DIVISION 1181 A.T.U. – NEW YORK WELFARE FUND
20 North Central Avenue, 3rd Floor, Valley Stream, N.Y. 11580
(718) 845-5800

Dear Participant:

Pursuant to the Patient Protection and Affordable Care Act (PPACA), the following document is a summary of benefits and coverage (SBC) through Division 1181 A.T.U. – New York Welfare Fund.

Please review and keep for your reference.

The format of the enclosed SBC including some of the examples is required by Federal Law and is only a summary of your Plan of benefits. Therefore, this summary may not describe all of the benefits available to you. Please continue to refer to your Summary Plan Description (SPD) for additional information about your benefits.

If you have any questions, feel free to contact the Fund Office at (718) 845-5800.

Very truly yours,

THE FUND OFFICE

⚠ **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 1-718-845-5800. 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 www.cciio.cms.gov or call 1-866-513-2473 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?	No.	Generally, you will have to meet the deductible before the plan pays for any services. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $50 deductible for certain home health care services. 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?	For hospital and medical in network, **$3,600** for single/**$7,200** for family. For prescriptions, **$3,000** for single/**$6,000** for family. There are no out-of-network limits.	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, out-of-network copayments and coinsurance, non-essential benefits, 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. See www.empireblue.com or call 1-866-513-2473 for a list of network providers.	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 providers 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 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 copay	Excess of provider's charges over Fund's allowed amount.	None.
	Specialist visit	$40 copay	Excess of provider's charges over Fund's allowed amount.	None.
	Chiropractic care and acupuncture	$40 copay for chiropractic care and acupuncture.	Excess of provider's charges over Fund's allowed amount.	There is a $750 calendar year maximum combined in-network and out-of-network, and a 1 visit per day limitation for chiropractic care. Acupuncture is only covered when performed by a licensed medical provider.
	Preventive care/screening/ immunization	No charge	Excess of provider's charges over Fund's allowed amount.	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.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay	Excess of provider's charges over Fund's allowed amount.	Certain out-of-network services performed at in-network facilities may be treated as in-network without any balance billing to the extent required by law.
	Imaging (CT/PET scans, MRIs)	$25 copay	Excess of provider's charges over Fund's allowed amount.	Certain out-of-network services performed at in-network facilities may be treated as in-network without any balance billing to the extent required by law.

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 More information about prescription drug coverage is available by contacting Express Scripts at www.express-scripts.com or by calling 1-877-620-6727.	Generic drugs	$5.00 – Retail (up to 30 days supply) $12.50 – Mail Order (up to 90 days supply)	Not covered.	Retail (up to 30 days) Mail Order (up to 90 days) For a prescription you take on an ongoing basis (more than 3 months), you may use a retail pharmacy for your initial and up to 2 refills (for a total of 3 refills), for up to a 30-day supply each time. Subsequent refills must be placed through mail order in order to avoid a higher co-payment of $20 for generics, $60 for preferred brand drugs, and $120 for non-preferred brand drugs. The Fund has arranged for Payer Matrix to assist you in obtaining financial assistance to get your specialty drugs. You need to enroll with Payer Matrix to obtain such assistance. If you enroll with Payer Matrix but are not provided financial assistance, you will be provided with benefits at no copay. If you are not eligible to enroll in Payer Matrix, you will be provided with benefits with a copay. If you are eligible but refuse to enroll in Payer Matrix, you will have to pay the full cost of drug, unless you file an appeal.
	Preferred brand drugs	$15.00 – Retail (up to 30 days supply) $37.50 – Mail Order (up to 90 days supply)		
	Non-preferred brand drugs	$30.00 – Retail (up to 30 days supply) $75.00 – Mail Order (up to 90 days supply)		
	Specialty drugs	If enrolled in Payer Matrix: No copay If not enrolled in Payer Matrix: Not covered If ineligible to enroll in Payer Matrix: $30.00 – Retail (up to 30 days supply) $75.00 – Mail Order (up to 90 days supply)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge.	$500 copay plus the excess of provider's charges over the Fund's allowed amount.	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fees	No charge.	Excess of provider's charges over Fund's allowed amount.	Certain out-of-network services performed at in-network facilities may be treated as in-network without any balance billing to the extent required by law.

