

 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/](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> ?	Yes.	You don't have to meet an overall <a href="#">deductible</a> before the <a href="#">plan</a> pays for any services. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$7,350 individual / \$14,700 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> ?	Prescription drug 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. See <a href="http://www.Anthem.com">www.Anthem.com</a> or call 1-800-810-BLUE (2583) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	40% <a href="#">coinsurance</a>	Not covered	Telephone consultations including without limitation any consultation conducted electronically (e.g., zoom or video) are excluded, except for mental health services.  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.
	<a href="#">Specialist</a> visit	40% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	40% <a href="#">coinsurance</a>	Not covered	Not covered in an outpatient hospital setting.
	Imaging (CT/PET scans, MRIs)	40% <a href="#">coinsurance</a>	Not covered	Not covered in an outpatient hospital setting. <a href="#">Preauthorization</a> is required by calling 1-888-322-0928. If you don't get <a href="#">preauthorization</a> , a penalty of 25% of the payment will be imposed.
<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) 1-877-718-2375 Mail order provider: Affordable Scripts 1-800-325-7995	Generic drugs	40% <a href="#">coinsurance</a>	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	40% <a href="#">coinsurance</a>	Not covered	
	Non-preferred brand drugs	40% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Specialty drugs</a>	Not covered	Not covered	Contact Healthcare Advantage 1-888-623-5120

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)	40% <a href="#">coinsurance</a>	Not covered	Facility fees limited to \$1,500 per occurrence. <a href="#">Preauthorization</a> is required by calling 1-888-322-0928. If you don't get <a href="#">preauthorization</a> , a penalty of 25% of the payment will be imposed.
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	Not covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Benefit limited to \$1,000 per occurrence.
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Air transport not covered.
	<a href="#">Urgent care</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <a href="#">coinsurance</a>	Not covered	Facility fees limited to \$10,000 per admission. <a href="#">Preauthorization</a> is required by calling 1-888-322-0928. If you don't get <a href="#">preauthorization</a> , a penalty of 25% of the payment will be imposed.
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% <a href="#">coinsurance</a>	Not covered	None.
	Inpatient services	40% <a href="#">coinsurance</a>	Not covered	Facility fees limited to \$10,000 per admission. <a href="#">Preauthorization</a> is required by calling 1-888-322-0928. If you don't get <a href="#">preauthorization</a> , a penalty of 25% of the payment will be imposed.
If you are pregnant	Office visits	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">copays</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Inpatient facility fees limited to \$10,000 per admission.
	Childbirth/delivery professional services	40% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	40% <a href="#">coinsurance</a>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	40% <a href="#">coinsurance</a>	Not covered	Limited to 200 visits per calendar year, must follow a hospital stay. <a href="#">Preauthorization</a> is required by calling 1-888-322-0928. If you don't get <a href="#">preauthorization</a> , 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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Rehabilitation services</a>	40% <a href="#">coinsurance</a>	Not covered	Limited to 30 visits per calendar year. Not covered in an outpatient hospital setting. <a href="#">Preauthorization</a> for inpatient services is required by calling 1-888-322-0928. If you don't get <a href="#">preauthorization</a> , a penalty of 25% of the payment will be imposed. Inpatient facility fees limited to \$10,000 per admission.
	<a href="#">Habilitation services</a>	Not covered	Not covered	None.
	<a href="#">Skilled nursing care</a>	40% <a href="#">coinsurance</a>	Not covered	Limited to 60 days per calendar year, must follow a hospital stay and be for continued treatment. <a href="#">Preauthorization</a> is required by calling 1-888-322-0928. If you don't get <a href="#">preauthorization</a> , a penalty of 25% of the payment will be imposed.
	<a href="#">Durable medical equipment</a>	40% <a href="#">coinsurance</a>	Not covered	None.
	<a href="#">Hospice services</a>	40% <a href="#">coinsurance</a>	Not covered	In home only, treated as a Home Care benefit. <a href="#">Preauthorization</a> is required by calling 1-888-322-0928. If you don't get <a href="#">preauthorization</a> , a penalty of 25% of the payment will be imposed.
<b>If your child needs dental or eye care</b>	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  | • Infertility treatment | • Long-term care       |
| • Hearing aids                                       | • Routine foot care     | • Weight loss programs |
| • Non-emergency care when traveling outside the U.S. | • Cosmetic surgery      |                        |

#### 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](http://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](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 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](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 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 coinsurance](#) 40%
- Generic Drugs [coinsurance](#) 40%
- Hospital (facility) [coinsurance](#) 40%

**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>
---------------------------	-----------------

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

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$5,054
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,114</b>

**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 [coinsurance](#) 40%
- Branded Drugs [coinsurance](#) 40%
- Diagnostic testing [coinsurance](#) 40%

**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>
---------------------------	----------------

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

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$2,874
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2,929</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist coinsurance](#) 40%
- Emergency Room [coinsurance](#) 40%
- Diagnostic testing [coinsurance](#) 40%

**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>
---------------------------	----------------

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

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$770
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$770</b>