This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at by calling the Building Trades Welfare Benefit Fund at 516-833-9300 or 877-347-7225.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For participating providers, **$0**. For non-participating providers, **$100** Individual / **$250** Family annually for Major Medical benefits, $0 for Basic benefits. Does not apply to balance billing, coinsurance, vision and dental benefits.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
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 your costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$5,000**.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Deductibles, penalties for failure to obtain pre-authorization for services, premiums, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **participating providers** see BlueCross BlueShield's website at **www.Anthem.com** or call directly at **1-800-810-BLUE (2583)** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-444-EBSA (3272) to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay / visit	After a basic plan benefit of $40/visit up to $1,250/year, deductible & 20% coinsurance	The out-of-network basic plan benefit limits are aggregated among all categories of outpatient visits.
	Specialist visit			
	Other practitioner office visit			
	Preventive care/screening/immunization	No charge	Balance billing	Coverage for immunizations is limited to children up to age 19.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	After a basic plan benefit of $750/year, deductible & 20% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling 1-800-872-8276 or at the website www.americanhealthcare.com. For mail order, contact 1-800-881-1966 or visit www.mycatamaranRx.com.	Generic drugs	$3 copay / prescription (at retail & mail order)	Not covered	Coverage is limited to a 90-day supply per copay. Coverage of certain medications may require pre-authorization, and coverage of certain medications may be subject to step therapy, quantity limits, or may be excluded. Contact American Health Care at 1-800-872-8276 for specific details.
	Brand name drugs	$8 copay / prescription (at retail & mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Balance billing	Pre-authorization is required by calling 1-866-457-9882. Failure to pre-authorize will result in a penalty of $200.
	Physician/surgeon fees	No charge	After a basic plan benefit of $2,000/surgical procedure and $150/procedure for additional surgical opinions, deductible & 20% coinsurance	The out-of-network basic plan benefit includes all surgical procedures. Pre-authorization is required by calling 1-866-457-9882. Failure to pre-authorize will result in a penalty of $200.
If you need immediate medical attention	Emergency room services	No charge	Balance billing	——————none——————
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$15 copay / visit	After a basic plan benefit of $40/visit up to $1,250/year, deductible & 20% coinsurance	The out-of-network basic plan benefit limits are aggregated among all categories of outpatient visits.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Balance billing for first 120 days, then next 180 days at 50% coinsurance	Pre-authorization is required by calling 1-866-457-9882. Failure to pre-authorize will result in a penalty of $200.
	Physician/surgeon fee	No charge	After a basic plan benefit of $2,000/surgical procedure and $150/procedure for additional surgical opinions, deductible & 20% coinsurance	The out-of-network basic plan benefit includes all surgical procedures. Pre-authorization is required by calling 1-866-457-9882. Failure to pre-authorize will result in a penalty of $200.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copay / visit	After a basic plan benefit of $40/visit up to $1,250/year, deductible & 20% coinsurance	The out-of-network basic plan benefit limits are aggregated among all categories of outpatient visits.
	Mental/Behavioral health inpatient services	No charge	Balance billing for first 120 days, then next 180 days at 50% coinsurance	Pre-authorization is required by calling 1-866-457-9882. Failure to pre-authorize will result in a penalty of $200.
	Substance use disorder outpatient services	$15 copay / visit	After a basic plan benefit of $40/visit up to $1,250/year, deductible & 20% coinsurance	The out-of-network basic plan benefit limits are aggregated among all categories of outpatient visits.
	Substance use disorder inpatient services	No charge	Balance billing for first 120 days, then next 180 days at 50% coinsurance	Pre-authorization is required by calling 1-866-457-9882. Failure to pre-authorize will result in a penalty of $200.
If you are pregnant	Prenatal and postnatal care	No charge	After a basic plan benefit of $2,000/procedure, deductible & 20% coinsurance (Balance billing for inpatient services)	Coverage is limited to member & spouse only. The out-of-network basic plan benefit includes all surgical procedures. Pre-authorization is required by calling 1-866-457-9882. Failure to pre-authorize will result in a penalty of $200.
	Delivery and all inpatient services			

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	25% coinsurance	Coverage is limited to 40 visits (1 visit = 4 hours) in 12 consecutive months.
	Rehabilitation services	$15 copay / visit	20% coinsurance	Coverage is limited to 30 days per calendar year. Pre-authorization is required by calling 1-866-457-9882. Failure to pre-authorize will result in a penalty of $200.
	Habilitation services	Not covered	Not covered	——————none——————
	Skilled nursing care	No charge	20% coinsurance	Coverage is limited to 30 days per calendar year. Pre-authorization is required by calling 1-866-457-9882. Failure to pre-authorize will result in a penalty of $200.
	Durable medical equipment	10% coinsurance	20% coinsurance	Pre-authorization is required by calling 1-866-457-9882. Failure to pre-authorize will result in a penalty of $200.
	Hospice service	Not covered	Not covered	——————none——————
If your child needs dental or eye care	Eye exam	No charge	Balance billing	Coverage is limited to one exam and one pair of prescribed lenses and frames in a 12-month period; $250 annual maximum for individuals over age 26.
	Glasses			
	Dental check-up	No charge	Balance billing	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Habilitation services
- Hospice service
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

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Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture	• Bariatric Surgery	• Chiropractic care
• Dental care (Adult)	• Hearing Aids	• Infertility treatment
• Private-duty nursing	• Routine eye care (Adult)	• Routine foot care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 516-833-9300 or 877-347-7225. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Building Trades Welfare Benefit Fund, 825 East Gate Boulevard Suite 102, Garden City, NY 11530. Telephone: 516-833-9300 or 877-347-7225. The Fund office hours are 9:00 A.M. to 5:00 P.M.. You may also contact the Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.com. Additionally, a consumer assistance program can help you file your appeal. Contact the Community Service Society of New York, Community Health Advocates at 105 East 22nd Street, 8th floor, New York, NY 10010, 1-888-614-5400 or http://www.communityhealthadvocates.org.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services / Servicios de acceso lingüístico:

Para obtener asistencia en español, llame al 516-833-9300 o 877-347-7225.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,360
- **Patient pays:** $180

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$30
Coinsurance	$0
Limits or exclusions	$150
Total	**$180**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $5,010
- **Patient pays:** $390

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$350
Coinsurance	$0
Limits or exclusions	$40
Total	**$390**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.