** |

### 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 *copayment* | $50 |
| Hospital (facility) *coinsurance* | 20% |
| Other *coinsurance* | 20% |

**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** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $960 |
| Coinsurance | $20 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$980** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist *copayment* | $50 |
| Hospital (facility) ER *copayment* | $200 |
| Other *coinsurance* | 20% |

**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 | $480 |
| Coinsurance | $340 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$820** |

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