**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, go to www.iuoe139healthfund.org or call 1-800-242-7018. 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.www.dol.gov/ebsa/healthreform or call 1-800-242-7018 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-network: **$250** Individual/**$750** Family; Out-of-network: **$500** Individual/**$1,500** Family (June 1 – May 31) | 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. In-network routine physical exam, prescription drugs, in-network or retail pharmacy immunizations, in-network mental health/substance use disorder services, vision care, dental care, and transplant benefits are covered before you meet your deductible. | 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?** | In-network: **$3,500** Individual/ **$7,000** Family; Out-of-network: **$5,000** Individual/**$10,000** Family. Specialty drugs: **$3,000** Individual (January 1 – December 31) | 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 must be met. |
| **What is not included in the out-of-pocket limit?** | Premiums, the deductible, emergency room copayment, balance-billing charges, dental care, vision care, and health care this Plan does not 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 1-800-810-2583 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: In-Network Provider (You will pay the least) | What You Will Pay: Out-of-Network Provider[1] (You will pay the most) | 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 | 10% coinsurance | Not covered | None |
| | Specialist visit | 10% coinsurance | Not covered | None |
| | Preventive care/screening/ immunization | No charge for immunizations or routine physical exam (participant and spouse only); deductible does not apply. Otherwise, 10% coinsurance. | Retail pharmacies: No charge for immunizations; deductible does not apply. All other services are not covered. | 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) | Facility: 5% coinsurance; Professional: 10% coinsurance | Not covered | Only out-of-network services that originate from an in-network provider or facility are covered, and these out-of-network services are paid at in-network rates. |
| | Imaging (CT/PET scans, MRIs) | Facility: 5% coinsurance; Professional: 10% coinsurance | Not covered | Only out-of-network services that originate from an in-network provider or facility are covered, and these out-of-network services are paid at in-network rates. |

[1] In general, no out-of-network coverage is provided unless otherwise noted as an exception or unless required by federal law.

| 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[1] (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.optum.com. | Generic drugs | 10% coinsurance. Deductible does not apply. | 10% coinsurance. Deductible does not apply. | 90-day supply retail and mail order. |
| | Brand name drugs | 20% coinsurance. Deductible does not apply. | 20% coinsurance. Deductible does not apply. | |
| | Specialty drugs | 20% coinsurance up to $200 per prescription. Deductible does not apply. | Not covered | No charge after you reach $3,000 specialty drug out-of-pocket limit (maximum) per person per calendar year; preauthorization required and coverage will be denied if the Plan determines the care was not medically necessary. Medication for medically necessary infertility treatment limited to $10,000 per person per lifetime. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 5% coinsurance | Not covered | Preauthorization is required for certain services and coverage will be denied if the Plan determines the care was not medically necessary. |
| | Physician/surgeon fees | 10% coinsurance | Not covered to hospital. | |
| **If you need immediate medical attention** | Emergency room care | 5% coinsurance; $50 copay/visit also applies if not admitted to hospital. | 5% coinsurance based on recognized amount, as required by law; $50 copay/visit also applies if not admitted to hospital. | $50 copayment waived if admitted to hospital from emergency room. Copayment does not count toward the Plan's out-of-pocket limit. |
| | Emergency medical transportation | 5% coinsurance if billed by hospital; 10% coinsurance if billed by ambulance service. | 5% coinsurance if billed by hospital; 10% coinsurance if billed by ambulance service. | Coverage for ground and air transportation. |
| | Urgent care | Facility: 5% coinsurance; Professional: 10% coinsurance | Not covered | 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[1] (You will pay the most) | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 5% coinsurance | In the case of a medical emergency: 5% coinsurance. Otherwise, not covered. | Preauthorization is required (except in a medical emergency) and coverage will be denied if the Plan determines the care was not medically necessary.<br><br>Only semi-private room covered unless a private room is medically necessary. |
| | Physician/surgeon fees | 10% coinsurance | In the case of a medical emergency: 10% coinsurance. Otherwise, not covered. | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge. Deductible does not apply. | Not covered | An Employee Assistance Program (EAP) is available through Anthem Blue Cross Blue Shield. Contact the Fund Office for more information. |
| | Inpatient services | No charge. Deductible does not apply. | In the case of a medical emergency: no charge and deductible does not apply. Otherwise, not covered. | Preauthorization is required (except in a medical emergency) and coverage will be denied if the Plan determines the care was not medically necessary.<br><br>Only semi-private room covered unless a private room is medically necessary. |
| **If you are pregnant** | Office visits | 10% coinsurance | Not covered | Coverage only for member and spouse. Not covered for dependent children except for pregnancy complications. |
| | Childbirth/delivery professional services | 10% coinsurance | Not covered | |
| | Childbirth/delivery facility services | 5% coinsurance | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | Not covered | Preauthorization is required and coverage will be denied if the Plan determines the care was not medically necessary. |

