



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, visit www.iuoe513fringe.org or call the Fund Office at (314) 739-2973. 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.healthcare.gov/sbc-glossary/> or call (314) 739-2973 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$300 individual/ \$600 family for PPO providers. \$600 individual/ \$1,200 family for non-PPO providers.	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 <u>deductible</u> ?	Yes. The <u>deductible</u> does not apply to preventative care, <u>prescription drugs</u> , dental or vision care.	This <u>plan</u> covers some items and services even if you haven't met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers <u>certain preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$50 for dental benefits. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$2,000 individual/ \$5,100 family for medical. \$1,400 individual/ \$2,800 family for <u>prescription drugs</u> .	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> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Chiropractic care, premiums, balance-billed charges, non-covered expenses (such as amounts above any benefit maximums), and health care that is not covered under this <u>plan</u> .	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 <u>network provider</u> ?	Yes. For a list of PPO <u>providers</u> , see www.anthem.com and click on "Find Care" or call 1-800-810-BLUE. For a list of dental PPO <u>providers</u> , see www.deltadentalmo.com/IUOE513 , click on "Subscribers" and "Find a Participating Dentist".	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</u> charge 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 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
		Network Provider (You will pay the least)	Out-of-Network Provider (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	15% coinsurance after \$20 copay /visit	45% coinsurance after \$20 copay /visit	None. If a PPO provider is not available within a 30-mile radius of a Participant's residence, the coinsurance for a non-PPO provider within this area will be 35%. *\$0 copay if at Marathon Health clinics
	Specialist visit	15% coinsurance after \$40 copay /visit	45% coinsurance after \$40 copay /visit	None. If a PPO provider is not available within a 30-mile radius of a Participant's residence, the coinsurance for a non-PPO provider within this area will be 35%.
	Other practitioner office visit	50% coinsurance for chiropractic care	60% coinsurance for chiropractic care	Limited to 26 visits per calendar year for chiropractic care and \$100 per treatable condition for chiropractic x-rays. Chiropractic care does not count towards the out-of-pocket limit .
	Preventive care/screening /immunization	No charge	No charge	All benefits covered to the extent determined by the U.S. Preventive Care Task Force. You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive . Then check what your plan will pay for. Deductible does not apply.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	45% coinsurance	Limited to \$100 per treatable condition for chiropractic x-rays and \$100 per injury for physical therapy x-rays. Chiropractic and physical therapy x-rays do not count towards the out-of-pocket limit . If a PPO provider is not available within a 30-mile radius of a Participant's residence, the coinsurance for a non-PPO provider within this area will be 35%. *\$0 copay if at Marathon Health clinics
	Imaging (CT/PET scans, MRIs)	15% coinsurance	45% coinsurance	None. If a PPO provider is not available within a 30-mile radius of a Participant's residence, the

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.iuoe513fringe.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				<u>coinsurance</u> for a non-PPO <u>provider</u> within this area will be 35%.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.anthem.com , by calling CarelonRx at 844-483-2675, or through the Sydney Health app on your mobile device.	Generic drugs	30% <u>coinsurance</u> retail, \$7.50 per prescription mail order *\$0 copay if at Marathon Health clinics	35% <u>coinsurance</u> retail, Not covered mail order	<u>Deductible</u> does not apply. Limited to a 90-day supply for retail and mail order. Out-of-network prescription drug benefits will only be paid in cases where the Participant does not have reasonable access to an in-network source. Prior authorization from CarelonRx is required for GLP-1s. Prior authorization from CarelonRx is required for specialty drugs. Specialty drugs are required to be filled through the BioPlus Specialty Pharmacy which can be reached by calling (833) 549-2114. Specialty drugs are limited to a 30 day supply. The Cost Relief program could help save money on certain Specialty drugs. Contact Cost Relief at (877) 638-4008.
	Preferred brand drugs	30% <u>coinsurance</u> retail, \$40 per prescription mail order	35% <u>coinsurance</u> retail, Not covered mail order	
	Non-preferred brand drugs			
	Specialty drugs	\$40 per prescription	35% <u>coinsurance</u> retail, Not covered mail order	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	45% <u>coinsurance</u>	If a PPO <u>provider</u> is not available within a 30-mile radius of a Participant's residence, the <u>coinsurance</u> for a non-PPO <u>provider</u> within this area will be 35%.
	Physician/surgeon fees	15% <u>coinsurance</u>	45% <u>coinsurance</u>	None. If a PPO <u>provider</u> is not available within a 30-mile radius of a Participant's residence, the <u>coinsurance</u> for a non-PPO <u>provider</u> within this area will be 35%.
If you need immediate medical attention	Emergency room care	15% <u>coinsurance</u> after \$150 <u>copay</u> /visit	15% <u>coinsurance</u> after \$150 <u>copay</u> /visit	<u>Copay</u> waived if admitted. Must contact Utilization Review Service within 48 hours after an emergency admission or benefits will be reduced by \$300.
	Emergency medical transportation	15% <u>coinsurance</u>	15% <u>coinsurance</u>	None.
	Urgent care	15% <u>coinsurance</u> after \$40 <u>copay</u> /visit	45% <u>coinsurance</u> after \$40 <u>copay</u> /visit	None. If a PPO <u>provider</u> is not available within a 30-mile radius of a Participant's residence, the <u>coinsurance</u> for a non-PPO <u>provider</u> within this area

