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, contact the Plan at www.iwstldc.org or by calling 1-877-597-8704. 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 1-877-597-8704 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$400** person/**$1,200** family; Out-of-Network: **$700** person/**$1,400** family (January 1 – December 31)	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. Emergency room care, in-network office visits, hearing aids, chiropractic services, vision benefits, dental benefits, in-network prescription drugs, and in-network preventive care are covered before you meet your deductible.	This plan covers some items and services even if you have not 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/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. **$25** per person or **$75** per family for dental benefits. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical: In-Network: **$700** per person or **$2,100** per family; Out-of-Network **$1,400** per person or **$2,800** per family. Prescription Drug: In-Network: **$1,900** per person or **$3,800** per family; Out-of-Network: **No limit** (January 1 – December 31)	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?	Premiums, balance-billing charges, dental benefits administered separately by Delta Dental, vision benefits administered separately by VSP, and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call 1-800-810-BLUE 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
		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 copay per visit. Deductible does not apply.	30% coinsurance	In-Network benefit applies if no provider is within 25 miles or if care is needed when you are more than 150 miles from home. Telemedicine: $15 copay per visit.
	Specialist visit	$25 copay per visit. Deductible does not apply.	30% coinsurance	Chiropractic services/spinal manipulations $5 copay per visit ($25 copay for retirees); 26-day combined visit limit per calendar year. In-Network benefit applies if no provider is within 25 miles or if care is needed when you are more than 150 miles from home.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered	In-Network benefit applies if no provider is within 25 miles or if care is needed when you are more than 150 miles from home. 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)	$25 copay per visit in doctor's office; deductible does not apply. 10% coinsurance in hospital.	30% coinsurance	In-Network benefit applies if no provider is within 25 miles or if care is needed when you are more than 150 miles from home.
	Imaging (CT/PET scans, MRIs)	$25 copay per visit in doctor's office; deductible does not apply. 10% coinsurance in hospital.	30% coinsurance	

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	$10 copay per retail fill, $25 copay per mail order fill. Deductible does not apply.	Full price of the retail prescription minus the discounted retail price minus the copay amount	Covers up to a 30-day supply (retail); 31-90 day supply (mail order). No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).
	Preferred brand drugs	$25 copay per retail fill, $60 copay per mail order fill. Deductible does not apply.	Full price of the retail prescription minus the discounted retail price minus the copay amount	Covers up to a 30-day supply (retail); 31-90 day supply (mail order). Restricted coverage for OxyContin. After the first 30-day fill, refills of over 4 pills per day must be approved by the PBM or the prescription will not be filled.
	Non-preferred brand drugs	$40 copay per retail fill, $100 copay per mail order fill. Deductible does not apply.	Full price of the retail prescription minus the discounted retail price minus the copay amount	
	Specialty drugs	$100 copay per retail or mail order fill. Deductible does not apply.	Not covered	Must go through pharmacy benefit manager's specialty program to obtain specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	In-Network benefit applies if no provider is within 25 miles or if care is needed when you are more than 150 miles from home.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copay per visit. Deductible does not apply.	$150 copay per visit. Deductible does not apply.	Copay waived if admitted to hospital.
	Emergency medical transportation	10% coinsurance	30% coinsurance	In-Network benefit applies if no provider is within 25 miles or if care is needed when you are more than 150 miles from home.
	Urgent care	$25 copay per visit. Deductible does not apply.	30% coinsurance	