| 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[1] (You will pay the most) | |
| If you need help recovering or have other special health needs (cont'd) | Rehabilitation services | Outpatient: 10% coinsurance; Inpatient: 10% coinsurance for professional; 5% coinsurance for facility | Not covered | Speech therapy requires preauthorization and coverage will be denied if the Plan determines the care was not medically necessary.<br><br>Occupational/physical therapy limited to 40 combined visits per person per calendar year. |
| | Habilitation services | Not covered | Not covered | You must pay 100% of this service, even in-network. |
| | Skilled nursing care | Outpatient: 10% coinsurance; Inpatient: 10% coinsurance for professional and 5% coinsurance for facility | Not covered | Excludes custodial care.<br><br>Preauthorization is required for inpatient skilled nursing care and coverage will be denied if the Plan determines the care was not medically necessary. |
| | Durable medical equipment | 10% coinsurance | Not covered | Preauthorization is required for a rental that exceeds three months or at a cost that exceeds $500 and coverage will be denied if the Plan determines the equipment was not medically necessary.<br><br>Rental limited to purchase price.<br><br>$350 maximum for custom foot orthotics and<br><br>$700 maximum for diabetic shoes (obtained from network providers only) per person per calendar year. |
| | Hospice services | Outpatient: 10% coinsurance; Inpatient: 10% coinsurance for physician and 5% coinsurance for facility | Not covered | Preauthorization is required and coverage will be denied if the Plan determines the care was not medically necessary.<br><br>Must be terminally ill with a life expectancy of six months or less. |

| 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[1] (You will pay the most) | |
| **If your child needs dental or eye care** | Children's eye exam | No charge. Deductible does not apply. | No charge. Deductible does not apply. | Limited to one exam per person per calendar year. |
| | Children's glasses | No charge. Deductible does not apply. | No charge. Deductible does not apply. | Limited to $300 per person every two calendar years. Limit does not apply to lenses for individuals under age 19. |
| | Children's dental check-up | 5% coinsurance. Deductible does not apply. | 10% coinsurance. Deductible does not apply. | Limited to two exams per person per calendar year.<br><br>No dollar limit for preventive care for individuals under age 19.<br><br>Your cost sharing does not count toward the Plan's out-of-pocket limit. |

## 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 (except for medically necessary surgery or reconstructive surgery following mastectomy)<br>• Habilitation services | • Long-term care<br>• Non-emergency care when traveling outside the U.S. | • Routine foot care |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Acupuncture ($1,200 maximum per person per calendar year; out-of-network providers are covered)<br>• Bariatric surgery (gastric bypass surgery – covered for persons ages 18 to 65, one course of treatment per person per lifetime)<br>• Chiropractic care ($1,200 maximum per person per calendar year; out-of-network providers are covered) | • Dental care (Adult) ($2,500 maximum per person per calendar year for routine dental care)<br>• Hearing aids ($6,000 maximum per person in a 72-month period; out-of-network providers are covered)<br>• Infertility treatment ($10,000 maximum per person per lifetime (in-network only) and $10,000 maximum per person per lifetime for prescription drugs associated with medically necessary infertility treatment) | • Private-duty nursing<br>• Routine eye care (Adult) (one exam per person per calendar year; $300 maximum per person every 2 calendar years, except for vision exam)<br>• Weight loss programs (If physician supervised) |

**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: Department of Labor's Employee Benefits Security Administration at www.dol.gov/ebsa/healthreform, 1-866-444-EBSA (3272). 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: Plan Administrative Manager, Operating Engineers Local 139 Health Benefit Fund, N27 W. 23233 Roundy Drive, P. O. Box 160, Pewaukee, WI 53072-0160 or call 1-800-242-7018 or go to www.iuoe139healthfund.org. 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**

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.

*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** | **$250** |
| **Specialist coinsurance** | **10%** |
| **Hospital (facility) coinsurance** | **5%** |
| **Other coinsurance** | **10%** |

**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 | $250 |
| Copayments | $0 |
| Coinsurance | $1,160 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Peg would pay is** | **$1,430** |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$250** |
| **Specialist coinsurance** | **10%** |
| **Hospital (facility) coinsurance** | **5%** |
| **Other coinsurance** | **10%** |

**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 | $250 |
| Copayments | $0 |
| Coinsurance | $810 |
| *What isn't covered* | |
| Limits or exclusions | $250 |
| **The total Joe would pay is** | **$1,310** |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$250** |
| **Specialist coinsurance** | **10%** |
| **Hospital (facility) coinsurance** | **5%** |
| **Other coinsurance** | **10%** |

**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 | $250 |
| Copayments | $50 |
| Coinsurance | $230 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$530** |

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