

# Local 282 Welfare Trust Fund: Retirees – Non-Medicare

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2026 – 12/31/2026


Coverage for: Individual + Family | Plan Type: PPO



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. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact the Local 282 Welfare Trust Fund at (516) 488-2822 or (718) 343-3322 or visit our website at [www.teamsterslocal282.com](http://www.teamsterslocal282.com). 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 <https://www.healthcare.gov/sbc-glossary> or call (516) 488-2822 or (718) 343-3322 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$400 person / \$800 family (out-of-network only) per calendar year.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Services provided by a <a href="#">network provider</a> are covered before you meet your <a href="#">deductible</a> .	The <a href="#">plan</a> covers <a href="#">network</a> services even if you haven't met the deductible amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. You will have to meet the <a href="#">deductible</a> before the <a href="#">plan</a> pays for any <a href="#">out-of-network</a> services. 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">network providers</a> and <a href="#">out-of-network providers</a> \$9,200 person / \$18,400 family per calendar year.	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 plan, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Balance-billed charges, penalties for failure to pre-certify services, 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> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="https://ciipa.northwell.edu/providers/northwell-direct-search/">https://ciipa.northwell.edu/providers/northwell-direct-search/</a> for a list of Northwell Direct <a href="#">network providers</a> or <a href="http://www.bcbs.com">www.bcbs.com</a> or call 1-800-810-2583 for a list of	This <a href="#">plan</a> uses the Anthem Blue Cross Network ("Anthem") and Northwell Direct Network as its medical <a href="#">provider networks</a> . You will pay less if you use an Anthem <a href="#">provider</a> and, generally, even less if you use a Northwell Direct provider. 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 <a href="#">provider's</a> 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.

	Anthem <u>network providers</u> .	
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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	\$10 copay / visit (Northwell Direct); \$20 copay / visit (Anthem); <u>deductible</u> does not apply	20% coinsurance	None; you may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	<u>Specialist</u> visit	\$20 copay / visit (Northwell Direct); \$30 copay / visit (Anthem); <u>deductible</u> does not apply	20% coinsurance	
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	Not covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$10 copay / visit (Northwell Direct); \$20 copay / visit (Anthem); <u>deductible</u> does not apply	20% coinsurance	The Network co-payment is \$40 if the test can be performed by a Quest Diagnostics lab in New York or a LabCorp lab in New Jersey but you go to another Network lab in either state. When required by law, out-of-network diagnostic tests will be treated as in-network.
	Imaging (CT/PET scans, MRIs)	\$10 copay / visit (Northwell Direct); \$20 copay / visit (Anthem); <u>deductible</u> does not apply	20% coinsurance	Must pre-certify MRI/MRA or coverage could be lost. When required by law, out-of-network imaging will be treated as in-network.

\* For more information about limitations and exceptions, call (516) 488-2822 or (718) 343-3322 or see the plan document at [www.teamsterslocal282.com](http://www.teamsterslocal282.com)

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 at <a href="http://www.unifiedlaborrx.com">www.unifiedlaborrx.com</a>	Generic drugs and generic <a href="#">specialty drugs</a>	Up to \$4,000: \$10 copay / prescription (retail); \$20 copay / prescription (mail order); 20% coinsurance thereafter	Not covered	20% coinsurance applies after plan expenditures reach \$4,000; Covers up to 30-day supply (retail); up to 90-day supply (mail order); mail order is limited to maintenance medication; specified drugs must be preauthorized or coverage could be lost.
	Preferred brand drugs and preferred brand <a href="#">specialty drugs</a>	Up to \$4,000: \$10 copay / prescription (retail); \$20 copay / prescription (mail order); 20% coinsurance thereafter	Not covered	
	Non-preferred brand drugs and non-preferred brand <a href="#">specialty drugs</a>			
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge; <u>deductible</u> does not apply	20% coinsurance	Must pre-certify or coverage could be reduced.
	Physician/surgeon fees	\$20 surgeon copay / date of service (Northwell Direct); \$30 surgeon copay / date of service (Anthem); <u>deductible</u> does not apply	20% coinsurance	When required by law, out-of-network physician/surgeon fees will be treated as in-network.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100 copay / emergency room visit; <u>deductible</u> does not apply	20% coinsurance	Not covered unless for emergency—see page 57 of plan document; in-network copay waived if admitted to hospital; benefits may be reduced if not authorized within 48 hours. When required by law, out-of-network emergency room care will be treated as in-network.
	<a href="#">Emergency medical transportation</a>	\$20 copay / incident; <u>deductible</u> does not apply	20% coinsurance	Coverage limited to the first trip to and from a hospital for any one injury, sickness or pregnancy. When required by law, out-of-network air ambulance services will be treated as in-network.
	<a href="#">Urgent care</a>	\$10 copay / visit (Northwell Direct); \$20 copay / visit (Anthem); <u>deductible</u> does not apply	20% coinsurance	When required by law, out-of-network emergency services provided at urgent care facilities licensed in the state to provide emergency care will be treated as in-network.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge; <u>deductible</u> does not apply	20% coinsurance	Must pre-certify or coverage could be reduced.

