


Prices	Base Plan (HSA)	Bronze Plan	Blue Liberty	Liberty	Gold Plan
Member Only	\$654	\$769	\$879	\$942	\$1009
Member Plus Children	\$1079	\$1289	\$1389	\$1599	\$1784
Member Plus Spouse	\$1274	\$1489	\$1699	\$1989	\$2014
Family	\$1589	\$1794	\$2054	\$2294	\$2309



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 the Local 298 Fund Office at 1-516-872-6690. 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 1-516-872-6690 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$3,000 individual / \$6,000 family.	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, prescription drug and vision benefits.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For health care, \$5,350 individual / \$10,700 family. For prescription drugs, \$1,000 individual / \$2,000 family.	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 , the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit ?	Penalties for failure to obtain preauthorization for services, premiums , balance-billing charges, and health care this plan doesn't cover.	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. Visit BlueCross BlueShield's website at www.Anthem.com or call directly at 1-800-810-BLUE (2583) for a list of network providers .	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
		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	Deductible and 50% coinsurance	Not covered	None
	Specialist visit	Deductible and 50% coinsurance	Not covered	Acupuncture services are not covered.
	Preventive care/screening/immunization	No charge	Not covered	Coverage is limited to one general medical exam each calendar year, plus recommended testing and screenings. You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible and 50% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling; Retail provider: Broadreach Medical Resources (BMR) 1-877-718-2379 Mail order provider: Affordable Scripts 1-800-325-7995	Generic drugs	\$10 copay /prescription (retail) or \$25 copay /prescription (mail order)	Not covered	Coverage is limited to a 30-day supply maximum per copay at retail and a 60-day supply maximum for mail order. Once you have filled a prescription two (2) times at the pharmacy, the Plan requires that you use the Mail Order program to continuing filling prescriptions for the same medication.
	Preferred brand drugs	\$35 copay /prescription (retail) or \$87.50 copay /prescription (mail order)		
	Non-preferred brand drugs	\$70 copay /prescription (retail) or \$175 copay /prescription (mail order)		
	Specialty drugs	Not covered	Not covered	Contact Payer Matrix at 1-877-305-6202.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible and 50% coinsurance	Not covered	Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , your claim can be denied.
	Physician/surgeon fees			

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 immediate medical attention	Emergency room care	Deductible and 50% coinsurance	Deductible , 50% coinsurance and balance billing	For emergency room coverage, you must be treated within 48 hours of an accident or within 24 hours of onset of a life-threatening illness.
	Emergency medical transportation	Deductible and 50% coinsurance	Deductible , 50% coinsurance and balance billing	None
	Urgent care	Deductible and 50% coinsurance	Deductible , 50% coinsurance and balance billing	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible and 50% coinsurance (semi-private rate)	Not covered	Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , your claim can be denied.
	Physician/surgeon fees	Deductible and 50% coinsurance		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	None
	Inpatient services			
If you are pregnant	Office visits	Deductible and 50% coinsurance	Not covered	Coverage is limited to member and spouse only. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is required for confinements over 96 hours by calling 1-866-317-5386. If you don't get preauthorization , your claim can be denied.
	Childbirth/delivery professional services	Deductible and 50% coinsurance		
	Childbirth/delivery facility services	Deductible and 50% coinsurance (semi-private rate)		
If you need help recovering or have other special health needs	Home health care	Deductible and 50% coinsurance	Not covered	Coverage is limited to 40 visits per calendar year. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , your claim can be denied.
	Rehabilitation services	Deductible and 50% coinsurance	Not covered	Coverage is limited to 60 visits per condition per lifetime.
	Habilitation services	Not covered	Not covered	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 help recovering or have other special health needs	Skilled nursing care	Deductible and 50% coinsurance	Not covered	Coverage is limited to 60 consecutive days per condition per lifetime. Confinement must follow a hospital confinement and must be for continued treatment. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , your claim can be denied.
	Durable medical equipment	Deductible and 50% coinsurance	Not covered	Preauthorization is required by calling the Fund Office at 1-516-872-6690. If you don't get preauthorization , your claim can be denied.
	Hospice services	Deductible and 50% coinsurance	Not covered	Coverage is limited to 60 days per lifetime. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , your claim can be denied.
If your child needs dental or eye care	Children's eye exam	\$100 benefit provided every 24 months for children under age 19	Not covered	None
	Children's glasses			
	Children's dental check-up	Not covered	Not covered	None

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](#).)

