



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 : \$500 individual / \$1,500 family. For out-of-network providers : \$1,000 individual / \$3,000 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, 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?	In-Network: \$2,500 Individual/ \$7500 Family, Out-of-Network: \$5,000 Individual/\$15,000 Family	This 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /office visit	<u>Deductible</u> and 50% <u>coinsurance</u>	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.
	<u>Specialist</u> visit	\$50 <u>copay</u> /office visit	<u>Deductible</u> and 50% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge, deductible Does not apply	<u>Deductible</u> and 50% <u>coinsurance</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$40 <u>copay</u> at physician's office, \$100 <u>copay</u> at hospital	<u>Deductible</u> and 50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	\$75 <u>copay</u> at physician's office, \$100 <u>copay</u> at hospital	<u>Deductible</u> and 50% <u>coinsurance</u>	<u>Preauthorization</u> is required by calling 1-888-322-0928. If you don't get <u>preauthorization</u> , your claim can be denied.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> 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 <u>copay</u> /prescription (retail) or \$20 <u>copay</u> /prescription (mail order)	Not covered	Coverage is limited to a 30-day supply maximum per <u>copay</u> at retail and a 60-day supply maximum for mail order.
	Preferred brand drugs	\$45 <u>copay</u> /prescription (retail) or \$90 <u>copay</u> /prescription (mail order)		
	Non-preferred brand drugs	\$75 <u>copay</u> /prescription (retail) or \$150 <u>copay</u> /prescription (mail order)		
	<u>Specialty drugs</u>	Not covered	Not covered	Contact Healthcare Advantage 1-888-623-5120
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 <u>copay</u> / visit	<u>Deductible</u> and 50% <u>coinsurance</u>	None
	Physician/surgeon fees	No charge		

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	\$150 copay / visit Deductible does not apply	\$150 copay / visit	None.
	Emergency medical transportation	\$150 copay / visit Deductible does not apply	No charge	Coverage is limited to the nearest hospital or skilled nursing facility where treatment can be provided.
	Urgent care	\$50 copay /office visit	\$50 copay /office visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 copay / visit up to \$500/ admission	Deductible and 50% coinsurance (semi-private rate)	Preauthorization is required by calling 1-888-322-0928. If you don't get preauthorization , your claim can be denied.
	Physician/surgeon fees	No charge	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay / visit	Deductible and 50% coinsurance	None
	Inpatient services	\$250 copay / visit up to \$500/ admission	Deductible and 50% coinsurance (semi-private rate)	Preauthorization is required by calling 1-888-322-0928. 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 50% 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 1-888-322-0928. If you don't get preauthorization , your claim can be denied.
	Childbirth/delivery professional services	No charge	Deductible and 50% coinsurance	
	Childbirth/delivery facility services	\$250 copay / visit up to \$500/ admission	Deductible and 50% coinsurance (semi-private rate)	
If you need help recovering or have other special health needs	Home health care	\$10 copay / visit	Deductible and 50% coinsurance	Coverage is limited to 300 visits per calendar year. Preauthorization is required by calling 1-888-322-0928. If you don't get preauthorization , your claim can be denied.
	Rehabilitation services	\$25 copay / visit	Not covered	Coverage is limited to 24 visits per calendar year.
	Habilitation services	Not covered	Not covered	None
If you need help recovering or have	Skilled nursing care	\$250 copay / visit up to \$500/ admission	Not covered	Preauthorization is required by calling 1-888-322-0928. If you don't get preauthorization , your claim can be denied.

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)	
other special health needs	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 / visit up to \$500/ admission	Not covered	Coverage is limited to 105 days per lifetime. Preauthorization is required by calling 1-888-322-0928. 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
- Habilitation services
- Long-term care
- Routine foot care
- Cosmetic surgery
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Specialty drugs
- Dental care
- Infertility treatment
- Routine eye care
- Weight loss programs

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

- Acupuncture
- Private-duty nursing ([preauthorization](#) is required)
- Chiropractic care
- Emergency care when traveling outside the U.S.

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	\$500
■ Diagnostic test copayment	\$40
■ 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	\$12,840
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$1,520
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,080

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$500
■ Primary care copayment	\$25
■ Diagnostic test copayment	\$40
■ Branded drugs copayment	\$45

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,460
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$1,835
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$2,390

Mia's Simple Fracture

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

■ The plan's overall deductible	\$500
■ Physical therapy copayment	\$25
■ 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	\$2,010
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$379
Copayments	\$1,025
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,404

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.