



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/](http://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 <a href="#">deductible</a> ?	\$0.	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Not Applicable.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	Yes, for prescription drug expenses, \$100 individual / \$300 family. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For health care, \$5,350 individual / \$10,700 family. For prescription drugs, \$1,000 individual / \$2,000 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Out-of-network charges, penalties for failure to obtain <a href="#">preauthorization</a> for services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. Visit BlueCross BlueShield's website at <a href="http://www.Anthem.com">www.Anthem.com</a> or call directly at 1-800-810-BLUE (2583) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /office visit	Not covered	<p>Telephone consultations including without limitation any consultation conducted electronically (e.g., zoom or video) are excluded, except for mental health services.</p> <p>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.</p> <p>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 <a href="#">preventive</a>. Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.</p>
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /office visit	Not covered	
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$20 <a href="#">copay</a> for tests performed at a physician's office, and \$75 <a href="#">copay</a> for outpatient hospital tests	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$75 <a href="#">copay</a> /test	Not covered	<a href="#">Preauthorization</a> is required by calling 1-888-322-0928. If you don't get <a href="#">preauthorization</a> , 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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> 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 <a href="#">copay</a> /prescription (retail) or \$30 <a href="#">copay</a> /prescription (mail order)	Not covered	Coverage is limited to a 30-day supply maximum per <a href="#">copay</a> at retail and a 60-day supply maximum for mail order. Specialty and injectible drugs are not covered.
	Preferred brand drugs	\$35 <a href="#">copay</a> /prescription (retail) or \$70 <a href="#">copay</a> /prescription (mail order)		
	Non-preferred brand drugs	\$75 <a href="#">copay</a> /prescription (retail) or \$150 <a href="#">copay</a> /prescription (mail order)		
	<a href="#">Specialty drugs</a>	Not covered	Not covered	Contact Healthcare Advantage 1-888-623-5120
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$150 <a href="#">copay</a> / visit	Not covered	<a href="#">Preauthorization</a> is required by calling 1-888-322-0928. If you don't get <a href="#">preauthorization</a> , your claim can be denied.
	Physician/surgeon fees	\$150 <a href="#">copay</a> / visit		
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> / visit	\$150 <a href="#">copay</a> / visit	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.
	<a href="#">Emergency medical transportation</a>	No charge	No charge	None
	<a href="#">Urgent care</a>	\$30 <a href="#">copay</a> /office visit	\$30 <a href="#">copay</a> /office visit	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$500 <a href="#">copay</a> / day to a maximum \$1,000 / stay	Not covered	<a href="#">Preauthorization</a> is required by calling 1-888-322-0928. If you don't get <a href="#">preauthorization</a> , your claim can be denied.
	Physician/surgeon fees	\$150 <a href="#">copay</a>		

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 mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <a href="#">copay</a> / visit	Not covered	None
	Inpatient services	\$500 <a href="#">copay</a> / day to a maximum \$1,000 / stay	Not covered	<a href="#">Preauthorization</a> is required by calling 1-888-322-0928. If you don't get <a href="#">preauthorization</a> , your claim can be denied.
If you are pregnant	Office visits	\$30 <a href="#">copay</a> 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). <a href="#">Preauthorization</a> is required for confinements over 96 hours by calling 1-888-322-0928. If you don't get <a href="#">preauthorization</a> , your claim can be denied.
	Childbirth/delivery professional services	\$150 <a href="#">copay</a>		
	Childbirth/delivery facility services	\$500 <a href="#">copay</a> / day to a maximum \$1,000 / stay		
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$30 <a href="#">copay</a> / day	Not covered	Coverage is limited to 40 visits per calendar year. <a href="#">Preauthorization</a> is required by calling 1-888-322-0928. If you don't get <a href="#">preauthorization</a> , your claim can be denied.
	<a href="#">Rehabilitation services</a>	\$50 <a href="#">copay</a> / visit	Not covered	Coverage is limited to 60 visits per lifetime.
	<a href="#">Habilitation services</a>	Not covered	Not covered	None
If you need help recovering or have other special health needs	<a href="#">Skilled nursing care</a>	\$500 <a href="#">copay</a> / day to a maximum \$1,000 / stay	Not covered	Coverage is limited to 60 days per condition per lifetime. <a href="#">Preauthorization</a> is required by calling 1-888-322-0928. If you don't get <a href="#">preauthorization</a> , your claim can be denied.
	<a href="#">Durable medical equipment</a>	No charge	Not covered	Coverage is limited to \$1,500 maximum per calendar year. <a href="#">Preauthorization</a> is required by calling the Fund Office at 1-516-872-6690. If you don't get <a href="#">preauthorization</a> , your claim can be denied.
	<a href="#">Hospice services</a>	\$500 <a href="#">copay</a> / day to a maximum \$1,000 / stay	Not covered	Coverage is limited to 30 days per lifetime. <a href="#">Preauthorization</a> is required by calling 1-888-322-0928. If you don't get <a href="#">preauthorization</a> , 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			

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)	
	Children's dental check-up	Not covered		

**Excluded Services & Other Covered Services:**

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a>.)</b>		
• 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

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>		
• 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](http://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](http://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](http://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.

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*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*)

<b>Total Example Cost</b>	<b>\$12,840</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,545
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,605</b>

**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*)

<b>Total Example Cost</b>	<b>\$7,460</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$1,580
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,735</b>

**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*)

<b>Total Example Cost</b>	<b>\$2,010</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,015
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,015</b>