• Acupuncture	• Bariatric surgery	• Cosmetic surgery
• Dental care (adult and children)	• Habilitation services	• Hearing aids
• Infertility treatment	• Long-term care	• Mental/behavioral health services
• Non-emergency care when traveling outside the U.S.	• Routine eye care (adult)	• Routine foot care
• Specialty drugs	• Substance abuse services	• Weight loss programs

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

• Chiropractic care	• Emergency care when traveling outside the U.S.	• Private-duty nursing (limited to home health care and hospice services)
---------------------	--	---

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. The contact information for the [plan](#) is Local 298 Health Benefit Fund-1, 420 West Merrick Road, Valley Stream, NY 11580, telephone: 1-516-872-6690. 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: Local 298 Health Benefit Fund-1, 420 West Merrick Road, Valley Stream, NY 11580, telephone: 1-516-872-6690. The Fund office hours are 9:00 A.M. to 5:00 P.M. You may also contact the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.com. Additionally, a consumer assistance program can help you file your appeal. Contact the Community Service Society of New York, Community Health Advocates at 105 East 22nd Street, 8th floor, New York, NY 10010, 1-888-614-5400 or <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:

Para obtener asistencia en Español, llame al 1-516-872-6690.


To see examples of how this plan might cover costs for a sample medical situation, see the next section.



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 the Local 22 Health Benefit Fund at 1-516-872-6690. 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 1-516-872-6690 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes.	You don't have to meet an overall deductible before the plan pays for any services. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$7,350 individual / \$14,700 family.	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 , the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit ?	Prescription drug charges, penalties for failure to obtain preauthorization for services, premiums , balance-billing charges, and health care this plan doesn't cover.	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. See www.Anthem.com or call 1-800-810-BLUE (2583) for a list of network providers .	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
		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	40% coinsurance	Not covered	None.
	Specialist visit	40% coinsurance	Not covered	None.
	Preventive care/screening/immunization	40% coinsurance	Not covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	Not covered	Not covered in an outpatient hospital setting.
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not covered	Not covered in an outpatient hospital setting. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , a penalty of 25% of the payment will be imposed.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling: Retail provider: Broadreach Medical Resources (BMR) 1-877-718-2375 Mail order provider: Affordable Scripts 1-800-325-7995	Generic drugs	40% coinsurance	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Coverage is initially limited to \$3,000 per calendar year, then charges between \$3,000 and \$6,000 are not covered, and charges in excess of \$6,000 per calendar year are covered at 60% and you will pay 40%.
	Preferred brand drugs	40% coinsurance	Not covered	
	Non-preferred brand drugs	40% coinsurance	Not covered	
	Specialty drugs	Not covered	Not covered	Contact Payer Matrix at 1-877-305-6202.

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)	40% coinsurance	Not covered	Facility fees limited to \$1,500 per occurrence. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , a penalty of 25% of the payment will be imposed.
	Physician/surgeon fees	40% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	40% coinsurance	Not covered	Benefit limited to \$1,000 per occurrence.
	Emergency medical transportation	40% coinsurance	Not covered	Air transport not covered.
	Urgent care	40% coinsurance	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not covered	Facility fees limited to \$10,000 per admission. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , a penalty of 25% of the payment will be imposed.
	Physician/surgeon fees	40% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% coinsurance	Not covered	None.
	Inpatient services	40% coinsurance	Not covered	Facility fees limited to \$10,000 per admission. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , a penalty of 25% of the payment will be imposed.
If you are pregnant	Office visits	40% coinsurance	Not covered	Cost sharing does not apply to certain preventive services . Depending on the type of services, copays may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Inpatient facility fees limited to \$10,000 per admission.
	Childbirth/delivery professional services	40% coinsurance	Not covered	
	Childbirth/delivery facility services	40% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	40% coinsurance	Not covered	Limited to 200 visits per calendar year, must follow a hospital stay. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , a penalty of 25% of the payment will be imposed.

