



Why dThe 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, contact Local 306 TEHF Member Services at 888/993-8806 or 306@bpidocs.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 www.dol.gov/ebsa/healthreform or call 888/993-8806 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Not Applicable.	This <u>plan</u> does not have an overall <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Not Applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Not Applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
Will you pay less if you use a <u>network provider</u> ?	Not Applicable.	This <u>plan</u> does not use a <u>provider network</u> . You can receive covered services from any <u>provider</u> .
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	First home or office visit: Amount over \$35 <u>Plan</u> allowance; All other visits: Amount over \$25 <u>Plan</u> allowance	The Medical Expense Benefit (doctors' visits) covers visits to and by doctors, chiropractors, acupuncturists (with physician referral) and licensed psychotherapists for medical care required by an injury or sickness, but not while confined to a hospital. *See the description of the Medical Expense Benefit in the Summary <u>Plan</u> Description. Exclusions: Visits for x-ray examination or laboratory tests, except in connection with a second surgical opinion; visits made in a hospital or a convalescent nursing home; and certain visits made in connection with a surgical procedure. See the EmblemHealth SBC for additional coverage information.
	<u>Specialist</u> visit	First home or office visit: Amount over \$35 <u>Plan</u> allowance; All other visits: Amount over \$25 <u>Plan</u> allowance	
	<u>Preventive care/screening/immunization</u>	Not covered	You must pay 100% of these expenses. See the EmblemHealth SBC for additional coverage information.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Amount over reasonable and customary charges and/or over <u>Plan</u> allowance of \$100 per visit not otherwise payable under the EmblemHealth Benefits	*See the description of the X-ray and Lab Tests Benefit in the Summary <u>Plan</u> Description.
	Imaging (CT/PET scans, MRIs)	Amount over reasonable and customary charges and/or over <u>Plan</u> allowance of \$100 per visit not otherwise payable under the EmblemHealth Benefits	
If you need drugs to treat your illness or condition	Generic drugs	Not covered	You must pay 100% of these expenses. See the EmblemHealth SBC for additional coverage information.
	Brand drugs	Not covered	
	<u>Specialty drugs</u>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	You must pay 100% of these expenses. See the EmblemHealth SBC for additional coverage information.
	Physician/surgeon fees	Amount over <u>Plan</u> allowance of \$2,500 for each day of surgery	*Surgical benefits are payable up to the amount listed in the Surgical Procedure Reimbursement Schedule set forth in the Summary <u>Plan</u> Description.

* For more information about limitations and exceptions, see the SPD or plan document.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
<p>If you need immediate medical attention</p>	<p><u>Emergency room care</u></p>	<p>Professional fees: Amount over <u>Plan</u> allowance of \$50 (for professional fees) per treatment Facility fees: Not covered</p>	<p>Professional fees: *See the description of the Emergency Accident and Acute Illness Benefit in the Summary <u>Plan</u> Description.</p> <p>Facility fees: You pay 100% of these expenses. See the EmblemHealth SBC for additional coverage information for facilities.</p>
	<p><u>Emergency medical transportation</u></p>	<p>Amount over <u>Plan</u> allowance of \$2,400 per hospital stay</p>	<p>Where not covered by EmblemHealth, the <u>Plan</u> pays for <u>medically necessary</u> expenses incurred for <u>medically necessary</u> local ambulance services and administration of anesthesia by a physician. *See the description of Local Ambulance and Anesthesia benefit in the Summary <u>Plan</u> Description.</p> <p>See the EmblemHealth SBC for additional coverage information.</p>
	<p><u>Urgent care</u></p>	<p>First visit: Amount over \$35 <u>Plan</u> allowance; All other visits: Amount over \$25 <u>Plan</u> allowance</p>	<p>The Medical Expense Benefit (doctors' visits) covers visits to and by doctors, chiropractors, acupuncturists (with physician referral) and licensed psychotherapists for medical care required by an injury or sickness, but not while confined to a hospital. *See the description of the Medical Expense Benefit in the Summary <u>Plan</u> Description.</p> <p>Exclusions: Visits for x-ray examination or laboratory tests, except in connection with a second surgical opinion; visits made in a hospital or a convalescent nursing home; and certain visits made in connection with a surgical procedure.</p> <p>See the EmblemHealth SBC for additional coverage information.</p>

