
 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.iuoe139.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.iuoe139.org or call 1-800-242-7018 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	(June 1 – May 31) In-network provider: \$250/Individual or \$750/Family; Out-of-network provider: \$500/Individual or \$1,500/Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Prescription drugs</u> , Health Dynamics routine physical exam, in-network immunizations, in-network mental health and substance use disorder and transplant benefits are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	(January 1 – December 31) In-network: \$3,500/Individual, \$7,000/Family; Out-of-network: \$5,000/Individual, \$10,000/Family. Specialty drugs: \$3,000/Individual	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>deductibles</u> , emergency room <u>coinsurance</u> , <u>balance-billing</u> dental, vision, and health care this <u>plan</u> does not cover are not included in the <u>out-of-pocket limit</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u>?	Yes. See www.anthem.com or call 1-800-810-2583 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
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> .

 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider ¹ (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% <u>coinsurance</u>	Not covered	None
	Specialist visit	10% <u>coinsurance</u>	Not covered	None
	Preventive care/screening/immunization	No charge for immunizations or Health Dynamics (adults). <u>Deductible</u> does not apply. 10% <u>coinsurance</u> for other providers	No charge for immunizations; <u>deductible</u> does not apply. All other services are not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	5% <u>coinsurance</u> for facility fee; or 10% <u>coinsurance</u> for professional	Not covered	Only <u>out-of-network</u> services that originate from an <u>in-network provider</u> or facility are covered, and these <u>out-of-network</u> services are paid at <u>in-network</u> rates.
	Imaging (CT/PET scans, MRIs)	5% <u>coinsurance</u> for facility fee; or 10% <u>coinsurance</u> for professional	Not covered	Only <u>out-of-network</u> services that originate from an <u>in-network provider</u> or facility are covered, and these <u>out-of-network</u> services are paid at <u>in-network</u> rates.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com or call 1-866-750-3634	Generic drugs	10% <u>coinsurance</u>	10% <u>coinsurance</u>	90-day supply retail and mail order. <u>Deductible</u> does not apply.
	Brand drugs	20% <u>coinsurance</u>	20% <u>coinsurance</u>	90-day supply retail and mail order. <u>Deductible</u> does not apply.
	<u>Specialty drugs</u>	20% <u>coinsurance</u> up to \$200	Not covered	No charge after you reach \$3,000 specialty drug <u>out-of-pocket limit</u> (maximum) per calendar year; <u>preauthorization</u> required. <u>Deductible</u> does not apply.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> required for certain services.
	Physician/surgeon fees	10% <u>coinsurance</u>	Not covered	
If you need immediate medical attention	<u>Emergency room care</u>	5% <u>coinsurance</u> ; \$50 <u>copay/visit</u> also applies if not admitted from ER	In the case of a <u>medical emergency</u> where <u>in-network</u> treatment is not reasonably accessible: 25% <u>coinsurance</u> if billed by hospital; 30% <u>coinsurance</u> if billed by physician; \$50 <u>copay/visit</u> also applies if not admitted from ER. Otherwise, not covered.	None
	<u>Emergency medical transportation</u>	5% <u>coinsurance</u> if billed by hospital; 10% <u>coinsurance</u> if billed by ambulance service;	5% <u>coinsurance</u> if billed by hospital; 10% <u>coinsurance</u> if billed by ambulance service	Not covered if transportation is for convenience.
	<u>Urgent care</u>	10% <u>coinsurance</u>	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	5% <u>coinsurance</u>	In the case of a <u>medical emergency</u> where <u>in-network</u> treatment is not reasonably accessible: 25% <u>coinsurance</u> . Otherwise, not covered.	<u>Preauthorization</u> required.
	Physician/surgeon fees	10% <u>coinsurance</u>	In the case of a <u>medical emergency</u> where <u>in-network</u> treatment is not reasonably accessible: 30% <u>coinsurance</u> . Otherwise, not covered.	

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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 mental health, behavioral health, or substance abuse services	Outpatient services	No charge. <u>Deductible</u> does not apply.	Not covered	None
	Inpatient services	No charge. <u>Deductible</u> does not apply.	Not covered	<u>Preauthorization</u> required.
If you are pregnant	Office visits	10% <u>coinsurance</u>	Not covered	Coverage only for member and spouse. Not covered for dependent children except for pregnancy complications.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	5% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> required.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	Not covered	Speech therapy requires <u>preauthorization</u> ; occ/phys therapy limited to 40 visits per calendar year, combined.
	<u>Habilitation services</u>	Not covered	Not covered	You must pay 100% of cost for these services
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	Not covered	Excludes custodial care; <u>preauthorization</u> required.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> required for some equipment; rental limited to purchase price and \$350 maximum per calendar year for custom foot orthotics.
	<u>Hospice services</u>	10% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> required.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to one exam per calendar year.
	Children's glasses	No charge	No charge	Limited to \$300 maximum every two calendar years.
	Children's dental check-up	10% <u>coinsurance</u> diagnostic/preventive; 20% <u>coinsurance</u> routine and orthodontic	10% <u>coinsurance</u> diagnostic/preventive; 20% <u>coinsurance</u> routine and orthodontic	Limited to two exams per calendar year.

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

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
- Long-term care
- 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 max per person per calendar year)
- Bariatric surgery (ages 18 to 65; gastric bypass surgery - one course of treatment per person per lifetime)
- Chiropractic care (\$1,200 max per person per calendar year)
- Dental care (Adult) (\$2,500 calendar year max, not including diagnostic and preventive care)
- Hearing aids (one exam per person per calendar year; \$6,000 max in a 72-month period; \$300 max hearing aid repair per person)
- Infertility treatment (\$2,000 max per lifetime)
- Private duty nursing
- Routine eye care (Adult) (one exam per calendar year; \$300 max every 2 calendar years)
- Weight loss program (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 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: www.iuoe139.org, 1-800-242-7018. 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

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.

—————*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	\$448
■ Specialist [cost sharing]	\$0
■ Hospital (facility) [cost sharing]	5%
■ Other [cost sharing]	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	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$448
Copayments	\$0
Coinsurance	\$795
What isn't covered	
Limits or exclusions	\$11
The total Peg would pay is	\$1,254

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 [cost sharing]	\$0
■ Hospital (facility) [cost sharing]	5%
■ Other [cost sharing]	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	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$1,324
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$1,629

Mia's Simple Fracture

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

■ The plan's overall deductible	\$250
■ Specialist [cost sharing]	\$0
■ Hospital (facility) [cost sharing]	5%
■ Other [cost sharing]	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	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$50
Coinsurance	\$155
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$455

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