




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 973-735-6464. 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 973-735-6464 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$0 In-Network \$150 Out-Of-Network Individual \$300 Out-Of-Network Family	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers. .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	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.
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductible</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	Not Applicable.	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Not Applicable.	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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	\$10 <a href="#">copay</a> /office visit	20% <a href="#">coinsurance</a>	No coverage for hospital based/owned clinics.
	<a href="#">Specialist</a> visit	\$10 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	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)	No charge	20% <a href="#">coinsurance</a>	Out of Network Hospital Not Covered. <a href="#">Preauthorization</a> is required for CT/PETS, 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)	No charge	20% <a href="#">coinsurance</a>	
<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	\$10 <a href="#">copay</a> (retail) \$20 <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> 34-day supply, 3 fills maintenance medication must be obtained through mail order. <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 the diabetic disease management program.
	Preferred brand drugs	\$20 <a href="#">copay</a> (retail) \$40 <a href="#">copay</a> (mail order)	Not Covered	
	Non-preferred brand drugs	\$30 <a href="#">copay</a> (retail) \$60 <a href="#">copay</a> (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)	No charge	20% <a href="#">coinsurance</a>	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	No charge	20% <a href="#">coinsurance</a>	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.

\*For more information about limitations and exceptions, see the [plan](#) or policy document at [www.local99healthandwelfarefund.org](http://www.local99healthandwelfarefund.org)

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>	\$10 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	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	No charge	20% <a href="#">coinsurance</a>	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 service.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <a href="#">copay</a> /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	No charge	Not Covered	
If you are pregnant	Office visits	\$10 <a href="#">copay</a> initial visit only	20% <a href="#">coinsurance</a>	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	No charge	20% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	No charge	Not Covered	

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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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	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. <b>Habilitation services:</b> None
	<a href="#">Habilitation services</a>	Not Covered	Not Covered	
	<a href="#">Skilled nursing care</a>	No charge	Not Covered	30 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="#">Durable medical equipment</a>	No charge	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required in excess of \$1,000 or for 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.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Not covered	One exam per year.
	Children's glasses	Charges in excess of \$200	Charges in excess of \$200	One pair of glasses ever two years up to \$200.
	Children's dental check-up	Not covered	Not covered	None

\*For more information about limitations and exceptions, see the [plan](#) or policy document at [www.local99healthandwelfarefund.org](http://www.local99healthandwelfarefund.org)

## 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/healthreform](http://www.dol.gov/healthreform). You may also contact your Plan Administrator at 973-735-6464. 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.**

[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 [premium tax credit](#).

**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.*

\*For more information about limitations and exceptions, see the [plan](#) or policy document at [www.local99healthandwelfarefund.org](http://www.local99healthandwelfarefund.org)

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 copayment](#) \$10
- 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** \$12,686

**In this example, Peg would pay:**

Cost Sharing	
Deductibles	\$0
Copayments	\$20
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$660
<b>The total Peg would pay is</b>	<b>\$680</b>

**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 copayment](#) \$10
- 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** \$5,601

**In this example, Joe would pay:**

Cost Sharing	
Deductibles*	\$0
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$260
<b>The total Joe would pay is</b>	<b>\$560</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$10
- 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:**

Cost Sharing	
Deductibles*	\$0
Copayments	\$100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$190
<b>The total Mia would pay is</b>	<b>\$290</b>

Note: 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. Additional information regarding the wellness program can be found at [begin.livongo.com/LOCAL99](http://begin.livongo.com/LOCAL99)