* For more information about limitations and exceptions, see the SPD or plan document.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	You must pay 100% of these expenses. See the EmblemHealth SBC for additional coverage information.
	Physician/surgeon fees	<p>Doctor visit: Amount over <u>Plan</u> allowance of \$25 per day for the first through 60th day in the hospital, up to a maximum of \$750 per stay. Specialist consultations:</p> <p>For a consultation not requiring a completed physical exam: Amount over <u>Plan</u> allowance of \$35 per day; For a consultation requiring a complete physical exam: Amount over <u>Plan</u> allowance of \$50 per day; Surgeons fees: Amount over <u>Plan</u> allowance</p>	<p>The hospital medical expense benefit covers visits made by doctors during a hospital confinement. Visits made on or after the day a surgical procedure is performed are excluded. The surgical expense benefit will be paid when a doctor performs a covered surgical procedure.</p> <p>*Surgical benefits are payable up to the amount listed in the Surgical Procedure Reimbursement Schedule set forth in the Summary <u>Plan</u> Description. Maximum payment (for each date of surgery) is \$2,500.</p>
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<p>Office visits: First home or office visit: Amount over \$35 <u>Plan</u> allowance; All other visits: Amount over \$25 <u>Plan</u> allowance; Other outpatient/facility fee: Not covered</p>	<p>Office visits: The medical expense benefit (doctors' visits) covers visits to/by doctors, chiropractors, acupuncturists (with physician referral) and licensed psychotherapists for medical care required by an injury or sickness, but not while confined to a hospital. *See the description of the Medical expense Benefit in the Summary <u>Plan</u> Description. Exclusions: Visits for x-ray examination or laboratory tests, except in connection with a second surgical opinion; visits made in a hospital or a convalescent nursing home; and certain visits made in connection with a surgical procedure.</p> <p>Other outpatient/facility fees: You must pay 100% of these expenses. See the EmblemHealth SBC for additional coverage information.</p>
	Inpatient services	<p>Doctor visit: Amount over <u>Plan</u> allowance of \$25 per day for the first through 60th day in the hospital, up to a maximum of \$750 per stay; Specialist consultations:</p> <p>For a consultation not requiring a completed physical exam: Amount over <u>Plan</u> allowance of \$35 per day; For a consultation requiring a completed physical exam: Amount over <u>Plan</u> allowance of \$50 per day; Facility fees: Not covered</p>	<p>Facility fees: You must pay 100% of these expenses. See the EmblemHealth SBC for additional coverage information.</p> <p>The hospital medical expense benefit covers visits made by doctors during a hospital confinement.</p>

* For more information about limitations and exceptions, see the SPD or plan document.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	First home or office visit: Amount over \$35 <u>Plan</u> allowance; All other visits: Amount over \$25 <u>Plan</u> allowance	<p>You may have to pay extra for services billed separately from a prenatal or postnatal office visit. The medical expense benefit (doctors' visits) covers visits to and by doctors, chiropractors, acupuncturists (with physician referral) and licensed psychotherapists for medical care required by an injury or sickness, but not while confined to a hospital. *See the description of the Medical expense Benefit in the Summary <u>Plan</u> Description.</p> <p>Exclusions: Visits for x-ray examination or laboratory tests, except in connection with a second surgical opinion; visits made in a hospital or a convalescent nursing home; and certain visits made in connection with a surgical procedure.</p>
	Childbirth/delivery professional services	Doctor visit: Amount over <u>Plan</u> allowance of \$25 per day for the first through 60th day in the hospital, up to a maximum of \$750 per stay; Specialist consultations: For a consultation not requiring a completed physical exam: Amount over <u>Plan</u> allowance of \$35 per day; For a consultation requiring a complete physical exam: Amount over <u>Plan</u> allowance of \$50 per day; Surgeons fees: Amount over <u>Plan</u> allowance.	<p>The hospital medical expense benefit covers visits made by doctors during a hospital confinement. Visits made on or after the day a surgical procedure is performed are excluded. The surgical expense benefit will be paid when a doctor performs a covered surgical procedure.</p> <p>*Surgical benefits are payable up to the amount listed in the Surgical Procedure Reimbursement Schedule. Maximum payment (for each date of surgery) is \$2,500.</p>
	Childbirth/delivery facility services	Not covered	You must pay 100% of these expenses. See the EmblemHealth SBC for additional coverage information.

