This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling **1-212-255-7657**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$100	See the chart on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No	
Is there an out–of–pocket limit on my expenses?	No	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This plan has no **out-of-pocket limit.**	Not applicable because there's no **out-of-pocket** limit on your expenses.
Is there an overall annual limit on what the plan pays?	$2,000,000.00 per year	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. Please see your plan document for annual benefit limits on services such as sleep apnea, bariatric surgery, and infertility.
Does this plan use a network of providers?	Yes. For a list of **in-network providers**, see www.empireblue.com or call 1-800-553-9603	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	This plan will pay some or all of the costs to see a **specialist** for covered services and the member can "self-refer".
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	Balance Billed	none
	Specialist visit	No Charge	Balance Billed	none
	Other practitioner office visit	No Charge	Balance Billed	none
	Preventive care/screening/immunization	No Charge	Balance Billed	none
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Balance Billed	none
	Imaging (CT/PET scans, MRIs)	No Charge	Balance Billed	none
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.empireblue.com	Generic drugs	20%	20%	$25 deductible annually; $1700 annual max.
	Preferred brand drugs	20%	20%	$25 deductible annually; $1700 annual max.
	Non-preferred brand drugs	20%	20%	$25 deductible annually; $1700 annual max.
	Specialty drugs	Not Covered	Balance Billed	For a list of specialty drugs covered under Major Medical contact the Welfare Fund at 212-255-7657
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	none
	Physician/surgeon fees	No Charge	Balance Billed	none
If you need	Emergency room services	No Charge	No Charge	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
immediate medical attention	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 fee	No Charge	Balance Billed if not negotiated	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not Covered	Balance Billed	36 visits per Calendar year; Prior approval by the Fund is required
	Mental/Behavioral health inpatient services	Not Covered	Balance Billed if not negotiated	30 days per Calendar year, Prior approval by the Fund is required
	Substance use disorder outpatient services	Not Covered	Balance Billed	36 visits per Calendar year; Prior approval by the Fund is required
	Substance use disorder inpatient services	Not Covered	Balance Billed if not negotiated	30 days per Calendar year, Prior approval by the Fund is required
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Included in the Global fee for delivery
	Delivery and all inpatient services	No Charge	Balance Billed if not negotiated	——————none——————
If you need help recovering or have other special health needs	Home health care	No Charge	Balance Billed if not negotiated	Up to 200 visits per calendar year.
	Rehabilitation services	No Charge if approved, 50% penalty without prior approval	Balance Billed	Up to 30 visits per Calendar year maximum combined; in home, office or outpatient facility. Speech/Language, Occupational, Vision Therapies: Up to 30 visits each per Calendar year
	Habilitation services	No Charge if approved, 50% penalty without prior approval	Balance Billed	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Skilled nursing care	No Charge	Balance Billed if not negotiated	Up to 60 days per calendar year, prior approval by the Fund is required
	Durable medical equipment	No Charge	Balance Billed	Prior approval by the Fund is required
	Hospice service	No Charge	Balance Billed	Up to 210 visits per calendar year.
If your child needs dental or eye care	Eye exam	Not Covered	Balance Billed	1 exam per Calendar year, see optical benefits
	Glasses	Not Covered	Balance Billed	1 pair per Calendar year; see optical benefits
	Dental check-up	Not Covered	Balance Billed	See the dental benefits

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Long term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

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

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

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/

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,370
- **Patient pays** $170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$100
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$100**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,820
- **Patient pays** $580

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$100**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.