Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Eligible Actives/Retirees/Dependents | **Plan Type:** PPO

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. This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling (888) 512-5863 or (925) 208-9996. 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 https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-new.pdf or call to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$200** person / **$400** family (Annually)	Generally, you must pay all the covered 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 be their own individual **deductible** until the total amount of **deductible** expense paid by all family members meets the overall family **deductible**. Check your policy or plan document to see when the **deductible** starts over. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible	**Yes. Preventive care and primary care services 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. For example, this **plan** covers certain **preventive services** without **cost sharing** and before you meet your **deductible**. See a list of covered **preventive services** at **https://www.healthcare.gov/coverage/prevenive-care-benefits/**.
Are there other deductibles for specific services?	**No.**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out–of–pocket limit for this plan?	For medical expenses, $10,000 (Family) (see exceptions pages 2 – 5). For prescription drugs, $1046 (Individual)/$3446 (Family).	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	**Copayments** for certain services, **premiums, deductibles, balance-billed** charges, and health care this **plan** doesn't 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. For a list of participating providers, see www.anthem.com or call 1-800-333-0912	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**

		(doctor or hospital) may use an out-of-network **provider** for some services (such as lab work). Check with your **provider** before you get services. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this **plan**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Anthem Blue Cross in-network **providers** by charging you lower **deductibles**, **co-payments**, and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions: All Non-Network charges are subject to Reasonable & Customary Charge limitations
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% **co-insurance** after **deductible**	40% **co-insurance** after **deductible**	
	Specialist visit	20% **co-insurance** after **deductible**	40% **co-insurance** after **deductible**	
	Other practitioner office visit	20% **co-insurance** after **deductible**	40% **co-insurance** after **deductible**	
	Preventive care/screening/immunization	No **co-insurance**	40% **co-insurance** after **deductible**	
	Chiropractic	20% **co-insurance** after **deductible**	40% **co-insurance** after **deductible**	30 Visits per Calendar Year
	Live Health Online	$10 Copay not subject to **deductible**	Not available	

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If you have a test	**Diagnostic test** (x-ray, blood work)	20% **co-insurance** after **deductible**	40% **co-insurance** after **deductible**	
	Imaging (CT/PET scans, MRIs)	20% **co-insurance** after **deductible**	40% **co-insurance** after **deductible**	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com.	Generic drugs	$5 **co-pay**(retail) $10 **co-pay** (mail order)	$5 **co-pay**(retail)	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription – in-network only)
	Preferred brand drugs	$20 **co-pay**(retail) $40 **co-pay** (mail order)	$20 **co-pay**(retail)	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription – in-network only)
	Non-preferred brand /**Specialty drugs**	$35 **co-pay**(retail) $70 **co-pay** (mail order)	$35 **co-pay**(retail)	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription – in-network only)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **co-insurance** after **deductible**	40% **co-insurance** after **deductible**	
	Physician/surgeon fees	20% **co-insurance** after **deductible**	40% **co-insurance** after **deductible**	
If you need immediate medical attention	**Emergency room services**	20% **co-insurance** after **deductible**	40% **co-insurance** after **deductible**	
	Emergency medical transportation	20% **co-insurance** after **deductible**	40% **co-insurance** after **deductible**	

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	Urgent care	20% **co-insurance** after **deductible**	40% **co-insurance** after **deductible**	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **co-insurance** after **deductible**	40% **co-insurance** after **deductible**	A $250 charge will apply if you fail to choose a participating PPO in-patient Hospital facility when available. An additional $250 penalty will apply if pre-certification is not obtained for either PPO or non-PPO.
	Physician/surgeon fee	20% **co-insurance** after **deductible**	40% **co-insurance** after **deductible**	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% **co-insurance** after **deductible**	40% **co-insurance** after **deductible**	
	Mental/Behavioral health inpatient services	20% **co-insurance** after **deductible**	40% **co-insurance** after **deductible**	There is also $250 penalty if pre-certification is not obtained for either PPO or non-PPO.
	Substance use disorder outpatient services	20% **co-insurance** after **deductible**	40% **co-insurance** after **deductible**	
	Substance use disorder inpatient services	20% **co-insurance** after **deductible**	40% **co-insurance** after **deductible**	There is also $250 penalty if pre-certification is not obtained for either PPO or non-PPO.
If you are pregnant	Prenatal and postnatal care	20% **co-insurance** after **deductible**	40% **co-insurance** after **deductible**	
	Delivery and all inpatient services	20% **co-insurance** after **deductible**	40% **co-insurance** after **deductible**	

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If you need help recovering or have other special health needs	Home health care	20% co-insurance after deductible	40% co-insurance after deductible	Home health care
	Rehabilitation services	20% co-insurance after deductible	40% co-insurance after deductible	Rehabilitation services
	Habilitation services	20% co-insurance after deductible	40% co-insurance after deductible	Habilitation services
	Skilled nursing care	20% co-insurance after deductible	40% co-insurance after deductible	Skilled nursing care
	Durable medical equipment	20% co-insurance after deductible	40% co-insurance after deductible	Durable medical equipment
	Hospice service	20% co-insurance after deductible	40% co-insurance after deductible	Hospice service
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Weight loss programs
- Vision Care Services
- Cosmetic surgery
- Weight loss programs
- Vision Care Services
- Private-duty nursing

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric surgery (if pre-approved by medical review)
- Emergency care when traveling outside the U.S.

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 1-888-512-5863.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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.

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The Plan's Overall Deductible:** $200
- **Specialist Copayment:** $0
- **Hospital (facility) coinsurance:** 20%
- **Other coinsurance:** 20%

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	$200
Co-pays	$0
Co-insurance	$520
What isn't covered	
Limits or exclusions	$0
Total Peg would pay is	**$720**

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The Plan's Overall Deductible:** $200
- **Specialist Copayment:** $0
- **Hospital (facility) coinsurance:** 20%
- **Other coinsurance:** 20%

This EXAMPLE event includes services like:

Specialist Office Visits (prenatal care)	
Childbirth/Delivery Professional Services	
Childbirth/Delivery Facility Services	
Diagnostic tests (ultrasounds & blood work)	
Specialist visit (anesthesia)	
Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Co-pays	$0
Co-insurance	$2,000
What isn't covered	
Limits or exclusions	$0
Total Peg would pay is	**$2,200**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well- controlled condition)

- **The Plan's Overall Deductible:** $200
- **Specialist Copayment:** $0
- **Hospital (facility) coinsurance:** 20%
- **Other coinsurance:** 20%

This EXAMPLE event includes services like:

Specialist Office visits (including disease education)	
Diagnostic tests (blood work)	
Prescription Drugs – Mail Order 4 refills Generic	
Durable Medical Equipment (glucose meter)	
Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Co-pays	$40
Co-insurance	$1,080
What isn't covered	
Limits or exclusions	$0
Total Joe would pay is	**$1,320**

Note: These numbers assume the patient does not participate in the **plan's** wellness program. If you participate in the **plan's** wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: the Fund Office.
*Note: This **plan** has other **deductibles** for specific services included in this coverage example. See "Are there other **deductibles** for specific services?" row above.

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

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.