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	Rehabilitation services	40% coinsurance	Not covered	Limited to 30 visits per calendar year. Not covered in an outpatient hospital setting. Preauthorization for inpatient services is required by calling 1-866-317-5386. If you don't get preauthorization , a penalty of 25% of the payment will be imposed. Inpatient facility fees limited to \$10,000 per admission.
	Habilitation services	Not covered	Not covered	None.
	Skilled nursing care	40% coinsurance	Not covered	Limited to 60 days per calendar year, must follow a hospital stay and be for continued treatment. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , a penalty of 25% of the payment will be imposed.
	Durable medical equipment	40% coinsurance	Not covered	None.
	Hospice services	40% coinsurance	Not covered	In home only, treated as a Home Care benefit. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , a penalty of 25% of the payment will be imposed.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Maximum benefit \$150 every 24 months. Call 516-872-6690 for a voucher.
	Children's glasses	No charge	Not covered	
	Children's dental check-up	No charge	Not covered	Call DDS, Inc. 516-794-7700 for benefit information and a voucher.

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](#).)

- | | | |
|--|-------------------------|------------------------|
| • Acupuncture | • Bariatric surgery | • Cosmetic surgery |
| • Hearing aids | • Infertility treatment | • Long-term care |
| • Non-emergency care when traveling outside the U.S. | • Routine foot care | • Weight loss programs |

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

- | | | |
|----------------------------|-----------------------|------------------------|
| • Chiropractic care | • Dental care (adult) | • Private-duty nursing |
| • Routine eye care (adult) | | |

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. The contact information for the [plan](#) is Local 22 Health Benefit Fund, 420 West Merrick Road, Valley Stream, NY 11580, telephone: 1-516-872-6690. 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: Local 22 Health Benefit Fund, 420 West Merrick Road, Valley Stream, NY 11580, telephone: 1-516-872-6690. The Fund office hours are 9:00 A.M. to 5:00 P.M. You may also contact the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.com. Additionally, a consumer assistance program can help you file your appeal. Contact the Community Service Society of New York, Community Health Advocates at 105 East 22nd Street, 8th floor, New York, NY 10010, 1-888-614-5400 or <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:

Para obtener asistencia en Español, llame al 516-872-6690.

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 coinsurance](#) 40%
- Generic Drugs [coinsurance](#) 40%
- Hospital (facility) [coinsurance](#) 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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$5,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,060

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$0
- Primary care [coinsurance](#) 40%
- Branded Drugs [coinsurance](#) 40%
- Diagnostic testing [coinsurance](#) 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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,220

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist coinsurance](#) 40%
- Emergency Room [coinsurance](#) 40%
- Diagnostic testing [coinsurance](#) 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:


<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100



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 the Local 298 Fund Office at 1-516-872-6690. 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 1-516-872-6690 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In Network: \$1,500 Individual/ \$3,000 Family. Out-of-Network: \$0.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes, preventive care services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes, for prescription drug expenses, \$100 individual / \$300 family.	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: \$5,350 Ind. / \$10,700 Family, Out-of-Network: None. For prescription drugs, \$1,000 Ind. / \$2,000 Family.	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.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, and health care this plan doesn't cover.	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. Visit BlueCross BlueShield's website at www.Anthem.com or call directly at 1-800-810-BLUE (2583) for a list of network providers .	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
		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 copay /office visit	Not covered	None
	Specialist visit	\$50 copay /office visit	Not covered	Coverage for acupuncture services is limited to certain treatments and ten (10) visits per year. Coverage for chiropractic services is limited to twenty-four (24) visits per calendar year.
	Preventive care/screening/immunization	No charge, deductible does not apply	Not covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	\$20 copay for tests performed at a physician's office, and \$75 copay for outpatient hospital tests	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$50 copay /CT scan, \$75 copay /MRI or PET		
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling; Retail provider: Broadreach Medical Resources (BMR) 1-877-718-2379 Mail order provider: Affordable Scripts 1-800-325-7995	Generic drugs	\$15 copay /prescription (retail) or \$30 copay /prescription (mail order)	Not covered	Coverage is limited to a 30-day supply maximum per copay at retail and a 60-day supply maximum for mail order. Specialty and injectible drugs are not covered.
	Preferred brand drugs	\$35 copay /prescription (retail) or \$70 copay /prescription (mail order)		
	Non-preferred brand drugs	\$75 copay /prescription (retail) or \$150 copay /prescription (mail order)		
	Specialty drugs	Not covered	Not covered	Contact Payer Matrix at 1-877-305-6202.

