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, go to www.local807benefits.org or call (718) 274-5353. 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 or call (718) 274-5353 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network Medical and Hospital: $0 Out-of-Network Medical: $250 Individual / $750 Family Deductible applies for period 1/1 – 12/31 of each year.	In-Network Medical and Hospital: See the Common Medical Events chart below for your costs for services this plan covers. Out-of-Network Medical: 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?	In-Network Medical and Hospital: Not Applicable. Out-of-Network Medical: Yes. Emergency services and prescription drugs are covered before you meet your deductible.	In-Network Medical and Hospital: This plan does not have an in-network deductible. Out-of-Network Medical: This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. For a list of In-Network hospital providers see www.anthem.com or call 1-844-241-7089. For a list of In-Network medical providers see www.magnacare.com or call 1-800-235-7330.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. 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.
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 out-of-network medical **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	$15 copay/visit	30% coinsurance	Services not covered when furnished in a clinic. Limited to one specialist consultation per specialty every six months. Acupuncture and Chiropractic care: Limited to 30 visits/calendar year.
	Specialist visit	$15 copay/visit Acupuncture and Chiropractic care: $15 copay/visit	30% coinsurance	
	Preventive care/screening/ immunization	$15 copay/visit	30% coinsurance	Limited to one physical exam per calendar year. Fees for administration of vaccines and preventive injections not covered.
If you have a test	Diagnostic test (x-ray, blood work)	No charge at MagnaCare lab	30% coinsurance	Diagnostic tests and imaging must be furnished at a MagnaCare diagnostic lab to be covered In-Network. Services furnished elsewhere covered Out-of-Network.
	Imaging (CT/PET scans, MRIs)	No charge at MagnaCare lab	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.expressscripts.com	Generic drugs	Retail: $15 copay/prescription; Mail Order: $30 copay/ prescription	Retail: $15 copay/ prescription plus difference between in-network rate and out-of-network charges; Mail Order: Not covered	Deductible does not apply. Participating Retail: Up to a 90-day supply; Nonparticipating Retail: Up to a 30-day supply; Mail Order: Up to a 90-day supply Preventive vaccinations are covered with $0 cost-sharing. Drugs used to treat mental/behavioral health and substance use disorders: $5 copay/prescription. If you purchase a brand drug when a generic
	Preferred brand drugs	Retail: $25 copay/ prescription; Mail Order: $50 copay/ prescription	Retail: $25 copay/ prescription plus difference between in-network rate and out-of-network charges; Mail Order: Not covered	
	Non-preferred brand drugs	Retail: $50 copay/ prescription; Mail Order: $100 copay/ prescription	Retail: $50 copay/ prescription plus difference between in-network rate and out-of-network charges; Mail Order: Not covered	

* For more information about limitations and exceptions, see the plan or policy document

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)	
	Specialty drugs	Otherwise applicable copay depending on whether drug is generic, preferred brand name, non-preferred brand name.	Otherwise applicable copay depending on whether drug is generic, preferred brand name, non-preferred brand name.	alternative is available, you pay the applicable brand copay plus the difference in cost between the generic alternative and the brand name drug. Erectile dysfunction prescriptions are limited to 6 pills per month and subject to preauthorization. Standard copays for FDA-approved contraceptives. Six-month limit for habit-forming analgesics. Not all prescription drugs are covered by the Plan. *See the Prescription Drug section of the SPD.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Out-of-Network facility fees not covered.
	Physician/surgeon fees	No charge	30% coinsurance	None.
If you need immediate medical attention	Emergency room care	Facility fee: $100 copay/visit; Physician fees: No charge	Facility fee: $100 copay/visit; Physician fees: No Charge.	Copay waived if admitted to the hospital within 24 hours. If facility fee is not covered, professional fees are paid like an office visit.
	Emergency medical transportation	No charge	Amount over $500/ground transport	None.
	Urgent care	$15 copay/visit	30% coinsurance	Freestanding facility only. Services not covered when furnished at an outpatient hospital clinic.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Failure to precertify services will result in a benefit reduction of $100 per day up to $300. Out-of-Network facility fees not covered.
	Physician/surgeon fees	No charge	30% coinsurance	Limited to one visit per day per specialty.