* For more information about limitations and exceptions, see the SPD or plan document.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
<p>If you need help recovering or have other special health needs</p>	<p><u>Home health care</u></p>	<p>75% <u>coinsurance</u></p>	<p>Limited to 40 visits per <u>Plan</u> Year. Each visit by a member of a <u>home health care</u> team other than a home health aide is counted as one visit. Each four hours served by a home health aide is considered one visit. The home health care expense benefit also covers physical, occupational and speech therapy by a qualified therapist as well as medical supplies and drugs prescribed by a doctor.</p> <p>See the EmblemHealth SBC for additional coverage information.</p>
	<p><u>Rehabilitation services</u></p>	<p>Not covered</p>	<p>You must pay 100% of these expenses. See the EmblemHealth SBC for additional coverage information.</p>
	<p><u>Habilitation services</u></p>	<p>Not covered</p>	
	<p><u>Skilled nursing care</u></p>	<p>Not covered</p>	
	<p><u>Durable medical equipment</u></p>	<p>Not covered</p>	<p>You must pay 100% of these expenses.</p>
<p><u>Hospice services</u></p>	<p>Not covered</p>	<p>You must pay 100% of these expenses. See the EmblemHealth SBC for additional coverage information.</p>	
<p>If your child needs dental or eye care</p>	<p>Children's eye exam</p>	<p>Amount over \$300 <u>Plan</u> allowance combined with glasses</p>	<p>Vision benefits must be separately elected. Prescribed eyeglasses and related services may be obtained through Comprehensive Professional Systems, Inc. (CPS), General Vision Services, Inc. (GVS) or another <u>provider</u> of your choice. Limited to once per <u>Plan</u> Year for eye exam and/or glasses combined.</p>
	<p>Children's glasses</p>	<p>Amount over \$300 <u>Plan</u> allowance combined with eye exam</p>	
	<p>Children's dental check-up</p>	<p>Not covered</p>	<p>You must pay 100% of these expenses.</p>

* For more information about limitations and exceptions, see the SPD or plan document.

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.)

- Bariatric surgery
- Childbirth/delivery facility services
- Cosmetic surgery
- Dental care (Adult and Child)
- Drugs
- Durable medical equipment
- Facility fee (Ambulatory Surgery Center)
- Facility fee (Hospital Room)
- Habilitation services
- Hearing aids
- Hospice services
- Long-term care
- Mental health, behavioral health, or substance abuse services (Inpatient and Outpatient facility fees)
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Preventive care/screening/immunization
- Private-duty nursing
- Rehabilitation services
- Routine foot care
- Skilled nursing 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 (if prescribed by a physician)
- Chiropractic care
- Infertility treatment (benefits for doctors' services for the treatment of infertility limited to \$2,500/year and up to \$10,000/lifetime; diagnosis of infertility not covered by Plan)
- Routine eye care (Adult) (limited to \$300 once per Plan Year for eye exam and/or glasses combined)

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 on how 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: Local 306 Theatrical Employees Health Fund, PO Box 17928, Los Angeles CA 90017-0928 or call 888/993-8806 or e-mail: 306@bpidocs.com. 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 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; this health coverage, together with the Insured EmblemHealth Policy and Health Benefits, meet the Minimum Value Standards.**

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 1-646-380-8510.

—————*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)	Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)
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- **The plan's overall deductible** \$0
- **Specialist cost sharing** Balances over \$35
- **Hospital (facility) cost sharing** Not covered
- **Other cost sharing** Not applicable

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>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$12,100
The total Peg would pay is	\$12,340

- **The plan's overall deductible** \$0
- **Specialist cost sharing** Balances over \$35
- **Hospital (facility) cost sharing** Not covered
- **Other cost sharing** Not applicable

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>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$5,200
The total Joe would pay is	\$5,200

- **The plan's overall deductible** \$0
- **Specialist cost sharing** Balances over \$35
- **Hospital (facility) cost sharing** Not covered
- **Other cost sharing** Not applicable

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>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$920
The total Mia would pay is	\$920