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)	\$150 copay / visit	Not covered	Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , your claim can be denied.
	Physician/surgeon fees	\$150 copay / visit		
If you need immediate medical attention	Emergency room care	\$150 copay / visit	\$150 copay / visit and balance billing	None
	Emergency medical transportation	No charge	Balance billing	None
	Urgent care	\$30 copay / visit	\$30 copay / visit and balance billing	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 copay / day to a maximum \$1,000 / stay	Not covered	Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , your claim can be denied.
	Physician/surgeon fees	\$150 copay		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 copay / visit	Not covered	None
	Inpatient services	\$500 copay / day to a maximum \$1,000 / stay	Not covered	Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , your claim can be denied.
If you are pregnant	Office visits	\$30 copay for the first visit	Not covered	Coverage is limited to member and spouse only. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is required for confinements over 96 hours by calling 1-866-317-5386. If you don't get preauthorization , your claim can be denied.
	Childbirth/delivery professional services	\$150 copay		
	Childbirth/delivery facility services	\$500 copay / day to a maximum \$1,000 / stay		
If you need help recovering or have other special health needs	Home health care	\$30 copay / day	Not covered	Coverage is limited to 40 visits per calendar year. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , your claim can be denied.
	Rehabilitation services	\$50 copay / visit	Not covered	Coverage is limited to 60 visits per lifetime.
	Habilitation services	Not covered	Not covered	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 help recovering or have other special health needs	Skilled nursing care	\$500 copay / day to a maximum \$1,000 / stay	Not covered	Coverage is limited to 60 days per condition per lifetime. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , your claim can be denied.
	Durable medical equipment	No charge	Not covered	Coverage is limited to \$1,500 maximum per calendar year. Preauthorization is required by calling the Fund Office at 1-516-872-6690. If you don't get preauthorization , your claim can be denied.
	Hospice services	\$500 copay / day to a maximum \$1,000 / stay	Not covered	Coverage is limited to 30 days per lifetime. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , your claim can be denied.
If your child needs dental or eye care	Children's eye exam	\$100 benefit provided every 24 months for children under age 19	Not covered	None
	Children's glasses			
	Children's dental check-up	Not covered		

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](#).)

• Bariatric surgery	• Cosmetic surgery	• Dental care (adult and children)
• Habilitation services	• Hearing aids	• Infertility treatment
• Long-term care	• Routine eye care (adult)	• Routine foot care
• Weight loss programs	• Non-emergency care when traveling outside the U.S.	• Specialty and injectable drugs

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

• Acupuncture	• Chiropractic care	• Emergency care when traveling outside the U.S.
• Private-duty nursing (limited to home health care and hospice services)		

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. The contact information for the [plan](#) is Local 298 Health Benefit Fund-1, 420 West Merrick Road, Valley Stream, NY 11580, telephone: 1-516-872-6690. 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: Local 298 Health Benefit Fund-1, 420 West Merrick Road, Valley Stream, NY 11580, telephone: 1-516-872-6690. The Fund office hours are 9:00 A.M. to 5:00 P.M. You may also contact the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.com. Additionally, a consumer assistance program can help you file your appeal. Contact the Community Service Society of New York, Community Health Advocates at 105 East 22nd Street, 8th floor, New York, NY 10010, 1-888-614-5400 or <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:

Para obtener asistencia en Español, llame al 1-516-872-6690.

