

 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, [insert contact information]. 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.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). To obtain more detail or a copy of the complete terms of coverage call 973-735-6464 or [www.local99healthandwelfarefund.org](http://www.local99healthandwelfarefund.org).


Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0 In-Network	Generally, you must pay all of the costs from providers 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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. 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="#">deductible</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Not Applicable	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Not Applicable	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
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 1-800-810-2583 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	\$20 <a href="#">copay</a> /office visit	Not Covered	No coverage for hospital based/owned clinics.
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> /visit	Not Covered	No coverage for hospital based/owned clinics.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	Not Covered	Must be performed at a free-standing facility, unless medically necessary. <a href="#">Preauthorization</a> is required for CT/PETS scans, MRIs. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	Not Covered	
<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.benecard.com">www.benecard.com</a>	Generic drugs	\$3 <a href="#">copay</a> (retail) \$10 <a href="#">copay</a> (mail order)	Not Covered	Non-prescription OTC drugs not covered. Non-preferred brand name drugs are covered, if medically necessary. (retail and mail order) <b>Retail:</b> 14-day supply, limited to 2X per drugs every 6 mos. Mandatory Generic if available. (retail) <b>Mail Order:</b> 90-day supply <b>Specialty Drugs:</b> <a href="#">Preauthorization</a> is required. Not covered at retail. No copay charge if enrolled in diabetic disease management program.
	Preferred brand drugs)	\$10 <a href="#">copay</a> (retail) \$15 <a href="#">copay</a> (mail order)	Not Covered	
	Non-preferred brand drugs	\$15 <a href="#">copay</a> (retail and mail order)	Not Covered	
	<a href="#">Specialty drugs</a>	\$10 <a href="#">copay</a> (mail order)	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	Not Covered	No coverage for out-of-network hospitals. <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	Not Covered	Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as anesthesia). Check with your <a href="#">provider</a> before you get services. <a href="#">Preauthorization</a> is required.

 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 need immediate medical attention	<a href="#">Emergency room care</a>	\$50 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a>	Emergency copay is waived if admitted. Emergency medical transportation: \$750 limit per occurrence.
	<a href="#">Emergency medical transportation</a>	No Charge	No Charge	
	<a href="#">Urgent care</a>	\$20 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <a href="#">copay</a>	Not Covered	120 days limit per occurrence. <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	Not Covered	Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as anesthesia). Check with your <a href="#">provider</a> before you get services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <a href="#">copay</a> /office visit	Not Covered	<b>Outpatient services:</b> 30 visits limit per year. <b>Inpatient services:</b> 120 days limit per occurrence. <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	Inpatient services	\$100 <a href="#">copay</a>	Not Covered	
If you are pregnant	Office visits	\$20 <a href="#">copay</a> initial visit	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Normal delivery covered up to 48 hours, Cesarean section covered up to 96 hours. <a href="#">Preauthorization</a> is required if stay is beyond 48 / 96 hours. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	Not Covered	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	Not covered	

 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 need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	Not Covered	90 visits limit per year. <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	<a href="#">Rehabilitation services</a>	Inpatient / No charge Out-patient / \$10 <a href="#">copay</a> / visit	Not Covered	<b>Inpatient services:</b> 30 days limit per year. Includes physical therapy, speech therapy, occupational therapy and cardiac rehabilitation. <b>Outpatient services:</b> 30 visits limit per year. Includes physical therapy, speech therapy, occupational therapy and cardiac rehabilitation. <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	<a href="#">Habilitation services</a>	Not Covered	Not Covered	<b>Habilitation services:</b> None
	<a href="#">Skilled nursing care</a>	No Charge	Not Covered	30 days limit per year. <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required in excess of \$1000 or any rentals. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	<a href="#">Hospice services</a>	No Charge	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service or denied as not covered.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	One exam year.
	Children's glasses	No Charge	Charges in excess of \$200	One pair of glasses every two years up to \$200.
	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
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric Surgery, [Preauthorization](#) is required. If you don't get [preauthorization](#), benefits could be reduced by 50% of the total cost of the service or denied as not covered.
- Chiropractic Care, 30 visits limit per year, in-network only. [Preauthorization](#) is required. If you don't get [preauthorization](#), benefits could be reduced by 50% of the total cost of the service or denied as not covered.
- Routine eye care (Adult), one exam limit per year. Eye Glasses 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:** 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 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa). You may also contact your Plan Administrator at 973-735-64. 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: 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](http://www.dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? **Yes.**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet 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 973-735-6464

————— *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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	\$0
■ Other <a href="#">coinsurance</a>	\$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>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$120
Coinsurance	\$780
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$900</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	\$0
■ Other <a href="#">coinsurance</a>	\$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>\$7,500</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$0
Copayments	\$160
Coinsurance	\$68
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$228</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	\$0
■ Other <a href="#">coinsurance</a>	\$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>\$520</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$0
Copayments	\$210
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$210</b>

Note: Managing Joe's type 2 Diabetes: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: <http://alicare.personaladvantage.com>.