**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. See www.ohcementmasonsbenefits.org or call 1-330-779-8860. 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.healthcare.gov or call 1-833-610-1799 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network: **$500** per individual, **$1,000** per family<br>Out-of-Network: **$1,000** per individual, **$2,000** per 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 deductible until the total amount of deductible expenses paid by all family members meets the overall deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Network office visits for illness or injury, network preventive care, telemedicine visits, Minute Clinic (CVS retail clinic) visits, and prescription drugs 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. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Network: **$3,000** per individual, **$6,000** per family<br>Out-of-Network: **$6,000** per individual, **$12,000** per family | 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?** | Copays, premiums, balance-billed charges, prescription drugs, 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. See www.anthem.com or call 1-833-610-1799 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 | 20% coinsurance after $20 copay per visit. Deductible does not apply. | 40% coinsurance of allowed amount | 20% coinsurance after $20 copay per visit for non-LiveHealth telehealth physician visits (copayment waived for Anthem LiveHealth telehealth physician visits); deductible does not apply; 20% coinsurance after $20 copay per visit for Minute Clinics (CVS retail clinics); deductible does not apply; diagnostic labs paid in full after copay is paid. |
| | Specialist visit | $20 copay per visit. Deductible does not apply. | 40% coinsurance of allowed amount | Acupuncture is not covered. Chiropractic care is covered at 20% coinsurance in network and 40% coinsurance out-of-network; deductible applies; limit of 12 visits per calendar year combined in network and out-of-network. |
| | Preventive care/screening/immunization | No charge. Deductible does not apply. | 40% coinsurance of allowed amount | None |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance of allowed amount | Effective August 1, 2022, charges from out-of-network providers rendered at an in-network facility will be covered at the in-network rate. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance of allowed amount | See Note above. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.optum.com. | Generic Drugs and Brand Name Drugs | 20% coinsurance (retail and mail order); deductible does not apply | You must submit claim for reimbursement of the amount the plan would have paid for the drug (retail or mail order) in network minus 20% coinsurance; deductible does not apply | Retail: 34-day supply; Mail Order: 90-day supply.<br><br>Over-the-counter drugs available only with a prescription.<br><br>If a brand name drug is prescribed "Dispense as Written" and a generic equivalent is available, you pay the cost difference between the brand and generic drug plus 20% 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) | |
| | Specialty drugs | 20% coinsurance (retail and mail order); deductible does not apply | You must submit claim for reimbursement of the amount the plan would have paid for the drug (retail or mail order) in network minus 20% coinsurance; deductible does not apply | Your cost sharing does not count toward the out-of-pocket limit. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance of allowed amount | None |
| | Physician/surgeon fees (Outpatient) | 20% coinsurance | 40% coinsurance of allowed amount | None |
| **If you need immediate medical attention** | Emergency room services | 20% coinsurance | 20% coinsurance of allowed amount | 40% coinsurance applies for non-emergency medical conditions in ER. Effective August 1, 2022, the Plan will cover all emergency services at out-of-network Emergency Rooms at the in-network rate. |
| | Emergency medical transportation | 20% coinsurance | 40% coinsurance of allowed amount | Effective August 1, 2022, the Plan will cover all emergency air ambulance services at the in-network rate. |
| | Urgent care | 20% coinsurance | 40% coinsurance of allowed amount | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance of allowed amount | None |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance of allowed amount | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance | 40% coinsurance of allowed amount | None |
| | Inpatient services | 20% coinsurance | 40% coinsurance of allowed amount | None |
| **If you are pregnant** | Office visits | 20% coinsurance | 40% coinsurance of allowed amount | Coverage for subscriber and subscriber spouse only. |

| 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 professional services | 20% coinsurance | 40% coinsurance of allowed amount | Coverage for subscriber and subscriber spouse only. |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance of allowed amount | Coverage for subscriber and subscriber spouse only. |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance of allowed amount | Limited to 40 visits per calendar year. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance of allowed amount | None |
| | Habilitation services | 20% coinsurance | 40% coinsurance of allowed amount | None |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance of allowed amount | None |
| | Durable medical equipment (DME) | 20% coinsurance | 40% coinsurance of allowed amount | None |
| | Hospice services | 20% coinsurance | 40% coinsurance of allowed amount | None |
| **If your child needs dental or eye care** | Children's eye exam | One exam every 12 months; $0 copay | Not Covered | Dental and Vision Coverage is a voluntary program that you purchase through your Dollar Bank. Out-of-Network vision allowances vary by materials (lens/contacts). Coverage is not available if you decline dental and vision coverage at Open Enrollment. |
| | Children's glasses | One pair of lenses every 12 months: $180 frame allowance & $0 lens/frame copay | Up to $70 frame allowance | |
| | Children's dental check-up | 100% | 100% | |

## 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
- Cosmetic surgery (except for reconstructive surgery following mastectomy)
- Hearing aids
- Infertility treatment
- Long-term Care
- Routine eye care (Adult and Child)
- Non-emergency care when traveling outside the U.S.
- Routine foot care

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

- Bariatric Surgery
- Chiropractic care (limited to 12 visits per calendar year)
- Private-duty nursing (only for home health care)
- Out-of-network emergency services
- Out-of-network providers at in-network facilities
- Air ambulance services
- Dental/Vision Coverage (Child and Adult, if purchased at open enrollment)

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa. 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 330-779-8860 or visit https://www.ourbenefitoffice.com/ohcementmasons/Benefits/MedicalBenefits.aspx. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa.

**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.

**Language Services:** Language Access Services: Um Helf in Deitsch zu greige, rull dei Anthem Sales Representative, Drupp Blan Sponsor odder die Member Service uff dei ID karate aa. (Pennsylvania Dutch)

*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 network provider pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist copayment | 20% |
| 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 and blood work*)
Specialist visit (*anesthesia*)

| | |
|---|---|
| **Total Example Cost** | **$12,700** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $0 |
| Coinsurance | $2,420 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Peg would pay is** | **$2,940** |

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist copayment | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (DME) (*glucose meter*)

| | |
|---|---|
| **Total Example Cost** | **$5,600** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $120 |
| Copayments | $0 |
| Coinsurance | $1,010 |
| *What isn't covered* | |
| Limits or exclusions | $250 |
| **The total Joe would pay is** | **$1,380** |

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist copayment | $50 |
| 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 (DME) (*crutches*)
Rehabilitation services (*physical therapy*)

| | |
|---|---|
| **Total Example Cost** | **$1,900** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $700 |
| Copayments | $50 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,050** |

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