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.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?	(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 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. Prescription drugs, Health Dynamics routine physical exam, immunizations, in-network mental health/substance use disorder 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?	(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 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, deductibles, emergency room coinsurance, balance billing, dental, vision, and health care this Plan does not cover are not included in the out-of-pocket limit.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
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		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% coinsurance	Not covered	None
	Specialist visit	10% coinsurance	Not covered	None
	Preventive care/screening/ immunization	No charge for immunizations or Health Dynamics exam (adults). Deductible does not apply. 10% coinsurance for exams from other in-network providers.	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)	5% coinsurance for facility fee; or 10% coinsurance for professional.	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)	5% coinsurance for facility fee; or 10% coinsurance for professional.	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.caremark.com or call 1-866-750-3634	Generic drugs	10% coinsurance	10% coinsurance	90-day supply retail and mail order. Deductible does not apply.
	Brand drugs	20% coinsurance	20% coinsurance	
	Specialty drugs	20% coinsurance up to $200	Not covered	No charge after you reach $3,000 specialty drug out-of-pocket limit (maximum) per calendar year; preauthorization required. Deductible does not apply. Medication for medically necessary infertility treatment limited to $2,000 lifetime maximum per person.
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	
If you need immediate medical attention	Emergency room care	5% coinsurance; $50 copay/visit also applies if not admitted from ER.	In the case of a medical emergency where in-network treatment is not reasonably accessible: 25% coinsurance if billed by hospital; 30% coinsurance if billed by physician; $50 copay/visit also applies if not admitted from ER. Otherwise, not covered.	$50 copayment waived if admitted from emergency room.
	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.	Not covered if transportation is for convenience.
	Urgent care	5% coinsurance for facility fee; or 10% coinsurance for professional.	Not covered	None

[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 a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance	In the case of a medical emergency where in-network treatment is not reasonably accessible: 25% coinsurance. Otherwise, not covered.	Preauthorization is required and coverage will be denied if the Plan determines the care was not medically necessary. Only semi-private room covered unless a private room is medically necessary.
	Physician/surgeon fees	10% coinsurance	In the case of a medical emergency where in-network treatment is not reasonably accessible: 30% 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	None
	Inpatient services	No charge. Deductible does not apply.	In the case of a medical emergency where in-network treatment is not reasonably accessible: 30% coinsurance. Otherwise, not covered.	Preauthorization is required and coverage will be denied if the Plan determines the care was not medically necessary. 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.

[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 help recovering or have other special health needs (Cont'd)	Rehabilitation services	10% coinsurance	Not covered	Speech therapy requires preauthorization and coverage will be denied if the Plan determines the care was not medically necessary; occupational/physical therapy limited to 40 visits per calendar year, combined.
	Habilitation services	Not covered	Not covered	You must pay 100% of cost for these services, even if a Network provider is used.
	Skilled nursing care	10% coinsurance	Not covered	Excludes custodial care; preauthorization is required 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 some equipment and coverage will be denied if the Plan determines the equipment was not medically necessary; rental limited to purchase price. $350 maximum for custom foot orthotics and $700 maximum for diabetic shoes (obtained from Network providers only) per calendar year per person.
	Hospice services	10% coinsurance	Not covered	Preauthorization is required and coverage will be denied if the Plan determines the care was not medically necessary.
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% coinsurance diagnostic/preventive; 20% coinsurance routine and orthodontic	10% coinsurance diagnostic/preventive; 20% coinsurance 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 lifetime maximum per person for medical services and $2,000 lifetime maximum per person for prescription drugs)
- 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: 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.iuoe139.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

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 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	**$12,800**

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 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	**$7,400**

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 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	**$1,900**

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.