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	\$1,500
■ Diagnostic test copayment	\$20
■ Childbirth/Delivery copayment	\$150
■ Hospital (facility) copayment (per day, maximum \$1,000/stay)	\$500

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:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$1,400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,960

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1,500
■ Primary care copayment	\$30
■ Diagnostic test copayment	\$20
■ Branded drugs copayment	\$35

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:

<i>Cost Sharing</i>	
Deductibles	\$1,200
Copayments	\$1,000
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,220

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,500
■ Physical therapy copayment	\$50
■ Emergency room copayment	\$150
■ Durable medical equipment copayment	\$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	\$2,800
---------------------------	----------------

In this example, Mia would pay:


<i>Cost Sharing</i>	
Deductibles	\$1,300
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,500



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 the Local 298 Fund Office at 1-516-872-6690. 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 1-516-872-6690 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Not Applicable.	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, for prescription drug expenses, \$100 individual / \$300 family. 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 ?	For health care, \$5,350 individual / \$10,700 family. For prescription drugs, \$1,000 individual / \$2,000 family.	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 , the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit ?	Out-of-network charges, penalties for failure to obtain preauthorization for services, premiums , balance-billing charges, and health care this plan doesn't cover.	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. Visit BlueCross BlueShield's website at www.Anthem.com or call directly at 1-800-810-BLUE (2583) for a list of network providers .	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
		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 copay /office visit	Not covered	None
	Specialist visit	\$50 copay /office visit	Not covered	Coverage for acupuncture services is limited to certain treatments and ten (10) visits per year. Coverage for chiropractic services is limited to twenty-four (24) visits per calendar year.
	Preventive care/screening/immunization	No charge	Not covered	Coverage is limited to one general medical exam per calendar year, plus recommended testing and screenings. You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	\$20 copay for tests performed at a physician's office, and \$75 copay for outpatient hospital tests	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$75 copay /test		
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling; Retail provider: Broadreach Medical Resources (BMR) 1-877-718-2379 Mail order provider: Affordable Scripts 1-800-325-7995	Generic drugs	\$15 copay /prescription (retail) or \$30 copay /prescription (mail order)	Not covered	Coverage is limited to a 30-day supply maximum per copay at retail and a 60-day supply maximum for mail order. Specialty and injectible drugs are not covered.
	Preferred brand drugs	\$35 copay /prescription (retail) or \$70 copay /prescription (mail order)		
	Non-preferred brand drugs	\$75 copay /prescription (retail) or \$150 copay /prescription (mail order)		
	Specialty drugs	Not covered	Not covered	Contact Payer Matrix at 1-877-305-6202.

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)	\$150 copay / visit	Not covered	Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , your claim can be denied.
	Physician/surgeon fees	\$150 copay / visit		
If you need immediate medical attention	Emergency room care	\$150 copay / visit	\$150 copay / visit and balance billing	For emergency room coverage, you must be treated within 48 hours of an accidental injury or within 12 hours of onset of a sudden or serious illness.
	Emergency medical transportation	No charge	Balance billing	None
	Urgent care	\$30 copay / visit	\$30 copay / visit and balance billing	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 copay / day to a maximum \$1,000 / stay	Not covered	Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , your claim can be denied.
	Physician/surgeon fees	\$150 copay		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 copay / visit	Not covered	None
	Inpatient services	\$500 copay / day to a maximum \$1,000 / stay	Not covered	Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , your claim can be denied.
If you are pregnant	Office visits	\$30 copay for the first visit	Not covered	Coverage is limited to member and spouse only. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is required for confinements over 96 hours by calling 1-866-317-5386. If you don't get preauthorization , your claim can be denied.
	Childbirth/delivery professional services	\$150 copay		
	Childbirth/delivery facility services	\$500 copay / day to a maximum \$1,000 / stay		
If you need help recovering or have other special health needs	Home health care	\$30 copay / day	Not covered	Coverage is limited to 40 visits per calendar year. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , your claim can be denied.
	Rehabilitation services	\$50 copay / visit	Not covered	Coverage is limited to 60 visits per lifetime.
	Habilitation services	Not covered	Not covered	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 help recovering or have other special health needs	Skilled nursing care	\$500 copay / day to a maximum \$1,000 / stay	Not covered	Coverage is limited to 60 days per condition per lifetime. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , your claim can be denied.
	Durable medical equipment	No charge	Not covered	Coverage is limited to \$1,500 maximum per calendar year. Preauthorization is required by calling the Fund Office at 1-516-872-6690. If you don't get preauthorization , your claim can be denied.
	Hospice services	\$500 copay / day to a maximum \$1,000 / stay	Not covered	Coverage is limited to 30 days per lifetime. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , your claim can be denied.
If your child needs dental or eye care	Children's eye exam	\$100 benefit provided every 24 months for children under age 19	Not covered	None
	Children's glasses			
	Children's dental check-up	Not covered		