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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)	
	Physician/surgeon fees	\$10 physician copay / date of service (Northwell Direct); \$20 physician copay / date of service (Anthem); \$20 surgeon copay / date of service (Northwell Direct); \$30 surgeon copay / date of service (Anthem); <u>deductible</u> does not apply	20% coinsurance	When required by law, out-of-network physician/surgeon fees will be treated as in-network.
<b>If you need mental health, behavioral health, or substance use disorder services</b>	Outpatient services	Office visits: \$20 copay / visit; <u>deductible</u> does not apply Other services: No charge; <u>deductible</u> does not apply	20% coinsurance	None
	Inpatient services	No charge; <u>deductible</u> does not apply	20% coinsurance	None
<b>If you are pregnant</b>	Office visits	\$30 copay / first visit only; <u>deductible</u> does not apply	20% coinsurance	Must pay copayment for non-routine lab tests during doctor visits; <u>cost sharing</u> does not apply for <u>preventive services</u> ; depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply; maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
	Childbirth/delivery professional services	\$30 copay / delivery; <u>deductible</u> does not apply	20% coinsurance	Must pre-certify or coverage could be reduced.
	Childbirth/delivery facility services	No charge; <u>deductible</u> does not apply	20% coinsurance	Must pre-certify or coverage could be reduced; <u>out-of-network</u> birthing center facilities are not covered.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge; <u>deductible</u> does not apply	20% coinsurance	Limited to 200 4-hour visits per person per calendar year (in-network and out-of-network combined); must pre-certify or coverage could be lost.
	<a href="#">Rehabilitation services</a>	No charge inpatient; \$20 copay / visit outpatient; <u>deductible</u> does not apply	20% coinsurance	Limited to 60 days inpatient and 30 days outpatient per person (in-network and out-of-network combined) per calendar year; must pre-certify or coverage could be lost.
	<a href="#">Habilitation services</a>	\$20 copay / visit; <u>deductible</u> does not apply	20% coinsurance	Limited to 30 outpatient facility visits per person per calendar year (in-network and

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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)	
				out-of-network combined) for occupational, speech or vision therapy; must pre-certify or coverage could be lost.
	<a href="#">Skilled nursing care</a>	No charge; <u>deductible</u> does not apply	Not covered	Limited to 120 days per calendar year; for medical care, nursing care or rehabilitation services; Must pre-certify or coverage could be lost; referral required.
	<a href="#">Durable medical equipment</a>	\$20 copay / purchase; <u>deductible</u> does not apply	20% coinsurance	Must pre-certify if in excess of \$1,000 or coverage could be lost.
	<a href="#">Hospice services</a>	No charge; <u>deductible</u> does not apply	20% coinsurance	Limited to 210 days per lifetime; must pre-certify or coverage could be lost.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge; <u>deductible</u> does not apply	No charge	Limited to one exam per calendar year; limited to a maximum of \$150 out-of-network for eye exam and glasses combined.
	Children's glasses	No charge; <u>deductible</u> does not apply	No charge	Limited to a maximum of \$150 out-of-network per calendar year for eye exam and glasses combined.
	Children's dental check-up	Not Covered	Not Covered	Service not covered.

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## Excluded Services & Other Covered Services:

**Services Your [Plan](#) Generally Does NOT Cover (This is not a complete list. Check your policy or plan document for more information and a list of any other [excluded services](#).)**

- Bariatric surgery – unless medically necessary and pre-certified
- Cosmetic surgery – unless medically necessary and pre-certified
- Dental Care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot 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 when performed by an M.D.
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing but only in conjunction with organ and tissue transplant; limited to \$5,000; must be provided on an outpatient basis by a registered nurse or licensed practical nurse.
- 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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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: (516) 488-2822 or (718) 343-3322 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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:

Spanish (Español): Para obtener asistencia en Español, llame al (516) 488-2822.

*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 Anthem in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0
- Anthem [Specialist copay](#) \$30
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$160
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$220</b>

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

- The [plan's](#) overall [deductible](#) \$0
- Anthem [Specialist copay](#) \$30
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

**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>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$290
<b>The total Joe would pay is</b>	<b>\$1,090</b>

- The [plan's](#) overall [deductible](#) \$0
- Anthem [Specialist copay](#) \$30
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$370
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$370</b>

Note: The amounts under "Patient pays" assume that for prescriptions, a 90-day supply is ordered via mail order.

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

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