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 212-255-7657. 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.iuoe15funds.org or call 1-212-255-7657 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network/Participating Provider: $0 Out-of-Network/Non-Participating Provider: $250/individual	In-Network/Participating Provider: See the Common Medical Events chart below for your costs for services this plan covers. Out-of-Network/Non-Participating Provider: Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Each individual family member must meet their own individual deductible before the plan begins to pay.
Are there services covered before you meet your deductible?	In-Network/Participating Provider: Not applicable. Out-of-Network/Non-Participating Provider: Prescription drugs are covered before you meet your overall deductible.	In-Network/Participating Provider: This plan does not have an in-network deductible. Out-of-Network/Non-Participating Provider: This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. $25/individual annually for prescription drug coverage. 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?	In-Network/Participating Provider: $1,000/individual, $2,000/family; In-Network Prescription Drugs: $6,900/individual, $13,800/family; Out-of-Network: None	In-Network/Participating Provider and Prescription Drugs: 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. Out-of-Network/Non-Participating Provider: This plan does not have an out-of-pocket limit on your out-of-network expenses.
What is not included in the out-of-pocket limit?	In-Network/Participating Provider and In-Network Prescription Drugs: Penalties for failure to obtain preauthorization and health care this plan doesn't cover. Out-of-Network: Not applicable.	In-Network/Participating Provider and In-Network Prescription Drugs: Even though you pay these expenses, they don't count toward the out-of-pocket limit. Out-of-Network/Non-Participating Provider: This plan does not have an out-of-pocket limit on your out-of-network/non-participating provider expenses.
Will you pay less if you use a network provider?	Yes. For a list of participating providers, see www.empireblue.com or call 1-800-553-9603.	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.

