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 Building Trades Welfare Benefit Fund at **1-516-833-9300** or **1-877-347-7225**. 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 **1-877-347-7225** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	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?	For network providers only, $5,850 individual / $11,700 family for health care coverage and $1,000 individual / $2,000 family for prescription drug coverage.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Out-of-network copayments and coinsurance, penalties for failure to obtain preauthorization for services, 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. See **www.Anthem.com** or call **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	$20 copay / office visit	Not covered	None
	Specialist visit	$40 copay / office visit	Not covered	Chiropractic services are not covered.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$50 copay/test	Not covered*	*To the extent required by law, certain out-of-network services may be covered as in-network services without any balance billing.
	Imaging (CT/PET scans, MRIs)	$50 copay/CT scan, $100 copay/PET scan or MRI	Not covered*	*To the extent required by law, certain out-of-network services may be covered as in-network services without any balance billing.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-800-872-8276 or www.maxorplus.com. For mail order, contact Maxor at 1-800-687-8629.	Generic drugs	$10 copay/prescription (retail) & $20 copay/ prescription (mail order)	Not covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). Coverage of certain medications may require preauthorization, or may be subject to step therapy, quantity limits, or may be excluded. Contact Maxor Pharmacy at 1-800-872-8276 for specific details.
	Preferred brand drugs	$25 copay/prescription (retail) & $50 copay/ prescription (mail order)	Not covered	
	Non-preferred brand drugs	$35 copay/prescription (retail) & $70 copay/ prescription (mail order)	Not covered	
	Specialty drugs	Not covered	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay / procedure	Not covered	Preauthorization is required for non-emergency services by calling 1-866-457-9882. If you don't get preauthorization, a penalty of $200 will be imposed. *To the extent required by law, certain out-of-network services performed at in-network facilities may be covered as in-network services without any balance billing.
	Physician/surgeon fees	$250 copay / procedure	Not covered*	

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	$50 copay / visit	$50 copay / visit	None
	Emergency medical transportation	$50 copay / trip	$50 copay / trip	None
	Urgent care	$20 copay / visit	$20 copay / visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay / admission	20% coinsurance and balance billing*	Preauthorization is required for non-emergency services by calling 1-866-457-9882. If you don't obtain preauthorization, a penalty of $200 will be imposed. *To the extent required by law, certain out-of-network services performed at in-network facilities may be covered as in-network services without any balance billing.
	Physician/surgeon fees	$40 copay / visit for physician visits and $250 copay / procedure for surgery	20% coinsurance and balance billing*	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	None
	Inpatient services	Not covered	Not covered	None
If you are pregnant	Office visits	$40 copay / pregnancy	Not covered	Coverage limited to member & spouse only. Cost sharing does not apply to certain preventive services. Depending on the type of services, copays may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is required for non-emergency services by calling 1-866-457-9882. If you don't obtain preauthorization, a penalty of $200 will be imposed. *To the extent required by law, certain out-of-network services may be covered as in-network services without any balance billing.
	Childbirth/delivery professional services	$250 copay / procedure	20% coinsurance and balance billing*	
	Childbirth/delivery facility services	$250 copay / admission	20% coinsurance and balance billing*	

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	Home health care	$40 copay / visit	Not covered	Coverage is limited to 40 visits (1 visit = 4 hours) in 12 consecutive months.
	Rehabilitation services	$40 copay / office visit or $250 copay / admission inpatient	Not covered	Without a Referral Coverage up to 10 visits during 30-day period, one time per calendar year. After 10 visits, you must receive pre-authorization for any further therapy sessions to be covered. With a Referral Coverage up to 12 visits within a 6-week period per injury or procedure per calendar year. For more than 12 visits, you should seek pre-authorization as soon as possible to avoid lapses in treatment by calling 1-866-457-9882. If you don't get preauthorization, a penalty of $200 will be imposed.
	Habilitation services	Not covered	Not covered	None
If you need help recovering or have other special health needs	Skilled nursing care	$250 copay / admission	Not covered	Coverage is limited to 30 days per calendar year combined with inpatient rehabilitation services.
	Durable medical equipment	20% coinsurance	Not covered	Preauthorization is required for items over $500 by calling 1-877-347-7225. If you don't get preauthorization, your claim will be denied.
	Hospice services	Not covered	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Coverage is limited to one exam and one pair of prescribed lenses and frames each calendar year, with a $100 annual maximum benefit for individuals over age 26.
	Children's glasses			
	Children's dental check-up	Not covered	Not covered	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.)		
• Acupuncture	• Bariatric surgery	• Chiropractic care
• Cosmetic surgery	• Dental care (adult and children)	• Habilitation services
• Hearing aids	• Hospice services	• Infertility treatment
• Long-term care	• Mental health services	• Non-emergency care when traveling outside the U.S.
• Routine foot care	• Specialty drugs	• Substance abuse services
• Weight loss programs		
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• 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. The contact information for the plan is: Building Trades Welfare Benefit Fund, 585 Stewart Avenue, Suite 330, Garden City, NY 11530, telephone: 516-833-9300 or 877-347-7225. 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: Building Trades Welfare Benefit Fund, 585 Stewart Avenue, Suite 330, Garden City, NY 11530, telephone: 516-833-9300 or 877-347-7225. 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 employer sponsored 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 516-833-9300 o 877-347-7225.

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 copayment** **$40**
- **Hospital (facility) copayment** **$250**
- **Diagnostic testing copayment** **$50**

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	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,060**

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** **$20**
- **Preferred brand drugs copayment** **$25**
- **Diagnostic testing copayment** **$50**

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	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

- **The plan's overall deductible** **$0**
- **Physical therapy copayment** **$40**
- **Emergency room copayment** **$50**
- **Durable medical equipment coinsurance** **20%**

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	$600
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$660**

Note: These numbers assume the patient does not participate in our Population Health Management wellness program. If you participate in the program, you may be able to reduce your costs. For more information, please contact Anthem at 1-866-962-0951.

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