This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.local99healthandwelfarefund.org or by calling 973-735-6464.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs. For services the plan covers.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	No	There is no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This plan has no **out-of-pocket limit**.	Not applicable because there's no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* coverage services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.anthem.com or call 1-800-810-2583.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	Not covered	No hospital based/owned clinics.
	Specialist visit	$20 copay/visit	Not covered	No hospital based/owned clinics.
	Other practitioner office visit	$10 copay/visit chiropractor	Not covered	Limited to 30 visits per year. Pre-certification required, if not, services not covered or not paid in full.
	Preventive care/screening/immunization	No charge	Not covered	--------------------none--------------------
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	Must be performed at a free-standing facility, unless medically necessary.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	Must be performed at a free-standing facility, unless medically necessary. Pre-certification required, if not, services not covered or not paid in full.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.benecard.com or 973-735-6464	Generic drugs	$3 copay (retail) $10 copay(mail order)	Not covered	No copay if enrolled in diabetic disease management program. Limited to antibiotics, cough/cold meds & painkillers. 14-day supply, limited to 2X per drug every 6 months. Mandatory Generic if available (retail) 90 –day supply (mail order). Non-prescription OTC drugs not covered. Non-preferred brand name drugs are covered, if medically necessary.(retail and mail order)
	Preferred brand drugs	$10 copay (retail) $15 copay (mail order)	Not covered	
	Non-preferred brand drugs	$15 copay (retail and mail order)	Not covered	
	Specialty drugs	Most specialty drugs covered under the medical at no charge.		Prior Authorization is required.

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	Pre-certification required, if not, services not covered or not paid in full.
	Physician/surgeon fees	10% coinsurance	Not covered	---------------------none---------------------
If you need immediate medical attention	Emergency room services	$50 copay/visit	20% co-insurance	$100 copay, if admitted.
	Emergency medical transportation	No charge	No charge	Limited to $750 per occurrence.
	Urgent care	$20 copay/visit	Not covered	---------------------none---------------------
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay	Not covered	Limited to 120 days per occurrence. Pre-certification required, if not, services not covered or not paid in full.
	Physician/surgeon fee	10% coinsurance	Not covered	---------------------none---------------------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copay/visit	Not covered	Limited to 30 visits per year. Pre-certification required, if not, services not covered or not paid in full.
	Mental/Behavioral health inpatient services	$100 copay	Not covered	Limited to 120 days per occurrence. Pre-certification required, if not, services not covered or not paid in full.
	Substance use disorder outpatient services	$10 copay/visit	Nor covered	Limited to 30 visits per year Pre-certification required, if not, services not covered or not paid in full.
	Substance use disorder inpatient services	$100 copay	Not covered	Limited to 120 days per occurrence. Pre-certification required, if not, services not covered or not paid in full.
If you are pregnant	Prenatal and postnatal care	$20 copay initial visit	Not covered	Normal delivery covered up to 48 hours, Cesarean section covered up to 96 hours. Pre-certification required if stay is beyond 48/96 hours, if not, services not covered or not paid in full.
	Delivery and all inpatient services	10% coinsurance	Not covered	

If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Limited to 90 visits per year. Pre-certification required, if not, services not covered or not paid in full.
	Rehabilitation services	No charge	Not covered	Limited to 30 days as in-patient per year. Limited to 30 out-patient visits per year. Pre-certification required, if not, services not covered or not paid in full.
	Habilitation services	Not covered	Not covered	---------------------none---------------------
	Skilled nursing care	No charge	Not covered	Limited to 30 days per year. Pre-certification required, if not, services not covered or not paid in full.
	Durable medical equipment	10% coinsurance	Not covered	Pre-certification required in excess of $1,000, if not, services not covered or not paid in full.
	Hospice service	No charge	Not covered	Pre-certification required, if not, services not covered or not paid in full.
If your child needs dental or eye care	Eye exam	No charge	Not covered	Limited to one eye exam per year.
	Glasses	No charge	Charges in excess of $200	Limited to one pair of glasses every two years.
	Dental check-up	Not covered	Not covered	Coverage may be available under your dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult), Coverage may be available under your dental plan.
- Habilitation Services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric surgery. Pre-certification required. Failure to pre-cert may result in services not covered or not paid in full.
- Chiropractic care limited to 30 visits per year, in-network only. Pre-certification required. Failure to pre-cert may result in services not covered or not paid in full.
- Most coverage provided outside the United States. See www.BCBS.com/bluecardworldwide.
- Routine eye care (Adult), limited to one exam per year. Eye glassed limited to $200 every two years.
- Routine foot care covered for diabetics only
- Weight loss programs, as described in the Federal Preventive Guidelines

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the Plan Administrator at 973-735-6464. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the Plan Administrator at 973-735-6464 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This Plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-related coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard". **This health coverage does meet the minimum value standard for the benefit it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 973-735-6464

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,220
- **Patient pays** $320

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$160
Coinsurance	$160
Limits or exclusions	$0
Total	**$320**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact the Plan Administrator at 973-735-6464.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,110
- **Patient pays** $290

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$80
Coinsurance	$210
Limits or exclusions	$0
Total	**$290**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact the Plan Administrator at 973-735-6464.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.