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 .)		
• Bariatric surgery	• Cosmetic surgery	• Dental care (adult and children)
• Habilitation services	• Hearing aids	• Infertility treatment
• Long-term care	• Routine eye care (adult)	• Routine foot care
• Weight loss programs	• Non-emergency care when traveling outside the U.S.	• Specialty and injectable drugs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic care	• Emergency care when traveling outside the U.S.
• Private-duty nursing (limited to home health care and hospice services)		

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. The contact information for the [plan](#) is Local 298 Health Benefit Fund-1, 420 West Merrick Road, Valley Stream, NY 11580, telephone: 1-516-872-6690. 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: Local 298 Health Benefit Fund-1, 420 West Merrick Road, Valley Stream, NY 11580, telephone: 1-516-872-6690. The Fund office hours are 9:00 A.M. to 5:00 P.M. You may also contact the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.com. Additionally, a consumer assistance program can help you file your appeal. Contact the Community Service Society of New York, Community Health Advocates at 105 East 22nd Street, 8th floor, New York, NY 10010, 1-888-614-5400 or <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:

Para obtener asistencia en Español, llame al 1-516-872-6690.

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
- [Diagnostic test copayment](#) \$20
- Childbirth/Delivery [copayment](#) \$150
- Hospital (facility) [copayment](#) \$500
(per day, maximum \$1,000/stay)

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:

<i>Cost Sharing</i>	
Deductibles	\$10
Copayments	\$1,500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,570

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- Prescription drugs [deductible](#) \$100
- Primary care [copayment](#) \$30
- [Diagnostic test copayment](#) \$20
- Branded drugs [copayment](#) \$35

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:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$1,500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,620

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

- The [plan's](#) overall [deductible](#) \$0
- Physical therapy [copayment](#) \$50
- Emergency room [copayment](#) \$150
- Durable medical equipment [copayment](#) \$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	\$2,800
---------------------------	----------------

In this example, Mia would pay:


<i>Cost Sharing</i>	
Deductibles	\$10
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$810



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 the Local 22 Health Benefit Fund at 1-516-872-6690. 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 1-516-872-6690 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers : None. For out-of-network providers \$200 individual / \$500 family	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes, services with network providers .	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers only, \$7,350 individual / \$14,700 family.	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 , the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Out-of-network charges, prescription drug charges, penalties for failure to obtain preauthorization for services, premiums , balance billing charges, and health care this plan doesn't cover.	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. See www.Anthem.com or call 1-800-810-BLUE (2583) for a list of network providers .	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
		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	\$10 copay /office visit and 20% coinsurance	Deductible and 40% coinsurance	None.
	Specialist visit	\$10 copay /office visit and 20% coinsurance	Deductible and 40% coinsurance	None.
	Preventive care/screening/immunization	No charge	Deductible and 40% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Deductible and 40% coinsurance	Not covered in an outpatient hospital setting.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Deductible and 40% coinsurance	Not covered in an outpatient hospital setting. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , a penalty of 25% of the payment will be imposed.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling: Retail provider: Broadreach Medical Resources (BMR) 1-877-718-2375 Mail order provider: Affordable Scripts 1-800-325-7995	Generic drugs	\$10 copay /prescription (retail and mail order pharmacies)	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription), Coverage is initially limited to \$3,000 per calendar year, then charges between \$3,000 and \$6,000 are not covered, and charges in excess of \$6,000 per calendar year are covered at 60% and you will pay 40%.
	Preferred brand drugs	\$20 copay /prescription (retail and mail order pharmacies)	Not covered	
	Non-preferred brand drugs	\$20 copay /prescription (retail and mail order pharmacies)	Not covered	
	Specialty drugs	Not covered	Not covered	Contact Payer Matrix at 1-877-305-6202.

