




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, 1-800-522-0456. 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 1-800-522-0456 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-Network: \$100/person; \$200/family, Out-of-Network: \$500/person; \$1,000/family, per calendar year; medical benefits only	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, the overall deductible must be met before the plan begins to pay. The deductible applies to medical benefits only.
Are there services covered before you meet your deductible ?	Yes In-Network Preventive care	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 ?	In-Network: Medical: \$1,100/person; \$2,200/family. Rx: \$400/person; \$800/family. Out-of-Network: Medical: \$2,900/person; \$5,900/family. Rx: \$1,100/person; \$2,100/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on the plan, the overall family out-of-pocket limit must be met before the plan begins to pay.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, 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 1-800-810-BLUE 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. Balance billing does not apply to services protected by the Federal "No Surprises Act".
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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copayment</u>	30% <u>coinsurance</u> of <u>UCR</u> , plus <u>balance billing</u> , where applicable.	Telephonic and video physician visits are covered through Anthem LiveHealth OnLine only. <u>Copayment</u> does not apply.
	<u>Specialist</u> visit	\$40 <u>copayment</u>	30% <u>coinsurance</u> of <u>UCR</u> , plus <u>balance billing</u> , where applicable.	
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply	30% <u>coinsurance</u> of <u>UCR</u> , plus <u>balance billing</u> , where applicable.	None
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	30% <u>coinsurance</u> of <u>UCR</u> , plus <u>balance billing</u> , where applicable.	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	30% <u>coinsurance</u> of <u>UCR</u> , plus <u>balance billing</u> , where applicable.	<u>Preauthorization</u> required. Failure may result in a denial or penalty of 50% up to \$500.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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.Express-Scripts.com	Generic drugs	Retail: 20% up to \$10; Mail: 20% up to \$20	Same as In-network , plus balance billing , where applicable.	Retail limited to 34-day supply; mail order limited to 90-day supply. You may obtain a brand name medication when a generic equivalent is available, you pay the generic coinsurance plus the difference between the cost of the brand name drug and the generic. Utilization Management Program in effect. Preauthorization required for some drugs. Failure to do so may result in a denial of benefits. For more information contact Express Scripts, Inc. at 1-877-861-8145. Specialty drugs must be filled through Accredo, an Express Scripts, Inc. specialty pharmacy. For more information regarding the SaveOnSP program, please contact SaveOnSP at 1-800-683-1074 or the UFCW Local 1500 Welfare Fund at (516) 214-1337/(516) 214-1336.
	Preferred brand drugs	Retail: 20% up to \$25; Mail: 20% up to \$50	Same as In-network , plus balance billing , where applicable.	
	Non-preferred brand drugs	Retail: 20% up to \$50; Mail: 20% up to \$100	Same as In-network , plus balance billing , where applicable.	
	Specialty drugs	Same as non-preferred brand drugs. Drugs covered under SaveOnSP: Enrolled in program: No charge. Not enrolled in program: 30% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Preauthorization required for certain services. Failure may result in a denial or penalty of 50% up to \$500.
	Physician/surgeon fees	20% coinsurance	30% coinsurance of UCR , plus balance billing , where applicable.	
If you need immediate medical attention	Emergency room care	\$100 facility copayment , plus copays or 20% coinsurance (medical services)	\$100 facility copayment , plus copays or 20% coinsurance (medical services)	Facility Copayment waived if admitted. Limited to initial visit for Emergency Medical Conditions as defined by the Summary Plan Description.
	Emergency medical transportation	20% coinsurance	20% coinsurance up to allowed amount , balance billing where applicable.	If air ambulance, medical condition must warrant air ambulance services. Out-of-network air ambulance is paid the same as In-network .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	\$20 copayment	30% coinsurance of UCR , plus balance billing , where applicable.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered except in emergencies. Emergency: 20% coinsurance	Preauthorization required. Failure may result in a denial or penalty of 50% up to \$500. Semi-private room and board allowed only.
	Physician/surgeon fees	20% coinsurance	30% coinsurance of UCR , plus balance billing , where applicable. Emergency: 20% coinsurance	Preauthorization required for certain services. Failure may result in a denial or penalty of 50% up to \$500.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copayment	30% coinsurance of UCR , plus balance billing , where applicable.	Telephonic and video physician visits are covered. Copayment does not apply to Anthem LiveHealth OnLine visits only.
	Inpatient services	20% coinsurance	Mental health, behavioral health services: Not covered Substance abuse services: 30% coinsurance of UCR , plus balance billing , where applicable. Emergency: 20% coinsurance	Residential mental health or substance abuse treatment is limited to sixty days per calendar year in a non-hospital setting In-Network only. Out-of Network: coverage for Substance Abuse only. Preauthorization required. Failure may result in a denial or penalty of 50% up to \$500. Semi-private room and board allowed only.
If you are pregnant	Office visits	\$20 copayment	30% coinsurance of UCR , plus balance billing , where applicable.	Cost sharing does not apply to certain preventive services . Depending on the type of service, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance of UCR , plus balance billing , where applicable. Emergency: 20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	20% coinsurance	Not covered. Emergency: 20% coinsurance	Preauthorization should be obtained within first 3 months of pregnancy, but not required.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance of UCR , plus balance billing , where applicable.	In-Network – 200 visits/year. Out-of-Network – 40 visits/year. Preauthorization required. Failure may result in a denial or penalty of 50% up to \$500.
	Rehabilitation services	20% coinsurance	30% coinsurance of UCR , plus balance billing , where applicable.	30 visits/year for both In and Out-of-Network services combined for each therapeutic category inclusive of physical, speech, occupational and orthoptic therapies.
	Habilitation services	20% coinsurance	30% coinsurance of UCR , plus balance billing , where applicable.	Preauthorization required. Failure may result in a denial or penalty of 50% up to \$500.
	Skilled nursing care	20% coinsurance	Not covered	60 days/year. Preauthorization required. Failure may result in a denial or penalty of 50% up to \$500.
	Durable medical equipment	20% coinsurance	30% coinsurance of UCR , plus balance billing , where applicable.	Preauthorization required. Failure may result in a denial or penalty of 50% up to \$500.
	Hospice services	20% coinsurance	Not covered	210 days per lifetime. Preauthorization required. Failure may result in a denial or penalty of 50% up to \$500.
If your child needs dental or eye care	Children's eye exam	See the Plan's vision/dental Fee Schedule to find your cost for specific services	See the Plan's vision/dental Fee Schedule to find your cost for specific services	None
	Children's glasses			
	Children's dental check-up			

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 .)		
<ul style="list-style-type: none">• Cosmetic Surgery	<ul style="list-style-type: none">• Infertility Treatment• Long-term care	<ul style="list-style-type: none">• 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.)		
<ul style="list-style-type: none">• Acupuncture (if prescribed for rehabilitation purposes)• Bariatric Surgery	<ul style="list-style-type: none">• Chiropractic care• Dental care (Adult)• Hearing Aids (\$2,500/Lifetime exclusively through Start Hearing only)	<ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.• Private-duty nursing (Out-of-Network Only)• 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: U.S. Department of Labor 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 the [plan](#) at 1-800-522-0456. 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](#) for a month, [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 1-800-522-0456 Ext. 1336

—————*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 [plan's](#) overall [deductible](#) \$100
- [Specialist \[copayment\]](#) \$40
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 20%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$10
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$1,110

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist \[copayment\]](#) \$40
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 20%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$600
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$40
The total Joe would pay is	\$840

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist \[copayment\]](#) \$40
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 20%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$200
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$700