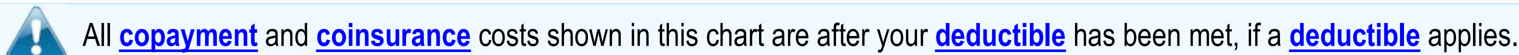
Building Trades Welfare Benefit Fund: Plan E

Coverage for: Individual and Family | Plan Type: PPO

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 the Building Trades Welfare Benefit Fund at **1-516-833-9300** or **1-877-347-7225**. 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 **1-877-347-7225** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers: $0. For out-of-network providers $100 Individual / $250 Family for Major Medical benefits, $0 for Basic benefits.	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, all prescription drug, vision, dental benefits, preventive care and all services with network providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. 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?	For out-of-network providers only, $5,000 in covered charges per individual.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Deductibles, penalties for failure to obtain preauthorization for services, premiums, balance-billing charges, in-network 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 (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	No charge	After a basic plan benefit of $40/visit up to $1,250/year, deductible & 20% coinsurance, and balance billing	The out-of-network basic plan benefit limits are aggregated among all categories of outpatient visits.
	Specialist visit			
	Preventive care/screening/ immunization	No charge	Balance billing	Coverage for immunizations is limited to children up to age 19. 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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	After a basic plan benefit of $750/year, deductible & 20% coinsurance, and balance billing*	*To the extent required by law, certain out-of-network services performed at in-network facilities may be covered as in-network services without any balance billing.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-800-872-8276 or www.maxorplus.com. For mail order, contact Maxor at 1-800-687-8629.	Generic drugs	No charge (at retail & mail order)	Not covered	Coverage is limited to a 90-day supply per copay. Coverage of certain medications may require preauthorization, and coverage of certain medications may be subject to step therapy, quantity limits, or may be excluded. Contact Maxor Pharmacy at 1-800-872-8276 for specific details.
	Preferred brand drugs	No charge (at retail & mail order)	Not covered	
	Non-preferred brand drugs			
	Specialty drugs			

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Balance billing	The out-of-network basic plan benefit includes all surgical procedures. Preauthorization is required for non-emergency services by calling 1-866-457-9882. If you don't obtain preauthorization, a penalty of $200 will be imposed. *To the extent required by law, certain out-of-network services may be covered as in-network services without any balance billing.
	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, and balance billing*	
If you need immediate medical attention	Emergency room care	No charge	No charge	None
	Emergency medical transportation	No charge	No charge	None
	Urgent care	No charge	$15 copay / visit except for emergency services for which there is no charge	None
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 and balance billing	The out-of-network basic plan benefit includes all surgical procedures. Preauthorization is required for non-emergency services by calling 1-866-457-9882. If you don't get preauthorization, a penalty of $200 will be imposed. *To the extent required by law, certain out-of-network services may be covered as in-network services without any balance billing
	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, and balance billing*	

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	No charge	After a basic plan benefit of $40/visit up to $1,250/year, deductible & 20% coinsurance, and balance billing	The out-of-network basic plan benefit limits are aggregated among all categories of outpatient visits.
	Inpatient services	No charge	Balance billing for first 120 days, then next 180 days at 50% coinsurance and balance billing*	Preauthorization is required for non-emergency service by calling 1-866-457-9882. If you don't obtain preauthorization, a penalty of $200 will be imposed. *To the extent required by law, certain out-of-network services performed at in-network facilities may be covered as in-network services without any balance billing.
If you are pregnant	Office visits	No charge	After a basic plan benefit of $40/visit up to $1,250/year, deductible & 20% coinsurance, and balance billing	The out-of-network basic plan benefit limits are aggregated among all categories of outpatient visits.
	Childbirth/delivery professional services	No charge	After a basic plan benefit of $2,000/ procedure, deductible & 20% coinsurance, and balance billing	Coverage limited to member & spouse only, except to the extent required under the preventive care rules. The out-of-network basic plan benefit includes all surgical procedures. Preauthorization is required for non-emergency services by calling 1-866-457-9882. If you don't obtain preauthorization, a penalty of $200 will be imposed.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	No charge	25% coinsurance and balance billing	Coverage is limited to 40 visits (1 visit = 4 hours) in 12 consecutive months.
	Rehabilitation services	No charge	20% coinsurance and balance billing	Without a Referral Coverage up to 10 visits during 30-day period, one time per calendar year. After 10 visits, you must receive pre-authorization for any further therapy sessions to be covered. With a Referral

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)	
				Coverage up to 12 visits within a 6-week period per injury or procedure per calendar year. For more than 12 visits, you should seek pre-authorization as soon as possible to avoid lapses in treatment by calling 1-866-457-9882. If you don't get preauthorization, a penalty of $200 will be imposed.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	No charge	20% coinsurance and balance billing	Coverage is limited to 30 days per calendar year. Preauthorization is required by calling 1-866-457-9882. If you don't get preauthorization, a penalty of $200 will be imposed.
If you need help recovering or have other special health needs	Durable medical equipment	No charge	20% coinsurance and balance billing	Preauthorization is required by calling 1-877-347-7225. If you don't obtain preauthorization, a penalty of $200 will be imposed.
	Hospice services	Not covered	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Balance billing	Coverage is limited to one exam and one pair of prescribed lenses and frames each calendar year, with a $350 annual maximum benefit for individuals over age 26.
	Children's glasses			
	Children's dental check-up	No charge	Balance billing	None

* To the extent required under the federal No Surprises Act, out-of-network provider services will be covered at the copay applicable to in-network provider services, and balance billing will not apply.

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• 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: 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. The contact information for the plan is: Building Trades Welfare Benefit Fund, 585 Stewart Avenue, Suite 330, Garden City, NY 11530, telephone: 516-833-9300 or 877-347-7225. 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: Building Trades Welfare Benefit Fund, 585 Stewart Avenue, Suite 330, 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-EBSA (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 plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes employer sponsored 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:
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 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** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) copayment** **$0**
- **Generic drugs copayment** **$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	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

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

- **The plan's overall deductible** **$0**
- **Primary care copayment** **$0**
- **Diagnostic testing copayment** **$0**
- **Preferred brand drugs copayment** **$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	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$0**

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

- **The plan's deductible** **$0**
- **Physical therapy copayment** **$0**
- **Emergency room copayment** **$0**
- **Durable medical equipment 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	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

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