



**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, call (330) 270-0453. 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](http://www.dol.gov/ebsa/healthreform) or call (330) 270-0453 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	<u>Network provider</u> : <b>\$600</b> Individual or <b>\$1,200</b> Family; <u>Non-Network provider</u> : <b>\$1,200</b> Individual or <b>\$2,400</b> Family	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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Network provider preventive services</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. For example, this <u>plan</u> covers certain <u>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	Yes. <b>\$50</b> Individual or <b>\$150</b> Family for dental. 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 plan begins to pay for these services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	<b>Medical</b> : <u>Network provider</u> : <b>\$3,000</b> Individual or <b>\$6,000</b> Family; <u>Non-Network provider</u> : <b>\$6,000</b> Individual or <b>\$12,000</b> Family. <b>Prescription drugs</b> : <u>Network provider</u> : <b>\$3,850</b> Individual or <b>\$7,700</b> Family; <u>Non-Network provider</u> : <b>No limit</b>	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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance billing</u> charges, and health care this <u>plan</u> does not cover. <u>Prescription drugs</u> : <u>Cost sharing</u> for certain non-essential <u>specialty drugs</u> does not count toward the <u>prescription drug out-of-pocket limit</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.anthem.com">www.anthem.com</a> 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</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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	25% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	<u>Specialist</u> visit	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Chiropractic limit of 26 visits per person per calendar year. No chiropractic coverage after 26 visits unless deemed to be <u>medically necessary</u> .
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	25% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.caremark.com">www.caremark.com</a></p>	Generic drugs	\$15 <u>copay</u> /fill retail; \$30 <u>copay</u> /fill mail order	Not covered	<p>30-day supply or 100 units retail 90-day supply mail order No charge for ACA-required generic preventive drugs (such as contraceptives) (or brand drug if generic is not medically appropriate). <b>If a brand medication is elected when a generic is available, you will be charged the difference between the cost of the brand and generic plus the brand <u>copay</u>.</b> <u>Specialty drugs</u> are filled through the PrudentRx <u>Copay</u> Program. There is no charge for covered specialty medications that are on the Plan's Exclusive <u>Specialty Drug</u> List and filled at CVS Specialty® Pharmacy. If the <u>specialty drug</u> you take is not included on the Exclusive <u>Specialty Drug</u> List, you will continue to pay the <u>specialty drug copay</u> per prescription. If you do not enroll in PrudentRx, you will pay 30% <u>coinsurance</u> for <u>specialty drugs</u>. <u>Deductible</u> does not apply. Your <u>cost sharing</u> for certain non-essential <u>specialty drugs</u>, as well as any amount paid by the drug manufacturer through its <u>copay</u> assistance program, does not count toward your <u>out-of-pocket limit</u>.</p>
	Preferred brand drugs	20% <u>coinsurance</u> with \$20 minimum retail / \$40 minimum mail order		
	Non-preferred brand drugs	40% <u>coinsurance</u> with \$35 minimum retail / \$70 minimum mail order		
	<u>Specialty drugs</u>	40% <u>coinsurance</u> retail and mail order with \$100 minimum and \$150 maximum		
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency Room care</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>		35% <u>coinsurance</u> , except 25% for air ambulance services	
	<u>Urgent Care</u>		35% <u>coinsurance</u>	
If you have a hospital stay	Facility Fee (e.g., hospital room)	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Room and board in excess of the hospital's most common semi-private room rate is not covered.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	Inpatient services			Room and board in excess of the hospital's most common semi-private room rate is not covered.
If you are pregnant	Office visits	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Room and board in excess of the hospital's most common semi-private room rate is not covered. Prenatal care (other than ACA-required preventive <u>screenings</u> ) is not covered for dependent children. Delivery expenses are not covered for dependent children.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	<u>Rehabilitation services</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	<u>Habilitation services</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	<u>Durable medical equipment</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Equipment rentals are limited to purchase price.
	<u>Hospice services</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Must be facing a life-limiting illness.
If your child needs dental or eye care	Children's eye exam	\$10 <u>copay</u>	Cost over \$45	Vision benefits separately administered by VSP.
	Children's glasses	\$25 <u>copay</u>	Not covered	Vision benefits separately administered by VSP. Frames covered up to \$150 <u>network</u> , up to \$70 <u>non-network</u> .
	Children's dental check-up	No charge	No charge	Dental benefits separately administered by Medical Mutual. Includes one exam and cleaning every 6 months. Up to \$1,000 annual max.

## 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
- Cosmetic surgery (except to correct or improve a bodily function or congenital malformation, or reconstructive surgery following mastectomy)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs (except as required by the health reform law)

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

- Chiropractic care (limited to 26 visits per person per calendar year; review required for additional visits)
- Dental care (Adult and Child) (Up to \$1,000 annual max; \$1,500 lifetime max for orthodontia. Dental benefits separately administered by Medical Mutual.)
- Glasses (Adult and Child) (Vision benefits separately administered by VSP. Frames up to \$150 network, up to \$70 non-network)
- Hospice services
- Private-duty nursing
- Routine eye care (Adult and Child)

**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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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: the Administrative Manager, Plumbers & Pipefitters Local Union No. 396 Welfare Fund, BeneSys, Inc., 3660 Stutz Drive Suite 101 Canfield, OH 44406, **(330) 270-0453**. 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](http://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.

*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 \$600
- Specialist coinsurance 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$600
<u>Copayments</u>	\$60
<u>Coinsurance</u>	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$3,080</b>

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

- The plan's overall deductible \$600
- Specialist coinsurance 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$600
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$830
<i>What isn't covered</i>	
Limits or exclusions	\$230
<b>The total Joe would pay is</b>	<b>\$1,960</b>

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

- The plan's overall deductible \$600
- Specialist coinsurance 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

This **EXAMPLE** event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$600
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$550
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,160</b>