District Council 37 Health & Benefit Fund

Coverage Period: 01/01/2024-12/31/2024

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

Coverage for: Individual or Family | Plan Type: EPO

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 healthcare 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 1-212-334-0096. 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 1-833-440-8480 to request a copy. If you want more detail about your coverage and costs, you can get the complete terms in the Summary Plan Description or by calling the Fund office at 1-212-334-0096 or Empire BC Blue Access at 1-833-440-8480.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	No deductible for in-network services. $500 individual/$1,500 family deductible for out-of-network services.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	No deductible for in-network. $500 individual/$1,500 family **deductible** for out-of-network services.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No deductible for in-network. $500 individual/$1,500 family **deductible** for out-of-network services.	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?	There is no **out-of-pocket** limit for this plan.	The **Out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Services that are excluded from coverage.	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. In-Network benefits, you will only pay a co-pay.	The out-of-network benefits are subject to **deductible** plus co-insurance and balance billing.
Do you need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.

- Co-payment are fixed dollar amounts (for example, $10) you pay for covered health care, usually when you received the service.
- Co-insurance 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 **co-insurance** payment of 30% would be $300. 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 amounts is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use participating providers by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

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	$ 30 co-pay / visit	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Specialist visit	$ 35 co-pay / visit	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Preventive care/screening/ immunization	No Charge	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
If you have a test	Diagnostic test (x-ray, blood work)	$ 30 co-pay / visit	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Imaging (CT/PET scans, MRIs)	$ 100 co-pay / visit	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.procarerx.com or (800) 699-3542.	Generic drugs	The greater of a $25 co-pay or 25% of the cost of the medication	Not Covered	It covers up to 30 days of supply for retail and 90 days for mail orders.
	Preferred brand drugs	The greater of $20 co-pay or 25% of the cost of the medication	Not Covered	It covers up to 30 days of supply for retail and 90 days for mail orders.
	Non-preferred brand drugs	The greater of $30 co-pay or 25% of the cost of the medication	Not Covered	It covers up to 30 days of supply for retail and 90 days for mail orders.
	Specialty drugs	The greater of $30 co-pay or 25% of the cost of the medication	30% co-insurance	It covers up to 30 days of supply for retail and 90 days for mail orders.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$ 70 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Physician/surgeon fees	$ 0 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
If you need immediate medical attention	Emergency room care	$ 150 co-pay	30% co-insurance	Waived if admitted.
	Emergency medical transportation	$ 0 co-pay	30% co-insurance	Maximum allowance ALS $1,290 BLS $704 plus $12 per mile transport.
	Urgent care	$ 50 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Physician/surgeon fees	$ 0 co-pay	30% co-insurance	Allowed one visit per day.
If you need mental health, behavioral health, or substance abuse services	Outpatient services office visit.	$ 30 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Inpatient services	$100 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Substance use disorder outpatient services office visit.	$ 30 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Substance use disorder inpatient services	$ 100 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
If you are pregnant	Office visits	$ 30 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Childbirth/delivery professional services	$ 0 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Childbirth/delivery facility services	$100 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.

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 help recovering or have other special health needs	Home health care	$ 0 co-pay	30% co-insurance	Maximum 90 visits per year. Pre-authorization required.
	Rehabilitation services	$ 30 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Habilitation services	$ 30 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Skilled nursing care	$ 30 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Durable medical equipment	$ 30 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Hospice services	$ 30 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
If your child needs dental or eye care	Children's eye exam	$ 0 co-pay / visit	Schedule	Limited to one exam every 24 months.
	Children's glasses	$ 0 co-pay	Schedule	Limited to one pair of glasses every 24 months.
	Children's dental check-up	No Charge	Not Covered	If enrolled in Dental HMO.

Excluded Services & Other Covered Services:

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

- Cosmetic Surgery
- Motor vehicle related expenses
- Infertility treatment
- Long-term care
- Medical care when traveling outside the U.S.
- Private-duty nursing
- Hearing aids
- Routine foot care

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

- Acupuncture (if prescribed for rehabilitation purposes)
- Dialysis (in-network only)
- Chiropractic care
- Dental Care
- Organ transplants (requires prior approval)
- Vision care
- Routine medical checkup
- Chemotherapy

Your Rights to Continue Coverage:

** Individual health insurance sample -

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you or your employer pay the premium. There are exceptions, however, such as if:

- You commit fraud
- The Fund Stops offering services
- you move outside the coverage area

For more information on your rights to continue coverage, contact the Fund at 1-212-334-0096. You may also contact your state insurance department.

Group health 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 1-212-334-0096. You may also contact 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 x 61565 or www.cciio.cms.gov.

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: [insert applicable contact information from instructions].

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 1-844-241-7089.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-241-7089.]
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-844-241-7089.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-241-7089.]

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 *Co-payment*	$35
Hospital (facility) *Co-payment*	$100
Other *Co-insurance*	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	$0
Copayments	$135
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	$235

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 *Co-payment*	$35
Hospital (facility) *Co-payment*	$100
Other *Co-insurance*	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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$135
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Joe would pay is	$235

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

The plan's overall deductible	$0
Specialist *Co-payment*	$35
Hospital (facility) *Co-payment*	$100
Other *Co-insurance*	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	$0
Copayments	$135
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Mia would pay is	$235

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**, **co-payments**, and **co-insurance** 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 received 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 Example to compare plans?

✓ Yes. When you look at the Summary of the 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 **co-payments**, **deductibles**, and **co-insurance**. 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.