**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?** | For network providers: None. For out-of-network providers $1,500 individual / $3,750 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, prescription drug and vision benefits, and 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?** | Not Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| **What is not included in the out-of-pocket limit?** | Not Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| **Will you pay less if you use a network provider?** | Yes. 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 | $25 copay/office visit | Deductible and 30% coinsurance | None |
| | Specialist visit | $25 copay/office visit | Deductible and 30% coinsurance | Coverage for acupuncture services is limited to network providers only and 10 visits / calendar year. Coverage for chiropractic services is limited to 24 visits per calendar year and an out-of-network maximum of $30 per visit. |
| | Preventive care/screening/ immunization | No charge for immunizations, $10 copay for screenings and child preventive care visits, and $25 copay for adult preventive care visits | Deductible and 30% coinsurance | 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) | $10 copay at physician's office, $100 copay at hospital | Deductible and 30% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | $50 copay at physician's office, $100 copay at hospital | Deductible and 30% coinsurance | Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization, your claim can be denied. |
| **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 $20 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. |
| | Preferred brand drugs | $35 copay/prescription (retail) or $70 copay/ prescription (mail order) | | |
| | Non-preferred brand drugs | $45 copay/prescription (retail) or $90 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) | $100 copay/ visit | Deductible and 30% coinsurance | None |
| | Physician/surgeon fees | No charge | | |
| **If you need immediate medical attention** | Emergency room care | $100 copay/ visit | Deductible and 30% coinsurance | Copay waived if admitted. |
| | Emergency medical transportation | No charge | Not covered | Coverage is limited to the nearest hospital or skilled nursing facility where treatment can be provided. |
| | Urgent care | $25 copay/ visit | Deductible and 30% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $250 copay/ stay | Deductible and 30% coinsurance (semi-private rate) | Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization, your claim can be denied. |
| | Physician/surgeon fees | No charge | 30% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay/ visit | Deductible and 30% coinsurance | None |
| | Inpatient services | $250 copay/ stay | Deductible and 30% coinsurance (semi-private rate) | 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 | $25 copay for the first visit | Deductible and 30% coinsurance | Coverage is limited to member and spouse only. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization for inpatient services is required by calling 1-866-317-5386. If you don't get preauthorization, your claim can be denied. |
| | Childbirth/delivery professional services | No charge | Deductible and 30% coinsurance | |
| | Childbirth/delivery facility services | $250 copay/ stay | Deductible and 30% coinsurance (semi-private rate) | |
| **If you need help recovering or have other special health needs** | Home health care | $10 copay/ visit | Deductible and 30% coinsurance | Coverage is limited to 300 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 | $25 copay/ visit | Not covered | Coverage is limited to 30 visits per calendar year. |
| | 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 | $250 copay/ stay | Not covered | 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 | 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 | $250 copay plus 30% coinsurance | Not covered | Coverage is limited to 105 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 | See supplemental material | See supplemental material | None |
| | Children's glasses | | | |
| | Children's dental check-up | See supplemental material | See supplemental material | 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.)**

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

**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 (preauthorization is required)

**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 | $10 |
| Hospital (facility) copayment | $250 |
| Childbirth/Delivery copayment | $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** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$560** |

### 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 | $25 |
| Diagnostic test copayment | $10 |
| 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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $1,400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,420** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Physical therapy copayment | $25 |
| Emergency room copayment | $100 |
| 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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$400** |

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