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 injectible 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:

Cost Sharing	
Deductibles	$1,500
Copayments	$1,400
Coinsurance	$0
What isn't covered	
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:

Cost Sharing	
Deductibles	$1,200
Copayments	$1,000
Coinsurance	$0
What isn't covered	
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:

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

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