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 immediate medical attention	Emergency room services	$100 copay	Excess of provider's charges over Fund's allowed amount.	Out-of-network emergency services may be treated as in-network without any balance billing to the extent required by law.
	Emergency medical transportation	No charge.	Excess of provider's charges over Fund's allowed amount.	Out-of-network air ambulance services may be treated as in-network without any balance billing to the extent required by law.
	Urgent care	$25 copay	Excess of provider's charges over Fund's allowed amount.	To the extent considered "emergency services" under applicable federal law, out-of-network urgent care services may be treated as in-network without any balance billing to the extent required by law.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge.	$500 copay plus the excess of provider's charges over the Fund's allowed amount.	Failure to obtain preauthorization may result in non-coverage or reduced coverage. Limited to 120 days per admission for in-network and out-of-network providers combined.
	Physician/surgeon fees	No charge.	Excess of provider's charges over Fund's allowed amount.	Limited to 120 days per admission for in-network and out-of-network providers combined. Certain out-of-network services performed at in-network facilities may be treated as in-network without any balance billing to the extent required by law.
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	$25 copay	Excess of provider's charges over Fund's allowed amount.	Failure to obtain preauthorization may result in non-coverage or reduced coverage for in-network providers. Substance use disorder services are not covered.
	Mental/Behavioral health inpatient services	No charge.	Excess of provider's charges over Fund's allowed amount.	Failure to obtain preauthorization may result in non-coverage or reduced coverage. Limited to 120 days per admission for in-network and out-of-network providers combined. Substance use disorder services are 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 are pregnant	Prenatal and postnatal care	$25 copay	Excess of provider's charges over Fund's allowed amount.	Maternity coverage for a dependent daughter is not covered, except as required by applicable law. Depending on the type of services a copayment may apply.
	Delivery and all inpatient services	No charge	Excess of provider's charges over Fund's allowed amount.	Your doctor's charges for delivery are part of prenatal and postnatal care. Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you need help recovering or have other special health needs	Home health care	No charge	Excess of provider's charges over Fund's allowed amount.	Limited to 200 visits per calendar year for in-network and out-of-network providers combined. Without prior hospital confinement or not within 7 days of hospital confinement there is a 40 visit per year limit and a $50 deductible that applies.
	Rehabilitation services	No charge for inpatient services $40 copay for outpatient services	Excess of provider's charges over Fund's allowed amount.	Failure to obtain preauthorization may result in non-coverage or reduced coverage. Inpatient rehabilitation limited to 20 days per calendar year for in-network and out-of-network providers combined. Outpatient rehabilitation limited to 36 visits per calendar year for in-network and out-of-network providers combined.
	Habilitation services	No charge for inpatient services $40 copay for outpatient services	Excess of provider's charges over Fund's allowed amount.	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	No charge	Excess of provider's charges over Fund's allowed amount.	Failure to obtain preauthorization may result in non-coverage or reduced coverage. Limited to 30 days per calendar year for in-network and out-of-network providers.
	Durable medical equipment	No charge	Excess of provider's charges over Fund's allowed amount.	Failure to obtain preauthorization may result in non-coverage or reduced coverage for in-network providers.
	Hospice services	No Charge.	Excess of provider's charges over Fund's allowed amount.	Failure to obtain preauthorization may result in non-coverage or reduced coverage. Limited to 210 days per lifetime.

If your child needs dental or eye care	Children's eye exam	No charge.	Reimbursed up to $100 of cost (glasses and eye exam combined)	None.
	Children's glasses		Reimbursed up to $100 of cost (glasses and eye exam combined)	No charge for glasses is contingent on selecting the provider's preferred frames. Selection of non-preferred frames will be reimbursed up to $100 of cost; participant will pay the difference.
	Children's dental check-up		Reimbursed up to $30 of cost; participant responsible for remainder	There is a $2,000 annual limit for adult dental benefits, but pediatric dental benefits are unlimited.

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
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Substance abuse disorder services
- Weight loss programs

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 ($750 annual limit)
- Dental Care (Adult) ($2,000 annual limit)
- Most coverage provided outside the United States. See http://www.BCBS.com/bluecardworldwide
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)

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: 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: Board of Trustees – Division 1181 A.T.U. – New York Welfare Fund, 20 North Central Avenue, 3rd Floor, Valley Stream, NY 11580 or Department of Labor's Employee Benefits Security Administration, 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: Community Service Society of New York, Community Health Advocates, 105 East 22nd Street, 8th floor, New York, NY 10010 (888) 614-5400 http://www.communityhealthadvocates.org/.

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 1-866-513-2473.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-513-2473.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-513-2473.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-513-2473.

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	**$40**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**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	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

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	**$40**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**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	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$800
The total Joe would pay is	**$1,500**

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

The plan's overall deductible	**$0**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**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	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

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