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				will be 35%. *\$0 copay if at Marathon Health clinics
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u> after \$0 <u>copay/admission</u>	45% <u>coinsurance</u> after \$0 <u>copay/admission</u>	Limited to the hospital's average semi-private daily rate. Must contact Utilization Review Service prior to admission or within 48 hours after an emergency admission or benefits will be reduced by \$300. If a PPO <u>provider</u> is not available within a 30-mile radius of a Participant's residence, the <u>coinsurance</u> for a non-PPO <u>provider</u> within this area will be 35%.
	Physician/surgeon fees	15% <u>coinsurance</u>	45% <u>coinsurance</u>	None. If a PPO <u>provider</u> is not available within a 30-mile radius of a Participant's residence, the <u>coinsurance</u> for a non-PPO <u>provider</u> within this area will be 35%.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% <u>coinsurance</u> after \$40 <u>copay/visit</u>	45% <u>coinsurance</u> after \$40 <u>copay/visit</u>	If a PPO <u>provider</u> is not available within a 30-mile radius of a Participant's residence, the <u>coinsurance</u> for a non-PPO <u>provider</u> within this area will be 35%. *\$0 copay if at Marathon Health clinics. **\$0 copay if through a Lyra Health provider, limited to 12 visits annually.
	Inpatient services	15% <u>coinsurance</u> after \$0 <u>copay/admission</u>	45% <u>coinsurance</u> after \$0 <u>copay/admission</u>	Must contact Utilization Review Service prior to admission or within 48 hours after an emergency admission or benefits will be reduced by \$300. If a PPO <u>provider</u> is not available within a 30-mile radius of a Participant's residence, the <u>coinsurance</u> for a non-PPO <u>provider</u> within this area will be 35%.
If you are pregnant	Office visits	15% <u>coinsurance</u> after \$40 <u>copay/visit</u>	45% <u>coinsurance</u> after \$40 <u>copay/visit</u>	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). If a PPO <u>provider</u> is not available within a 30-mile radius of a Participant's residence, the <u>coinsurance</u> for a non-PPO <u>provider</u> within this area will be 35%.
	Childbirth/delivery professional services	15% <u>coinsurance</u>	45% <u>coinsurance</u>	Must contact Utilization Review Service prior to admission or within 48 hours after an emergency admission or benefits will be reduced by \$300. If a PPO <u>provider</u> is not available within a 30-mile radius of a Participant's residence, the <u>coinsurance</u> for a

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	15% <u>coinsurance</u> after \$0 <u>copay</u> /admission	45% <u>coinsurance</u> after \$0 <u>copay</u> /admission	non-PPO <u>provider</u> within this area will be 35%. Must contact Utilization Review Service prior to admission or within 48 hours after an emergency admission or benefits will be reduced by \$300. If a PPO <u>provider</u> is not available within a 30-mile radius of a Participant's residence, the <u>coinsurance</u> for a non-PPO <u>provider</u> within this area will be 35%.
If you need help recovering or have other special health needs	Home health care	15% <u>coinsurance</u>	45% <u>coinsurance</u>	Limited to injuries or diseases that would have required full-time confinement in a hospital or convalescent facility in the absence of the home health care plan. Limited to 120 visits per calendar year. If a PPO <u>provider</u> is not available within a 30-mile radius of a Participant's residence, the <u>coinsurance</u> for a non-PPO <u>provider</u> within this area will be 35%.
	Rehabilitation services	15% <u>coinsurance</u> after \$40 <u>copay</u> /visit	45% <u>coinsurance</u> after \$40 <u>copay</u> /visit	Limited to \$75 per visit for physical therapy and \$100 per injury for x-rays. Physical therapy must be commenced within 180 days following a covered <u>hospitalization</u> , accident, or onset of a covered medical condition. If a PPO <u>provider</u> is not available within a 30-mile radius of a Participant's residence, the <u>coinsurance</u> for a non-PPO <u>provider</u> within this area will be 35%. Physical therapy is covered at 100% once <u>out-of-pocket limit</u> is met.
	Habilitation services	15% <u>coinsurance</u> after \$40 <u>copay</u> /visit	45% <u>coinsurance</u> after \$40 <u>copay</u> /visit	Speech and Occupational therapy is not covered unless required due to impairment caused by disease or injury. If a PPO <u>provider</u> is not available within a 30-mile radius of a Participant's residence, the <u>coinsurance</u> for a non-PPO <u>provider</u> within this area will be 35%.
	Skilled nursing care	15% <u>coinsurance</u>	45% <u>coinsurance</u>	Limited to the daily benefit as established by the Missouri Department of Health and Social Services and 45 days per confinement. Must contact Utilization Review Service prior to admission or within 48 hours after an emergency admission or benefits