* For more information about limitations and exceptions, see the plan or policy document

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 mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: $15 copay/visit; Other outpatient services: No charge Substance abuse: No charge.	Office visit: 30% coinsurance; Other outpatient services: Not covered Substance abuse: 30% coinsurance	Out-of-Network facility fees not covered.
	Inpatient services	No charge	Facility fee: Not covered; Physician: 30% coinsurance	Failure to precertify services will result in a benefit reduction of $100 per day up to $300. Out-of-Network facility fees not covered.
If you are pregnant	Office visits	$15 copay for first visit, no charge for follow-up visits.	30% coinsurance	None
	Childbirth/delivery professional services	No charge	30% coinsurance	
	Childbirth/delivery facility services	No charge	Not covered	Out-of-network facility fees not covered.
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Failure to precertify services will result in a benefit reduction of $100 per day up to $300 or denial of claim. Limited to 200 visits per calendar year. Up to four hours of care is equal to one visit. Out-of-Network services not covered.
	Rehabilitation services	Office visit: $15 copay/visit; Outpatient facility: No charge; Inpatient facility: No charge	Office visit: 30% coinsurance Outpatient facility: Not covered; Inpatient facility: Not covered	Failure to precertify outpatient occupational, speech, vision and respiratory therapies and cardiac rehab will result in a benefit reduction of $100 per day up to $300 or denial of claim. Outpatient occupational, speech and vision therapies limited to 30 visits per calendar. Outpatient kinetic and opthoptic therapies limited to 18 visits per calendar year. Outpatient physical therapy not covered. Inpatient services must be precertified with hospital admission. Inpatient physical therapy limited to 30 days per calendar year.
	Habilitation services	Not covered	Not covered	You must pay 100% of these expenses, even In-Network.

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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)	
	Skilled nursing care	No charge	Not covered	Failure to precertify services will result in a benefit reduction of $100 per day up to $300. Limited to 60 days per calendar year. Out-of-Network services not covered.
	Durable medical equipment	No charge	After hospitalization: Not covered; All other times: 30% coinsurance	Precertification required. Replacements not covered except for medically necessary prosthetic leg limited to 1 every 5 years with a $100,000 lifetime maximum.
	Hospice services	No charge	Not covered	Failure to precertify services will result in a benefit reduction of $100 per day up to $300. Limited to 210 days per lifetime. Out-of-Network services not covered.
If your child needs dental or eye care	Children's eye exam	No charge	Balances over $25 Plan allowance	Vision benefits are separately administered by Davis Vision. Limited to one eye exam and one pair of glasses once every 12-month period. Coverage can be declined by contacting Fund Office.
	Children's glasses	No charge	Balances over $75 Plan allowance	
	Children's dental check-up	No charge	Balances over Plan allowance	Dental benefits are separately administered by Delta Dental. Limited to 2 check-ups and $3,000 per individual per calendar year. Coverage can be declined by contacting Fund Office.

* For more information about limitations and exceptions, see the plan or policy document

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 (Except when medically necessary)
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

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

- Acupuncture (Limited to 30 visits/calendar year)
- Bariatric surgery (Precertification required)
- Chiropractic care (Limited to 30 visits/calendar year)
- Dental care (Adult) (Limited to $3,000/calendar year)
- Hearing aids (Limited to $500 per ear/every 3 years)
- Infertility treatment (Limited to $10,000/lifetime)
- Routine eye care (Adult) (Limited to one eye exam and one complete pair of glasses once every 12-month period)
- Routine foot care (Limited to 4 visits/calendar year; In-office surgery limited to $1,000/calendar year)

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. 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 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 Administrator at (718) 274-5353. 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 1-718-274-5353.

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

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 plan's overall deductible	**$0**
Specialist copay	**$15**
Hospital (facility) cost sharing	**$0**
Other cost sharing diagnostic test	**$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:

Cost Sharing	
Deductibles	$0
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$100**

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

The plan's overall deductible	**$0**
Specialist copay	**$15**
Hospital (facility) cost sharing	**$0**
Other cost sharing diagnostic test	**$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:

Cost Sharing	
Deductibles	$0
Copayments	$1,080
Coinsurance	$0
What isn't covered	
Limits or exclusions	$120
The total Joe would pay is	**$1,200**

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

The plan's overall deductible	**$0**
Specialist copay	**$15**
Hospital (facility) cost sharing	**$0**
Other cost sharing diagnostic test	**$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:

Cost Sharing	
Deductibles	$0
Copayments	$170
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$230**

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