
 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. 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: |
|---|---|--|
| What is the overall deductible? | \$400 person / \$800 family (out-of-network only) per calendar year. | 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. Services provided by a network provider are covered before you meet your deductible . | The plan covers network services even if you haven't met the deductible amount. But a copayment or coinsurance may apply. You will have to meet the deductible before the plan pays for any out-of-network 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | Yes. \$50 person / \$150 family for dental services (out-of-network only) per calendar year. There are no other specific deductibles . | 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? | For network providers and out-of-network providers \$9,200 person / \$18,400 family per calendar year. | 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? | Balance-billed charges, penalties for failure to pre-certify services, 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 https://ciipa.northwell.edu/providers/northwell-direct-search/ for a list of Northwell Direct network providers or www.bcbs.com or call 1-800-810-2583 for a list of Anthem network providers . | This plan uses the Anthem Blue Cross Network ("Anthem") and Northwell Direct Network as its medical provider networks . You will pay less if you use an Anthem provider and, generally, even less if you use a Northwell Direct provider. 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. |

| Important Questions | Answers | Why This Matters: |
|--|---------|--|
| 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 | \$10 copay / visit (Northwell Direct); \$20 copay / visit (Anthem); deductible does not apply | 20% coinsurance | None; 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. |
| | Specialist visit | \$20 copay / visit (Northwell Direct); \$30 copay / visit (Anthem); deductible does not apply | 20% coinsurance | |
| | Preventive care/screening/immunization | No charge; deductible does not apply | Not covered | |
| If you have a test | Diagnostic test (x-ray, blood work) | \$10 copay / visit (Northwell Direct); \$20 copay / visit (Anthem); deductible does not apply | 20% coinsurance | 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); deductible 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. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.unifiedlaborrx.com | Generic drugs and generic specialty drugs | \$10 copay / prescription (retail); \$20 copay / prescription (mail order); deductible does not apply | Not covered | Covers up to 30-day supply (retail); up to 90-day supply (mail order); mail order is limited to maintenance medication; drugs specified in plan document must be preauthorized or coverage could be lost. |
| | Preferred brand drugs and preferred brand specialty drugs | \$20 copay / prescription (retail); \$40 copay / prescription (mail order); deductible does not apply | Not covered | |
| | Non-preferred brand drugs and non-preferred brand specialty drugs | | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge; deductible does not apply | 20% coinsurance | Must pre-certify or coverage could be reduced. |

| 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 | \$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. |
| If you need immediate medical attention | Emergency room care | \$100 copay / emergency room visit; <u>deductible</u> does not apply | \$100 copay / emergency room visit; <u>deductible</u> does not apply | Not covered unless for emergency—see page 52 of plan document. |
| | Emergency medical transportation | \$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. |
| | Urgent care | \$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. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge; <u>deductible</u> does not apply | 20% coinsurance | Must pre-certify or coverage could be reduced. |
| | 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. |
| If you need mental health, behavioral health, or substance use disorder services | Outpatient services | Office visits: \$20 copay / visit; deductible does not apply Other services: No charge; deductible does not apply | 20% coinsurance | None |
| | Inpatient services | No charge; <u>deductible</u> does not apply | 20% coinsurance | None |
| If you are pregnant | 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 |

| 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) | |
| | | | | 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. |
| If you need help recovering or have other special health needs | Home health care | 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. |
| | Rehabilitation services | 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. |
| | Habilitation services | \$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 out-of-network combined) for occupational, speech or vision therapy; must pre-certify or coverage could be lost. |
| | Skilled nursing care | 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. |
| | Durable medical equipment | \$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. |
| | Hospice services | No charge; <u>deductible</u> does not apply | 20% coinsurance | Limited to 210 days per lifetime; must pre-certify or coverage could be lost. |
| | If your child needs dental or eye care | Children's eye exam | No charge; <u>deductible</u> does not apply | No charge |

| 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 glasses | No charge; <u>deductible</u> does not apply | No charge | Limited to a maximum of \$150 out-of-network for eye exam and glasses combined per calendar year. |
| | Children's dental check-up | No charge; <u>deductible</u> does not apply | No charge | \$50 individual and \$150 family deductible per calendar year for out-of-network provider. |

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
- 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
- Chiropractic care
- Dental care (Adult)
- Hearing aids (limited to active members only, not dependents)
- 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. 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: (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.

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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

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 |
| The total Peg would pay is | \$220 |

Managing Joe's type 2 Diabetes

(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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

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 |
| The total Joe would pay is | \$1,090 |

Mia's Simple Fracture

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

- 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

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 |
| The total Mia would pay is | \$370 |

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