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:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$2,500
What isn't covered	
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:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$200
What isn't covered	
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:

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

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