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 deductible?	**$300** individual/**$600** 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.** The deductible does not apply to prescription drugs.	This plan covers some items and services even if you haven't 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/preventive-care-benefits/.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles before the plan pays for any services.
What is the out-of-pocket limit for this plan?	**$5,650** individual/ **$11,300** family for medical. **$950** individual/ **$1,900** family for prescription drugs.	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 has been met.
What is not included in the out-of-pocket limit?	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 plan.	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 PPO providers, see www.anthem.com and click on "Find Care" or call 1-800-810-BLUE.	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.

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	25% coinsurance after $20 copay/visit	55% 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 40%. *$0 copay if at Marathon Health clinics
	Specialist visit	25% coinsurance after $40 copay/visit	55% 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 40%.
	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. 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 40%.
	Preventive care/screening/ immunization	No charge	No charge	Deductible does not apply. 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.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	55% 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 40%.

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)	
				*$0 copay if at Marathon Health clinics
	Imaging (CT/PET scans, MRIs)	25% coinsurance	55% coinsurance	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 40%.
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% coinsurance retail, $7.50 per prescription mail order *$0 copay if at Marathon Health clinics	35% coinsurance retail, Not covered mail order	Deductible 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% coinsurance retail, $40 per prescription mail order	35% coinsurance retail, Not covered mail order	
	Non-preferred brand drugs			
	Specialty drugs	$40 per prescription	35% coinsurance retail, Not covered mail order	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	55% coinsurance	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 40%.
	Physician/surgeon fees	25% coinsurance	55% coinsurance	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 40%.
If you need immediate medical attention	Emergency room care	25% coinsurance after $150 copay/visit	25% coinsurance after $150 copay/visit	Copay 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	25% coinsurance	25% coinsurance	None.

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)	
	Urgent care	25% coinsurance after $40 copay/visit	55% 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 40%. *$0 copay if at Marathon Health clinics
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	55% coinsurance	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 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 40%.
	Physician/surgeon fees	25% coinsurance	55% coinsurance	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 40%.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance after $40 copay/visit	55% coinsurance after $40 copay/visit	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 40%. *$0 copay if at Marathon Health clinics. **$0 copay if through a Lyra Health provider, limited to 12 visits annually.
	Inpatient services	25% coinsurance	55% coinsurance	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 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 40%.
If you are pregnant	Office visits	25% coinsurance after $40 copay/visit	55% coinsurance after $40 copay/visit	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 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 40%.
	Childbirth/delivery	25% coinsurance	55% coinsurance	Must contact Utilization Review Service prior to

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)	
	professional services			admission or within 48 hours after an emergency admission or benefits will be reduced by $300. 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 40%.
	Childbirth/delivery facility services	25% coinsurance	55% coinsurance	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 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 40%.
If you need help recovering or have other special health needs	Home health care	25% coinsurance	55% coinsurance	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 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 40%.
	Rehabilitation services	25% coinsurance after $40 copay/visit	55% coinsurance after $40 copay/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 hospitalization, accident, or onset of a covered medical condition. 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 40%. Physical therapy is covered at 100% once out-of-pocket limit is met.
	Habilitation services	25% coinsurance after $40 copay/visit	55% coinsurance after $40 copay/visit	Speech and Occupational therapy is not covered unless required due to impairment caused by disease or injury. 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 40%.
	Skilled nursing care	25% coinsurance	55% coinsurance	Limited to the daily benefit as established by the

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)	
				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 will be reduced by $300. 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 40%.
	Durable medical equipment	25% coinsurance	55% coinsurance	Limited to rental rate up to purchase price of equipment. 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 40%.
	Hospice services	25% coinsurance	55% coinsurance	Limited to one period of up to six consecutive months. 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 40%.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None.
	Children's glasses	Not covered	Not covered	None.
	Children's dental check-up	Not covered	Not covered	None.

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

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

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

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, kwiijigo 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** **25%**
- **Hospital (facility) coinsurance** **25%**
- **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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$40
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,900**

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** **25%**
- **Hospital (facility) coinsurance** **25%**
- **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**
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** **25%**
- **Hospital (facility) coinsurance** **25%**
- **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**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$600
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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