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 have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Private rooms covered only if medically necessary. In-Network benefit applies if no provider is within 25 miles or if care is needed when you are more than 150 miles from home.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay per office visit and related services; deductible does not apply. 10% coinsurance for other outpatient services	30% coinsurance	In-Network benefit applies if no provider is within 25 miles or if care is needed when you are more than 150 miles from home.
	Inpatient services	10% coinsurance	30% coinsurance	
If you are pregnant	Office visits	$25 copay, 1st visit only (if billed separately from the delivery fee) for confirmation of the pregnancy. Deductible does not apply.	30% coinsurance	In-Network benefit applies if no provider is within 25 miles or if care is needed when you are more than 150 miles from home. Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	Private rooms covered only if medically necessary. In-Network benefit applies if no provider within 25 miles or you are more than 150 miles from home. Delivery expenses are not covered for dependent children.
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	In-Network benefit applies if no provider within 25 miles, or if you are more than 150 miles from home.
	Rehabilitation services	10% coinsurance	30% coinsurance	Limited to 60 combined visits per person per calendar year for physical, occupational and speech therapy. In-Network benefit applies if no provider within 25 miles or if care is needed when you are more than 150 miles from home.

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)	
	Habilitation services (speech therapy)	10% coinsurance	30% coinsurance	Coverage for speech therapy only. In-Network benefit applies if no provider is within 25 miles or if care is needed when you are more than 150 miles from home.
	Skilled nursing care	10% coinsurance	30% coinsurance	Custodial care not covered. Limited to 45 days per calendar year. Limited to semi-private room. In-Network benefit applies if no provider is within 25 miles or if care is needed when you are more than 150 miles from home.
	Durable medical equipment	10% coinsurance	30% coinsurance	Rental cost up to the purchase price. In-Network benefit applies if no provider is within 25 miles or if care is needed when you are more than 150 miles from home.
	Hospice services	10% coinsurance	30% coinsurance	In-Network benefit applies if no provider is within 25 miles or if care is needed when you are more than 150 miles from home.
If your child needs dental or eye care	Children's eye exam	$10 copayment per exam. Deductible does not apply.	Reimbursement up to $42. Deductible does not apply.	Coverage limited to one exam per year. Only for Locals 46, 392, 396 and 782. Administered separately by VSP. Your cost sharing does not count toward the out-of-pocket limit.
	Children's glasses	No charge for most lenses. Frames are covered up to $115 allowance, plus 20% off the amount over your allowance. Deductible does not apply.	Frames reimbursed up to $45. Reimbursement up to $80 for certain lenses. Other lenses not covered. Deductible does not apply.	Lenses are covered once per calendar year. Frames are covered once per two calendar years. Certain lenses are not covered. Only for Locals 46, 392, 396 and 782. Administered separately by VSP. Your cost sharing does not count toward the out-of-pocket limit.
	Children's dental check-up	No charge after $25 dental deductible.	No charge after $25 dental deductible if in-network provider is more than 25 miles from your home. Otherwise, 30% coinsurance.	Deductible: $25 per person and $75 per family. $2,000 annual maximum per person. Only for Locals 46, 392, 396 and 782. This benefit is separately insured and administered by Delta Dental. Your cost sharing does not count toward the out-of-pocket limit.

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
- Infertility Treatment
- Long-term care (except for skilled nursing care)
- Weight loss programs (unless required under ACA)

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

- Bariatric Surgery (if certain criteria are met)
- Chiropractic care (limit of 26 visits per calendar year)
- Cosmetic surgery (for reconstructive surgery following mastectomy, repair of injury, or congenital anomaly)
- Dental Care (Adult) (administered separately by Delta Dental)
- Hearing aids (after a $250 copay in-network and $500 copay out-of-network, up to $2,600 per hearing aid every two years for medically necessary hearing aids prescribed by an audiologist or other physician specializing in ear, nose, and throat). Provided through Ear Professional International Corporation (EPIC).
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult) (administered separately by VSP)
- Routine foot 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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 the Plan at www.iwstldc.org or by calling 1-877-597-8704. 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	$400
Specialist copayment	$25
Hospital (facility) coinsurance	10%
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	$400
Copayments	$25
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$785**

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

The plan's overall deductible	$400
Specialist copayment	$25
Hospital (facility) coinsurance	10%
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	$40
Copayments	$950
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,050**

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

The plan's overall deductible	$400
Specialist copayment	$25
Hospital (facility) coinsurance	10%
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	$400
Copayments	$250
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$690**