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
		Participating Provider (You will pay the least)	Non-Participating 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	$15 copay/visit	20% of Fee Schedule/ allowed amount plus balances above allowed amount	No charge for SwiftMD Telemedicine Program virtual visits. Acupuncture covered for up to 16 visits per covered individual per calendar year. Chiropractic care covered for up to 24 visits and 4 x-rays per covered individual per calendar year.
	Specialist visit	$30 copay/visit	20% of Fee Schedule/ allowed amount plus balances above allowed amount	
	Preventive care/screening/ immunization	No Charge	20% of Fee Schedule/ allowed amount plus balances above allowed amount	Not covered if performed in Hospital-based Outpatient Facility except for mammograms and for other services if office or free-standing setting is deemed medically inappropriate by attending physician and precertification by the Fund Office is obtained. Professional Evaluation Medical Group (PEMG) provides no-cost annual physicals and hearing tests. Inner Imaging provides lung, abdomen, pelvis and cancer scans at no cost. Frequency limitations apply. 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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% of Fee Schedule/ allowed amount plus balances above allowed amount	Not covered if performed in Hospital-based Outpatient Facility except for: tilt table testing; pulmonary function testing; pre-surgical testing done within 10 days of inpatient admission; breast sonograms; and mammograms. Precertification by the Fund is required in the event services in an office or free-standing setting are deemed medically inappropriate by attending physician.
	Imaging (CT/PET scans, MRIs)	$40 copay/test	20% of Fee Schedule/ allowed amount plus balances above allowed amount	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.optumrx.com**	Generic drugs	20% coinsurance	20% of Fee Schedule/ allowed amount plus balances above allowed amount	Overall Out-of-Network/Non-Participating provider deductible does not apply. Subject to separate $25 prescription drug deductible per covered individual per calendar year. Coinsurance and prescription drug deductible waived (and prescriptions covered at 100%) for generic contraceptives for women and other ACA-required preventive services prescriptions purchased at a participating pharmacy. Brand name preventive medications only covered if a generic is medically inappropriate or unavailable. Any over-the-counter drugs that are payable under this provision require a prescription to be covered. Precertification by the Fund Office is required for certain prescriptions.
	Formulary brand drugs	20% coinsurance	20% of Fee Schedule/ allowed amount plus balances above allowed amount	
	Non-formulary brand drugs	Not covered	Not covered	
	Specialty drugs	20% coinsurance	20% of Fee Schedule/ allowed amount plus balances above allowed amount	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copay/visit	Not Covered	Precertification required for certain surgical treatments. Benefits may be reduced by 50% for failure to obtain precertification for Participating Providers.
	Physician/surgeon fees	No Charge	20% of Fee Schedule/ allowed amount plus balances above allowed amount	Precertification required for certain surgical treatments. Benefits may be reduced by 50% for failure to obtain precertification for Participating Providers.
If you need immediate medical attention	Emergency room care	$200 copay/visit	Emergency services to treat an emergency medical condition: $200 copay/visit plus balances above allowed amount; All other service (those that are NOT considered emergency services to treat an emergency medical emergency conditions): 20% of Fee Schedule/allowed amount plus balances above allowed amount	Copay waived if admitted. Professional/physician charges may be billed separately.
	Emergency medical transportation	No Charge	20% of Fee Schedule/ allowed amount plus balances above allowed amount	None.
	Urgent care	$30 copay/visit	20% of Fee Schedule/ allowed amount plus balances above allowed amount	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/day to maximum of $250/calendar year	Not Covered	Precertification required for certain surgical treatments. Benefits may be reduced by 50% for failure to obtain precertification for Participating Providers.
	Physician/surgeon fees	No Charge	20% of Fee Schedule/ allowed amount plus balances above allowed amount	Precertification required for certain surgical treatments. Benefits may be reduced by 50% for failure to obtain precertification for Participating Providers.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Balance above Fee schedule/allowed amount	None.
	Inpatient services	Not covered	Balance above Fee schedule/allowed amount	Precertification by the Fund Office is required.
If you are pregnant	Office visits	No Charge	20% of Fee Schedule/ allowed amount plus balances above allowed amount	The Plan pays a global fee (a single amount) for professional services for prenatal and childbirth/delivery. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Depending on the type of service and whether it is received from a Participating or Non-Participating Provider, a copayment, coinsurance, or deductible may apply. Cost sharing does not apply for preventive services received from a Participating Provider.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services	$100 copay/day to maximum of $250/calendar year	Not Covered	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No Charge	Not covered	Up to 200 visits per calendar year. Precertification required.
	Rehabilitation services	Outpatient office or free-standing facility: $10 copay/visit; Inpatient (physical therapy only): $100 copay/day to maximum of $250/calendar year	Outpatient office or free-standing facility: 20% of Fee Schedule/allowed amount plus balances above allowed amount; Inpatient and Outpatient Facility: Not Covered	Speech/Language, Physical, and Occupational Therapies: Up to 30 visits/day per covered person per calendar year. Speech/language and occupational therapy not covered inpatient. Precertification required. Benefits may be reduced by 50% for failure to obtain precertification for Participating Providers. All rehabilitation and habilitation visits count toward visit limits.
	Habilitation services	Outpatient office or free-standing facility: $10 copay/visit; Inpatient (physical therapy only): $100 copay/day to maximum of $250/calendar year	Outpatient office or free-standing facility: 20% of Fee Schedule/allowed amount plus balances above allowed amount; Inpatient and Outpatient Facility: Not Covered	
	Skilled nursing care	Skilled nursing facility: No Charge	Skilled nursing facility: Not Covered	Up to 60 days per calendar year. Precertification is required. Benefits may be reduced by 50% for failure to obtain precertification for Participating Providers.
	Durable medical equipment	No Charge	20% of Fee Schedule/ allowed amount plus balances above allowed amount	Precertification is required. Benefits may be reduced by 50% for failure to obtain precertification for Participating Providers.
	Hospice services	No Charge	Not Covered	Up to 210 visits per calendar year.
If your child needs dental or eye care	Children's eye exam	Not Covered	Balances above allowed amount	One exam and pair of glasses per calendar year. Vision benefits may be declined by contacting the Fund Office.
	Children's glasses	Not Covered	Balances above allowed amount	
	Children's dental check-up	Not Covered	Balances above allowed amount	Paid according to Dental fee schedule. Limit to two check-ups annually. $2,000/individual annual maximum. Dental benefits may be declined by contacting the Fund Office.

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
- Non-emergency care when traveling outside the U.S.
- 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.)

- Acupuncture (up to 16 visits per calendar year)
- Bariatric surgery (must have BMI of 40 or greater and at least 100 lbs over weight)
- Chiropractic care
- Dental care (adult)(maximum $2,000 per calendar year)
- Hearing aids (maximum of $2,000 per ear once every calendar year)
- Infertility treatment (maximum $5,000 for medical and $5,000 for drugs per year)
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care (when necessary because of disease)

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: Welfare Fund of the International Union of Operation Engineers Local 15, 15A, 15C, 15D, 44-40 11TH Street, Long Island City, NY 11101 or by phone at 212-255-7657 You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Consumer Assistance Unit, NYS Department of Financial Services, 25 Beaver Street, New York, NY 10004-2319; Fax: 212-480-6282. 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 212-255-7657.

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** **$30**
- **Hospital (facility) copay** **$100/day to $250/year**
- **Other copay (diagnostic tests)** **$40**

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*	$10
Copayments	$180
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$250**

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** **$30**
- **Hospital (facility) copay** **$100/day to $250/year**
- **Other copay (diagnostic tests)** **$40**

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*	$25
Copayments	$240
Coinsurance	$690
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$955**

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

- **The plan's overall deductible** **$0**
- **Specialist copay** **$30**
- **Hospital (facility) copay** **$100/day to $250/year**
- **Other copay (diagnostic tests)** **$40**

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*	$10
Copayments	$360
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$370**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.
Your Medical Reimbursement Account (MRA) may be available for reimbursement for out-of-pocket expenses.
*NOTE: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.