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 (914) 737-7220. 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 (914) 737-7220 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers: $250 individual / $625 family. Deductible applies for each calendar year (January 1 – December 31)	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. In-network: primary care, specialist office visits, preventive care, emergency/urgent care, home health care, prescription drugs, vision and certain outpatient rehabilitation services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Medical network providers: $3,500 individual / $8,750 family; Prescription drugs: $3,520 individual / $8,800 family. Out-of-pocket limits apply for each calendar year (January 1 – December 31)	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?	Penalties for failure to obtain preauthorization for services, premiums, balance-billing charges, vision benefits 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 1-844-241-7089 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 full cost if you use an out-of-network provider. 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	$20 copay/office visit; deductible does not apply	Not covered	Medications administered in office: For network providers: 10% coinsurance after deductible; For out-of-network providers: Not covered.
	Specialist visit	$40 copay/visit; deductible does not apply Acupuncture: 10% coinsurance Outpatient hospital: 10% coinsurance Chiropractor: $40 copay/visit; deductible does not apply	Not covered	Medications administered in office: For network providers: 10% coinsurance after deductible; For out-of-network providers: Not covered
	Preventive care/screening/ immunization	No charge; deductible does not apply	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)	10% coinsurance	Not covered	Preauthorization required. Failure to obtain preauthorization may result in a 50% benefit reduction up to $5,000.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.OptumRx.com or by calling (866) 863-1408	Generic drugs	20% coinsurance; deductible does not apply	20% coinsurance plus amount over Average Wholesale Price; deductible does not apply	The deductible does not apply. Your cost sharing for these benefits count toward the plan's out-of-pocket limit for prescription drugs. No charge for generic contraceptives or other generic ACA-required preventive drugs (or for brand if the generic is not medically appropriate). Retail: 31-day supply. Mail-order: 90-day supply. Mail-order drugs should be ordered from OptumRx Mail Order. Your provider may fax prescriptions to 1-800-491-7997. For questions, call 1-877-889-6358. Preauthorization is required for some drugs in order to be covered. No coverage for non-formulary drugs. Specialty drugs must be ordered through BriovaRx Pharmacy. Your provider may fax prescriptions to 1-877-342-4596 or they may be sent electronically via escripts. For questions, call 1-855-427-4682.
	Preferred brand drugs	20% coinsurance; deductible does not apply	20% coinsurance plus amount over Average Wholesale Price; deductible does not apply	
	Non-preferred brand drugs	20% coinsurance; deductible does not apply	20% coinsurance plus amount over Average Wholesale Price; deductible does not apply	
	Specialty drugs	20% coinsurance; deductible does not apply No charge for certain generic specialty drugs.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	Failure to obtain preauthorization may result in a 50% benefit reduction up to $5,000.
	Physician/surgeon fees	10% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	$200 copay/visit; deductible does not apply	$200 copay/visit; deductible does not apply	Copay waived if admitted to hospital within 24 hours. Professional/physician charges may be billed separately
	Emergency medical transportation	10% coinsurance	Not covered	None.
	Urgent care	$35 copay/visit; deductible does not apply	Not covered	None.

* For more information about limitations and exceptions, see the plan or policy document at www.local21union.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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	Failure to obtain preauthorization may result in a 50% benefit reduction up to $5,000.
	Physician/surgeon fees	10% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Freestanding facility and Outpatient hospital services: 10% coinsurance; Office visit: $20 copay/visit, deductible does not apply.	Not covered	Preauthorization required for intensive outpatient, partial hospitalization and inpatient hospital services. Failure to obtain preauthorization may result in a 50% benefit reduction up to $5,000. No preauthorization required for outpatient office visits.
	Inpatient services	10% coinsurance	Not covered	
If you are pregnant	Office visits	10% coinsurance	Not covered	Cost-sharing does not apply for in-network preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% coinsurance	Not covered	
	Childbirth/delivery facility services	10% coinsurance	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 least)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance; deductible doesn't apply	Not covered	Limited to 200 visits per year.
	Rehabilitation services	Outpatient: $40 copay, deductible does not apply. Inpatient: 10% coinsurance	Not covered	Outpatient: Limited to 30 visits per year Inpatient: Limited to 30 days per year. Failure to obtain preauthorization for all inpatient physical therapy, occupational, and speech therapy admissions may result in a 50% benefit reduction up to $5,000. All habilitation visits count toward rehabilitation visit limit.
	Habilitation services	10% coinsurance	Not covered	
	Skilled nursing care	10% coinsurance	Not covered	Limited to 60 days per year. Failure to obtain preauthorization may result in a 50% benefit reduction up to $5,000.
	Durable medical equipment	10% coinsurance	Not covered	Failure to obtain preauthorization may result in a 50% benefit reduction up to $5,000.
	Hospice services	10% coinsurance	Not covered	Limited to 365 days per lifetime; 5 visits for family bereavement counseling.
If your child needs dental or eye care	Children's eye exam	Vision Network: Amount over $125 Plan allowance (combined with glasses) Vision Resource: $5 copay.	Amount over $50 Plan allowance.	Eye exam and lenses limited to once per year. Frames limited to once every two years. Active participants may also get one pair of Safety Glasses per year. Vision Resource: Eye Exam: In-network: $10 copay for new patients. Lenses: In-network: $5 copay/bifocals or $110 copay/progressives Vision benefits administered separately by Vision Resources and Vision Network. The deductible does not apply. Your cost sharing for these benefits is not included in the plan's out-of-pocket limit. Out-of-Network reimbursement based on Vision Resource schedule.
	Children's glasses	Vision Network: Amount over $125 Plan allowance (combined with eye exam) Vision Resource: Amount over $100 Plan allowance for frames and $1 copay/single vision lenses.	Amount over $100 Plan allowance for frames and amount over $29 Plan allowance for single vision lenses.	
	Children's dental check-up	Not covered	Not covered	You must pay 100% of these expenses.

* For more information about limitations and exceptions, see the plan or policy document at www.local21union.com.

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.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Private-duty nursing
- 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
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Long-term care (subject to Plan criteria)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)

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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. For more information on your rights to continue coverage, you may also contact the plan at (914) 737-7220. 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 on how 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 at (914) 737-7220. You may also contact 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 1-800-662-5193.

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

* For more information about limitations and exceptions, see the plan or policy document at www.local21union.com.

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 in-network 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	**$250**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$250
Copayments	$0
Coinsurance	$1,230
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,540**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$250**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$120
Copayments	$160
Coinsurance	$860
What isn't covered	
Limits or exclusions	$250
The total Joe would pay is	**$1,390**

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

The plan's overall deductible	**$250**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$250
Copayments	$520
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$850**

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