

 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.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 <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> , <u>Health Dynamics routine physical exam</u> , <u>in-network</u> or retail pharmacy immunizations, <u>in-network</u> mental health/substance use disorder services, <u>vision care</u> , <u>dental care</u> , and <u>transplant benefits</u> 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?	In-network: \$3,500 Individual/ \$7,000 Family; Out-of-network: \$5,000 Individual/ \$10,000 Family. <u>Specialty drugs</u> : \$3,000 Individual (January 1 – December 31)	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> , the <u>deductible</u> , <u>emergency room copayment</u> , <u>balance-billing charges</u> , <u>dental care</u> , <u>vision care</u> , and <u>health care this plan</u> does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <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.

Important Questions	Answers	Why This Matters:
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
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> 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
	<u>Specialist</u> visit	10% <u>coinsurance</u>	Not covered	None
	<u>Preventive care/screening/immunization</u>	No charge for immunizations or Health Dynamics exam (participant and spouse only); <u>deductible</u> does not apply. Otherwise, 10% <u>coinsurance</u> .	Retail pharmacies: 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)	Facility: 5% <u>coinsurance</u> ; Professional: 10% <u>coinsurance</u>	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)	Facility: 5% <u>coinsurance</u> ; Professional: 10% <u>coinsurance</u>	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	Generic drugs	10% <u>coinsurance</u> . <u>Deductible</u> does not apply.	10% <u>coinsurance</u> . <u>Deductible</u> does not apply.	90-day supply retail and mail order.

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
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider¹</u> (You will pay the most)	
More information about prescription drug coverage is available at www.optum.com .	Brand name drugs	20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	
	<u>Specialty drugs</u>	20% <u>coinsurance</u> up to \$200 per prescription. <u>Deductible</u> does not apply.	Not covered	No charge after you reach \$3,000 <u>specialty drug out-of-pocket limit</u> (maximum) per person per calendar year; <u>preauthorization</u> required and coverage will be denied if the <u>Plan</u> determines the care was not <u>medically necessary</u> . Medication for <u>medically necessary</u> infertility treatment limited to \$2,000 per person per lifetime.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required for certain services and coverage will be denied if the <u>Plan</u> determines the care was not <u>medically necessary</u> .
	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 to hospital	In the case of a medical emergency 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 to hospital. Otherwise, not covered.	\$50 <u>copayment</u> waived if admitted to hospital from emergency room. <u>Copayment</u> does not count toward the <u>Plan's out-of-pocket limit</u> .
	<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.	Coverage for ground and air transportation.
	<u>Urgent care</u>	Facility: 5% <u>coinsurance</u> ; Professional: 10% <u>coinsurance</u>	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% <u>coinsurance</u>	In the case of a medical emergency where <u>in-network</u> treatment is not reasonably accessible: 25% <u>coinsurance</u> . Otherwise, not covered.	<p><u>Preauthorization</u> is required and coverage will be denied if the <u>Plan</u> determines the care was not <u>medically necessary</u>.</p> <p>Only semi-private room covered unless a private room is <u>medically necessary</u>.</p>
	Physician/surgeon fees	10% <u>coinsurance</u>	In the case of a medical emergency where <u>in-network</u> treatment is not reasonably accessible: 30% <u>coinsurance</u> . Otherwise, not covered.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge. <u>Deductible</u> 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. <u>Deductible</u> does not apply.	In the case of a medical emergency where <u>in-network</u> treatment is not reasonably accessible: 30% <u>coinsurance</u> for the professional and 25% <u>coinsurance</u> for the facility. Otherwise, not covered.	<p><u>Preauthorization</u> is required and coverage will be denied if the <u>Plan</u> determines the care was not <u>medically necessary</u>.</p> <p>Only semi-private room covered unless a private room is <u>medically necessary</u>.</p>
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> is required and coverage will be denied if the <u>Plan</u> determines the care was not <u>medically necessary</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider¹</u> (You will pay the most)	
If you need help recovering or have other special health needs (Cont'd)	<u>Rehabilitation services</u>	Outpatient: 10% coinsurance; Inpatient: 10% coinsurance for professional; 5% coinsurance for facility	Not covered	Speech therapy requires <u>preauthorization</u> and coverage will be denied if the <u>Plan</u> determines the care was not <u>medically necessary</u> . Occupational/physical therapy limited to 40 combined visits per person per calendar year.
	<u>Habilitation services</u>	Not covered	Not covered	You must pay 100% of this service, even <u>in-network</u> .
	<u>Skilled nursing care</u>	Outpatient: 10% coinsurance; Inpatient: 10% coinsurance for professional and 5% coinsurance for facility	Not covered	Excludes custodial care. <u>Preauthorization</u> is required for inpatient <u>skilled nursing care</u> and coverage will be denied if the <u>Plan</u> determines the care was not <u>medically necessary</u> .
	<u>Durable medical equipment</u>	10% coinsurance	Not covered	<u>Preauthorization</u> is required for a rental that exceeds three months or at a cost that exceeds \$500 and coverage will be denied if the <u>Plan</u> determines the equipment was not <u>medically necessary</u> . Rental limited to purchase price. \$350 maximum for custom foot orthotics and \$700 maximum for diabetic shoes (obtained from <u>network providers</u> only) per person per calendar year.
	<u>Hospice services</u>	Outpatient: 10% coinsurance; Inpatient: 10% coinsurance for physician and 5% coinsurance for facility	Not covered	<u>Preauthorization</u> is required and coverage will be denied if the <u>Plan</u> determines the care was not <u>medically necessary</u> . Must be terminally ill with a life expectancy of six months or less.
If your child needs dental or eye care	Children's eye exam	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	Limited to one exam per person per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider¹</u> (You will pay the most)	
	Children's glasses	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> 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	10% <u>coinsurance</u> . <u>Deductible</u> does not apply.	10% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Limited to two exams per person per calendar year. No limit for <u>preventive care</u> for individuals under age 19.

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)
- 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 maximum per person per calendar year; out-of-network providers are covered)
- Bariatric surgery (gastric bypass surgery – covered for persons ages 18 to 65, one course of treatment per person per lifetime)
- Chiropractic care (\$1,200 maximum per person per calendar year; out-of-network providers are covered)
- Dental care (\$2,500 maximum per person per calendar year for routine dental care)
- Hearing aids (\$6,000 maximum per person in a 72-month period; out-of-network providers are covered)
- Infertility treatment (\$2,000 maximum per person per lifetime (in-network only) and \$2,000 maximum per person per lifetime for prescription drugs associated with medically necessary infertility treatment)
- Private-duty nursing
- Routine eye care (Adult) (one exam per person per calendar year; \$300 maximum per person every 2 calendar years, except for vision exam)
- 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 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 <u>deductible</u>	\$250
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	5%
■ <u>Other coinsurance</u>	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:

<i>Cost Sharing</i>	
<u>Deductibles*</u>	\$250
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$720
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Peg would pay is	\$980

Managing Joe's type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$250
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	5%
■ <u>Other coinsurance</u>	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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,020
<i>What isn't covered</i>	
Limits or exclusions	\$380
The total Joe would pay is	\$1,650

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$250
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	5%
■ <u>Other coinsurance</u>	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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$130
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$430

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