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 United Workers Health Fund Office at **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: None. For out-of-network providers $500 per individual.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes, prescription drug, vision and dental benefits, and 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.
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 prescription drugs, $300 per individual per calendar year, and for other network providers, $6,050 individual / $12,400 family.	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?	Out-of-network services, balance-billing charges, penalties for failure to obtain preauthorization for services, premiums, 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. Visit Empire / Anthem's website at **www.Anthem.com** or call directly at **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	$10 copay/ office visit	30% coinsurance	None
	Specialist visit	$15 copay/ office visit; $30 copay/ visit for chiropractic services	30% coinsurance	Coverage for chiropractic services is limited to ten (10) visits per calendar year.
	Preventive care/screening/ immunization	No charge	30% coinsurance	Coverage is limited to one general medical exam each calendar year, plus recommended screenings and immunizations. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$15 copay/ test	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$75 copay/ test	30% coinsurance	Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization, your claim can be denied.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling; Retail provider: Broadreach Medical Resources (BMR) at 1-866-718-2375.	Generic drugs	$10 copay/ prescription	Not covered	Coverage is limited to a 30-day supply maximum per copay for prescriptions filled at a retail pharmacy and a 90-day supply maximum for mail order.
	Preferred brand drugs	$20 copay/ prescription		
	Non-preferred brand drugs	$35 copay/ prescription		
	Specialty drugs	50% coinsurance		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay	30% coinsurance	Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization, your claim can be denied.
	Physician/surgeon fees	$15 copay	30% coinsurance	

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	Emergency room care	$200 copay / visit	$200 copay / visit and balance billing	Copay waived if admitted.
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	$50 copay / visit	$50 copay / visit and balance billing	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay / stay	30% coinsurance	Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization, your claim can be denied.
	Physician/surgeon fees	$15 copay		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	None
	Inpatient services			
If you are pregnant	Office visits	$10 copay for the first office visit	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	$15 copay	30% coinsurance	Coverage is limited to member and spouse only. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization, your claim can be denied.
	Childbirth/delivery facility services	$250 copay / stay	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Must follow a hospital confinement. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization, your claim can be denied.
	Rehabilitation services	$25 copay/ visit	30% coinsurance	All outpatient physical therapy visits are limited to twenty (20) visits per calendar year, and all other therapies are limited to twenty (20) visits per calendar year combined.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	$250 copay	30% coinsurance	Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization, your claim can be denied.

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 help recovering or have other special health needs	Durable medical equipment	Not covered	Not covered	None
	Hospice services	$250 copay and 30% coinsurance	$500 copay and 30% coinsurance	Coverage limited to 90 days per lifetime. Preauthorization is required by calling 1-866-317-5386. If you don't get preauthorization, your claim can be denied.
If your child needs dental or eye care	Children's eye exam	No charge	Balance billing	Coverage is limited to one exam and basic frames & lenses every twelve (12) months, and for individuals over age 18, limited to a $75 allowance every twelve (12) months.
	Children's glasses			
	Children's dental check-up	No charge	Not covered	Coverage is limited to $1,000 per family member per calendar year for charges incurred for individuals over age 18.

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
- Bariatric surgery
- Cosmetic surgery
- Durable medical equipment
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Mental/behavioral health services
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Substance abuse services
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Dental care (adult)
- Private-duty nursing (covered only in lieu of inpatient stay and preauthorization required)
- 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. The contact information for the plan is United Workers Health Fund, 50 Charles Lindbergh Blvd., Suite 207, Uniondale, NY 11553, telephone: 1-877-347-7225. 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: United Workers Health Fund, 50 Charles Lindbergh Blvd., Suite 207, Uniondale, NY 11553, telephone: 1-877-347-7225. 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.**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-877-347-7225.

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
Diagnostic test copayment	$15
Hospital (facility) copayment	$250
Surgery copayment	$15

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$520
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$580**

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	$10
Diagnostic test copayment	$15
Branded drugs copayment	$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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,360
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,420**

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

The plan's overall deductible	$0
Emergency room (facility) copayment	$200
Ambulance coinsurance	30%
Physical therapy copayment	$25

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$390
Coinsurance	$230
What isn't covered	
Limits or exclusions	$40
The total Mia would pay is	**$660**

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