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)	20% coinsurance	Deductible and 40% coinsurance	Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , a penalty of 25% of the payment will be imposed.
	Physician/surgeon fees	20% coinsurance	Deductible and 40% coinsurance	
If you need immediate medical attention	Emergency room care	\$35 copay / visit and 20% coinsurance	\$35 copay / visit and 20% coinsurance	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Air transport not covered.
	Urgent care	\$10 copay / visit and 20% coinsurance	\$10 copay / visit and 20% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Deductible and 40% coinsurance	Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , a penalty of 25% of the payment will be imposed. Maximum \$200,000 per admission.
	Physician/surgeon fees	20% coinsurance	Deductible and 40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 copay / visit and 20% coinsurance	Deductible and 40% coinsurance	None
	Inpatient services	20% coinsurance	Deductible and 40% coinsurance	Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , a penalty of 25% of the payment will be imposed. Maximum \$200,000 per admission.
If you are pregnant	Office visits	\$10 copay and 20% coinsurance	Deductible and 40% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, copays may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Inpatient services limited to \$200,000 per admission.
	Childbirth/delivery professional services	20% coinsurance	Deductible and 40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	Deductible and 40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Deductible and 40% coinsurance	Limited to 200 visits per calendar year, must follow a hospital stay. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , a penalty of 25% of the payment will be imposed.

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	Rehabilitation services	\$10 copay / visit and 20% coinsurance	Deductible and 40% coinsurance	Limited to 30 visits per calendar year. Not covered in an outpatient hospital setting. Preauthorization for inpatient services is required by calling 1-866-317-5386. If you don't get preauthorization , a penalty of 25% of the payment will be imposed.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	Not covered	Limited to 60 days per calendar year, must follow a hospital stay and be for continued treatment. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , a penalty of 25% of the payment will be imposed.
	Durable medical equipment	20% coinsurance	Deductible and 40% coinsurance	None.
	Hospice services	20% coinsurance	Deductible and 40% coinsurance	In home only, treated as a Home Care benefit. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization , a penalty of 25% of the payment will be imposed.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Maximum benefit \$150 every 24 months. Call 516-872-6690 for a voucher.
	Children's glasses	No charge	Not covered	
	Children's dental check-up	No charge	Not covered	Call DDS, Inc. 516-794-7700 for benefit information and a voucher.

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](#).)

- | | | |
|--|-------------------------|------------------------|
| • Acupuncture | • Bariatric surgery | • Cosmetic surgery |
| • Hearing aids | • Infertility treatment | • Long-term care |
| • Non-emergency care when traveling outside the U.S. | • Routine foot care | • Weight loss programs |

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

- | | | |
|----------------------------|-----------------------|------------------------|
| • Chiropractic care | • Dental care (adult) | • Private-duty nursing |
| • Routine eye care (adult) | | |

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. The contact information for the [plan](#) is Local 22 Health Benefit Fund, 420 West Merrick Road, Valley Stream, NY 11580, telephone: 1-516-872-6690. 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: Local 22 Health Benefit Fund, 420 West Merrick Road, Valley Stream, NY 11580, telephone: 1-516-872-6690. The Fund office hours are 9:00 A.M. to 5:00 P.M. You may also contact the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.com. Additionally, a consumer assistance program can help you file your appeal. Contact the Community Service Society of New York, Community Health Advocates at 105 East 22nd Street, 8th floor, New York, NY 10010, 1-888-614-5400 or <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:

Para obtener asistencia en Español, llame al 516-872-6690.

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 copayment](#) \$10
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%

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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$20
Coinsurance	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,580

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$0
- Primary care [copayment](#) \$10
- Primary care [coinsurance](#) 20%
- Diagnostic testing [coinsurance](#) 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	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$900
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,120

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$10
- [Specialist coinsurance](#) 20%
- Diagnostic testing [coinsurance](#) 20%

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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$700