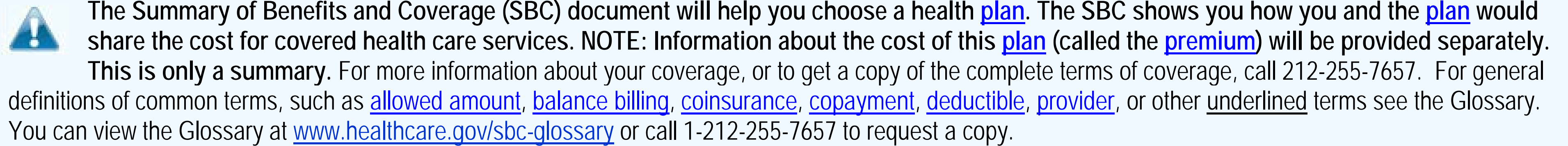
Welfare Fund of the IUOE Local 15,A,B,C & D AFL-CIO

Coverage Period: 01/01/2018-12/31/2018

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.healthcare.gov/sbc-glossary or call 1-212-255-7657 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$100 /individual	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes / preventive care and mental health and substance abuse treatment	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. $25.00 per person annually for prescription drug coverage.	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?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. For a list of in-network providers, 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 .

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	No Charge	Balance Billing	———————None———————
	Specialist visit	No Charge	Balance Billing	———————None———————
	Preventive care/screening/ immunization	No Charge	Balance Billing	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)	No Charge	Balance Billing	———————None———————
	Imaging (CT/PET scans, MRIs)	No Charge	Balance Billing	———————None———————
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Generic drugs	20%	20%	$25 deductible per person annually
	Preferred brand drugs	20%	20%	$25 deductible per person annually
	Non-preferred brand drugs	20%	20%	Precertification by the Fund is required.
	Specialty drugs	20%	20%	Precertification by the Fund is required
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	———————None———————
	Physician/surgeon fees	No Charge	Balance Billing	Precertification is required for certain procedures.
If you need immediate medical attention	Emergency room care	No Charge	No Charge	———————None———————
	Emergency medical transportation	No Charge	No Charge	———————None———————
	Urgent care	No Charge	Not Covered	———————None———————
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	———————None———————
	Physician/surgeon fees	No Charge	Balance Billing	———————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 mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Balance Billing	————————None————————
	Inpatient services	Not Covered	Balance Billing	Precertification by the Fund is required. Covered up to 120 days per calendar year.
If you are pregnant	Office visits	Not Covered	Not Covered	Included in the Global fee for delivery.
	Childbirth/delivery professional services	No Charge	Balance Billing	Included in the Global fee for delivery.
	Childbirth/delivery facility services	No Charge	Balance Billing	————————None————————
If you need help recovering or have other special health needs	Home health care	No Charge	Balance Billing	Up to 200 visits per calendar year, precertification is required.
	Rehabilitation services	No Charge if approved, 50% penalty without prior approval	Balance Billing	Speech/Language, Occupational, Vision Therapies: Up to 30 visits each, per diagnosis, per calendar year.
	Habilitation services	No Charge if approved, 50% penalty without prior approval	Balance Billing	All rehabilitation and habilitation visits count toward rehabilitation visit limits and requires precertification.
	Skilled nursing care	No Charge	Balance Billing	Up to 60 days per calendar year, precertification is required.
	Durable medical equipment	No Charge	Balance Billing	precertification is required.
	Hospice services	No Charge	Balance Billing	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 Billing	1 exam per calendar year.
	Children's glasses	Not Covered	Balance Billing	1 pair per calendar year.
	Children's dental check-up	Not Covered	Balance Billing	Paid according to Dental fee schedule.

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.

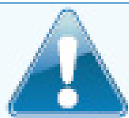
Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your 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.You may also contact the Department of Labor's Employee Benefits Security Administration 1-866-444-EBSA (3272) www.dol.gov/ebsa/healthreform

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.*––––––––––––––––––––



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 $100
- Specialist *[cost sharing]* $0
- 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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$100

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible $100
- Specialist *[cost sharing]* $0
- Hospital (facility) *[cost sharing]* 0%
- Other *[cost sharing]* 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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$125
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$425

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible $100
- Specialist *[cost sharing]* $0
- 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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$100

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