Welfare Fund of the IUOE Local 15, A,B,C,&D AFL-CIO

Coverage Period: 01/01/2020-12/31/2020

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Family | Plan Type: EPO/PPO

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?	$0 In-Network Provider $250.00 Out-of-Network individual	See the Common Medical Events chart below for your costs for services this plan covers. Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay for Out-of-Network expenses.
Are there services covered before you meet your deductible?	Yes (All In-Network services are paid regardless of the deductible)	out-of-network provider: You must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there other deductibles for specific services?	Yes. $25.00 per person annually for prescription drug coverage.	Generally, 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. This plan covers some items even if you have not met the deductible amount.
What is the out-of-pocket limit for this plan?	Medical/Hospital In-Network Provider: $1,000/individual, $2,000/family; Prescription drugs In-Network: $6,900/individual, $13,800/family:	Medical/Hospital In-Network Providers and prescription drugs in-Network: 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 provider, (medical, hospital and prescriptions): do not count towards your out-of-pocket limit.
What is not included in the out-of-pocket limit?	In-Network: balance billing charges, penalties for failure to obtain preauthorization and health care this plan doesn't cover. Out-Of-Network medical and prescription expenses.	All Out-Of-Network medical and prescription expenses: deductible, balance billed charges, penalties and all not covered services by the plan. Even though you pay for these expenses they do not count towards your out-of-pocket limits.

Will you pay less if you use a network provider?	Yes. For a list of **network provider**, see www.empireblue.com or call 1-800-553-9603	This **plan** uses a **providers 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
		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	$15.00 co-pay	**Balance Billed**	——————None——————
	Specialist visit	$30.00 co-pay	**Balance Billed**	——————None——————
	Preventive care/screening/ immunization	No Charge	**Balance Billed**	Coverage limitations based on age. You may have to pay for services that aren't preventive.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	**Balance Billed**	——————None——————
	Imaging (CT/PET scans, MRIs)	$40.00 co-pay	**Balance Billed**	——————None——————
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%	20%	$25 **deductible** per person annually. No co-pay for generic contraceptives for women (or brand name contraceptives if a generic is medically inappropriate) and other ACA-required preventive services prescriptions. Any over-the-counter drugs that are payable under this provision require a prescription to be covered. **Precertification** by the Fund is required for certain prescriptions.
	Preferred brand drugs	20%	20%	
	Non-preferred brand drugs	20%	20%	
	Specialty drugs	20%	20%	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50.00 co-pay	Not Covered	——————None——————
	Physician/surgeon fees	No Charge	**Balance Billed**	**Precertification** is required for certain procedures.
If you need immediate medical	Emergency room care	$200.00 co-pay	**Balance Billed**	Co-pay waived if admitted
	Emergency medical	No Charge	**Balance Billed**	——————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)	
attention	transportation			
	Urgent care	$30.00 co-pay	Balance Billed	——————None——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$100.00 co-pay per stay	Not Covered	$250.00 max per year
	Physician/surgeon fees	No Charge	Balance Billed	——————None——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Balance Billed	——————None——————
	Inpatient services	Not Covered	Balance Billed	Precertification by the Fund is required.
If you are pregnant	Office visits	Not Covered	Not Covered	Included in the Global fee for delivery.
	Childbirth/delivery professional services	No Charge	Balance Billed	Included in the Global fee for delivery.
	Childbirth/delivery facility services	$100.00 per day co-pay	Balance Billed	$250.00 max per year
If you need help recovering or have other special health needs	Home health care	No Charge	Balance Billed	Up to 200 visits per calendar year, Precertification is required.
	Rehabilitation services	$10.00 co-pay	Balance Billed	Speech/Language, Occupational, Therapies: Up to 30 visits each, per diagnosis, per calendar year.
	Habilitation services	$10.00 co-pay	Balance Billed	All rehabilitation and habilitation visits count toward rehabilitation visit limits and requires Precertification.
	Skilled nursing care	No Charge	Balance Billed	Up to 60 days per calendar year, Precertification is required.
	Durable medical equipment	No Charge	Balance Billed	Precertification is required.
	Hospice services	No Charge	Balance Billed	Up to 210 visits per calendar year, Precertification is required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Balance Billed	1 exam per calendar year.
	Children's glasses	Not Covered	Balance Billed	1 pair per calendar year.
	Children's dental check-up	Not Covered	Balance Billed	Paid according to Dental fee schedule. Limit to two check-ups annually. $2000.00/individual annual maximum.

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
- Dental retainer

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

- Acupuncture
- Chiropractic care
- Dental care adult
- Hearing aids
- Infertility treatment
- Private duty nursing
- Routine eye care adult
- Routine foot care
- Bariatric surgery

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-212-255-7657. You may also contact your state insurance department, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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:

Welfare Fund of the International Union of Operation Engineers Local 15, 15A, 15C, 15D, 44-40 11TH Street, Long Island City, NY 11101
212-255-7657
Department of Labor's Employee Benefits Security Administration
1-866-444-EBSA (3272)
www.dol.gov/ebsa/healthreform
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]
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 *[cost sharing]*** **$30**
- **Hospital (facility) *[cost sharing]*** **$100**
- **Other *[cost sharing]*** **$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)*

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$320
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$320**

The plan would be responsible for the other costs of these EXAMPL

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]*** **$30**
- **Hospital (facility) *[cost sharing]*** **$100**
- **Other *[cost sharing]*** **20%**

like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$370
Coinsurance	$800
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1170**

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

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **$30**
- **Hospital (facility) *[cost sharing]*** **$200**
- **Other *[cost sharing]*** **$10**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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