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. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact the Local 282 Welfare Trust Fund at (516) 488-2822 or (718) 343-3322 or visit our website at www.teamsterslocal282.com. 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 (516) 488-2822 or (718) 343-3322 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$400 person / $800 family (out-of -network only) per calendar year.	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. Services provided by a network provider are covered before you meet your deductible.	The plan covers network services even if you haven't met the deductible amount. But a copayment or coinsurance may apply. You will have to meet the deductible before the plan pays for any out-of-network services. 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, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For network providers and out-of-network providers $9,100 person / $18,200 family per calendar year.	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?	Balance-billed charges, penalties for failure to pre-certify services, 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.bcbs.com or call 1-800-810-2583 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 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 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 / visit; deductible does not apply	20% coinsurance	None; 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.
	Specialist visit	$30 copay / visit; deductible does not apply	20% coinsurance	
	Preventive care/screening/ immunization	No charge; deductible does not apply	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	$20 copay / visit; deductible does not apply	20% coinsurance	The Network co-payment is $40 if the test can be performed by a Quest Diagnostics lab in New York or a LabCorp lab in New Jersey but you go to another Network lab in either state. When required by law, out-of-network diagnostic tests will be treated as in-network.
	Imaging (CT/PET scans, MRIs)	$20 copay/ visit; deductible does not apply	20% coinsurance	Must pre-certify MRI/MRA or coverage could be lost. When required by law, out-of-network imaging will be treated as in-network.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carelonrx.com	Generic drugs and generic specialty drugs	Up to $4,000: $10 copay / prescription (retail); $20 copay / prescription (mail order; 20% coinsurance thereafter	Not covered	20% coinsurance applies after plan expenditures reach $4,000; Covers up to 30-day supply (retail); up to 90-day supply (mail order); mail order is limited to maintenance medication; specified drugs must be preauthorized or coverage could be lost.
	Preferred brand drugs and preferred brand specialty drugs	Up to $4,000: $10 copay / prescription (retail); $20 copay / prescription (mail order; 20% coinsurance thereafter	Not covered	
	Non-preferred brand drugs and non-preferred brand specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge; deductible does not apply	20% coinsurance	Must pre-certify or coverage could be reduced.

* For more information about limitations and exceptions, call (516) 488-2822 or (718) 343-3322 or see the plan document at www.teamsterslocal282.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)	
	Physician/surgeon fees	$30 surgeon copay / date of service; deductible does not apply	20% coinsurance	When required by law, out-of-network physician/surgeon fees will be treated as in-network.
If you need immediate medical attention	Emergency room care	$100 copay /emergency room visit; deductible does not apply	20% coinsurance	Not covered unless for emergency—see page 57 of plan document; in-network copay waived if admitted to hospital; benefits may be reduced if not authorized within 48 hours. When required by law, out-of-network emergency room care will be treated as in-network.
	Emergency medical transportation	$20 copay / incident; deductible does not apply	20% coinsurance	Coverage limited to the first trip to and from a hospital for any one injury, sickness or pregnancy. When required by law, out-of-network air ambulance services will be treated as in-network.
	Urgent care	$20 copay / visit; deductible does not apply	20% coinsurance	When required by law, out-of-network emergency services provided at urgent care facilities licensed in the state to provide emergency care will be treated as in-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge; deductible does not apply	20% coinsurance	Must pre-certify or coverage could be reduced.
	Physician/surgeon fees	$20 physician copay / date of service; $30 surgeon copay / date of service; deductible does not apply	20% coinsurance	When required by law, out-of-network physician/surgeon fees will be treated as in-network.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $20 copay / visit; deductible does not apply Other services: No charge; deductible does not apply	20% coinsurance	None
	Inpatient services	No charge; deductible does not apply	20% coinsurance	None
If you are pregnant	Office visits	$30 copay / first visit only; deductible does not apply	20% coinsurance	Must pay copayment for non-routine lab tests during doctor visits; cost sharing does not apply for preventive services; depending on the type of services, a copayment,

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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)	
				coinsurance, or deductible may apply; maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
	Childbirth/delivery professional services	$30 copay / delivery; deductible does not apply	20% coinsurance	Must pre-certify or coverage could be reduced.
	Childbirth/delivery facility services	No charge; deductible does not apply	20% coinsurance	Must pre-certify or coverage could be reduced; out-of-network birthing center facilities are not covered.
If you need help recovering or have other special health needs	Home health care	No charge; deductible does not apply	20% coinsurance	Limited to 200 4-hour visits per person per calendar year (in-network and out-of-network combined); must pre-certify or coverage could be lost.
	Rehabilitation services	No charge inpatient; $20 copay / visit outpatient; deductible does not apply	20% coinsurance	Limited to 60 days inpatient and 30 days outpatient per person (in-network and out-of-network combined) per calendar year; must pre-certify or coverage could be lost.
	Habilitation services	$20 copay / visit; deductible does not apply	20% coinsurance	Limited to 30 outpatient facility visits per person per calendar year (in-network and out-of-network combined) for occupational, speech or vision therapy; must pre-certify or coverage could be lost.
	Skilled nursing care	No charge; deductible does not apply	Not covered	Limited to 120 days per calendar year; for medical care, nursing care or rehabilitation services; Must pre-certify or coverage could be lost; referral required.
	Durable medical equipment	$20 copay / purchase; deductible does not apply	20% coinsurance	Must pre-certify if in excess of $1,000 or coverage could be lost.
	Hospice services	No charge; deductible does not apply	20% coinsurance	Limited to 210 days per lifetime; must pre-certify or coverage could be lost.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	No charge	Limited to one exam per calendar year; limited to a maximum of $150 out-of-network for eye exam and glasses combined.

* For more information about limitations and exceptions, call (516) 488-2822 or (718) 343-3322 or see the plan document at www.teamsterslocal282.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)	
	Children's glasses	No charge; deductible does not apply	No charge	Limited to a maximum of $150 out-of-network per calendar year for eye exam and glasses combined.
	Children's dental check-up	Not Covered	Not Covered	Service not covered.

* For more information about limitations and exceptions, call (516) 488-2822 or (718) 343-3322 or see the plan document at www.teamsterslocal282.com

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (This is not a complete list. Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery – unless medically necessary and pre-certified
- Cosmetic surgery – unless medically necessary and pre-certified
- Dental Care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- 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 when performed by an M.D.
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing but only in conjunction with organ and tissue transplant; limited to $5,000; must be provided on an outpatient basis by a registered nurse or licensed practical nurse.
- Routine eye care (Adult)

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 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 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: (516) 488-2822 or (718) 343-3322 or 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 (516) 488-2822.

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, call (516) 488-2822 or (718) 343-3322 or see the plan document at www.teamsterslocal282.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 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	$30
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$160
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$220**

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	$30
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$290
The total Joe would pay is	**$1,090**

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

The plan's overall deductible	$0
Specialist copay	$30
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	$370
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$370**

Note: The amounts under "Patient pays" assume that for prescriptions, a 90-day supply is ordered via mail order.

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