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				will be reduced by \$300. If a PPO <u>provider</u> is not available within a 30-mile radius of a Participant's residence, the <u>coinsurance</u> for a non-PPO <u>provider</u> within this area will be 35%.
	Durable medical equipment	15% <u>coinsurance</u>	45% <u>coinsurance</u>	Limited to rental rate up to purchase price of equipment. If a PPO <u>provider</u> is not available within a 30-mile radius of a Participant's residence, the <u>coinsurance</u> for a non-PPO <u>provider</u> within this area will be 35%.
	Hospice services	15% <u>coinsurance</u>	45% <u>coinsurance</u>	Limited to one period of up to six consecutive months. If a PPO <u>provider</u> is not available within a 30-mile radius of a Participant's residence, the <u>coinsurance</u> for a non-PPO <u>provider</u> within this area will be 35%.
If your child needs dental or eye care	Children's eye exam	No charge	Everything over applicable allowances	In-network benefits must be obtained from VSP <u>providers</u> . Maximum allowances for <u>out-of-network providers</u> : Exam: \$45, Frame: \$70, Lenses: \$30 for single vision, \$50 for progressive, \$50 for lined bifocal, and \$65 for lined trifocal. Benefit limited to once every other calendar year for frames beginning in 2018, and once every calendar year for lenses and exam. To find an in-network <u>provider</u> , please visit vsp.com or call (800) 877-7195
	Children's glasses	No charge for single vision, lined bifocal, lined trifocal lenses and polycarbonate lenses. Does not include lens enhancements. 80% of all amounts over your applicable allowance for frames. In-network allowances are \$110 for frames bought at Costco and \$200 - \$220 depending on frame for all other VSP <u>providers</u> .		
	Children's dental check-up	10% <u>coinsurance</u> after \$50 <u>deductible</u>	10% <u>coinsurance</u> after \$50 <u>deductible</u>	None.

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](#).)

- | | | |
|---|---|---|
| • Acupuncture | • Gene therapy procedures (both medical and prescription drugs) | • Routine foot care |
| • Bariatric surgery (except when <u>medically necessary</u> to treat morbid obesity) | • Infertility treatment | • Speech and Occupational therapy (except where required due to impairment caused by disease or injury) |
| • Cosmetic surgery (except for treatment for injury sustained in an accident while eligible or after a mastectomy as required by law) | • Long-term care | • Weight loss programs |
| | • Non-emergency care when traveling outside the U.S. | |
| | • Private-duty nursing | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|-----------------------|----------------|----------------------------|
| • Chiropractic care | • Hearing aids | • Routine eye care (Adult) |
| • Dental care (Adult) | | |

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Fund Office at (314) 739-2973. 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](#) or [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the Fund Office at (314) 739-2973 or the U.S. Department of Labor, 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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (314) 739-2973.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (314) 739-2973.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(314) 739-2973.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' (314) 739-2973.

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](#).

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$300
■ Specialist coinsurance	15%
■ Hospital (facility) copayment	\$0
■ Other coinsurance	30%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$40
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$600

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$300
■ Specialist coinsurance	15%
■ Hospital (facility) copayment	\$0
■ Other coinsurance	30%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$200
Coinsurance	\$1,200
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,720

Mia's Simple Fracture

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

■ The plan's overall deductible	\$300
■ Specialist coinsurance	15%
■ Hospital (facility) copayment	\$0
■ Other coinsurance	30%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$600
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100