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. Dental Out of Network: $100/Individual and $200/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 $10,600/family Prescription drugs (in-network): $3,800/individual or $7,600/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 and health care this plan doesn't cover.	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. For a list of in-network providers for medical see www.empireblue.com or call 1-800-553-9603. For a list of in-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 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.

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	Not covered	None
	Specialist visit	$20 copay/visit	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	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. Age and frequency limits apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-212-465-8888	Generic drugs	Retail: $10 copay (21-day supply); Mail Order: $40 copay (90-day supply);	Not covered	No charge for ACA-required generic preventive drugs (such as contraceptives) (or brand drug if generic is not medically appropriate). 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. Out-of-Network not covered. One direct reimbursement available per lifetime; reimbursement is made at the in-network cost. When you are enrolled, 100% coverage will be available at no cost to you through participation in the SaveOn SP Program. Contact the Fund Office or the SaveOn SP Program directly at 1-800-683-1074 for more information regarding implementation.
	Preferred brand drugs	Retail: $30 copay (21-day supply); Mail Order: $40 copay (90-day supply)	Not covered	
	Non-preferred brand drugs	Retail: $30 copay (21-day supply); Mail Order: $40 copay (90-day supply)	Not covered	
	Specialty drugs (Essential Health Benefits) Specialty drugs (Non-Essential - Health Benefits)	Retail: $30 copay (21-day supply); Mail Order: $40 copay (30-day supply) Non-Essential - Health Benefits - Not covered	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)	No charge	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Copay waived if admitted.
	Emergency medical transportation	No charge	Not covered	Local transport to nearest hospital.
	Urgent care	$20 copay/office visit	Not covered	There is no unique benefit for Urgent Care. If it is an emergency room visit, it will be subject to emergency room copay, not the office visit copay.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit No charge for other outpatient services	Not covered	None
	Inpatient services	No charge	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you are pregnant	Office visits	No charge	Not covered	None
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	None

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	No charge	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage. Limited to 200 visits per calendar year.
	Rehabilitation services	$20 copay/visit	Not covered	Limited to 60 visits per calendar year combined in home, office or outpatient facility.
	Habilitation services	$20 copay/visit	Not covered	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	No charge	Not covered	Limited to 120 days per lifetime. Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Durable medical equipment	No charge	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Hospice services	No charge	Not covered	Limited to 210 days per lifetime. Failure to obtain preauthorization may result in non-coverage or reduced coverage.
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.
	Children's glasses	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.
	Children's dental check-up	No charge	20% coinsurance after dental deductible	Limited to two oral exams per year.

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
- Chiropractic care
- Cosmetic surgery
- Hearing Aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs (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.)

- Bariatric surgery
- Dental care (Adult)(Up to $3,000 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: Metal Trades Branch Local 638 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 or New York State Department of Insurance, 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 *cost sharing*	$20
Hospital (facility) *cost sharing*	$0
Other *cost sharing*	$0

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	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

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 *cost sharing*	$20
Hospital (facility) *cost sharing*	$0
Other *cost sharing*	$0

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	$690
Coinsurance	$0
What isn't covered	
Limits or exclusions	$790
The total Joe would pay is	**$1,480**

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

The plan's overall deductible	$0
Specialist *cost sharing*	$20
Hospital (facility) *cost sharing*	$0
Other *cost sharing*	$0

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	$270
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$270**

The Plan would be responsible for the other costs of these EXAMPLE Covered services.