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.local392fringefunds.org or call 1-877-389-5398. 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 1-877-389-5398 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500** per person/**$1,500** per family per calendar year.	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. **Preventive care** and annual physical exams 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. 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. **$200** (inpatient)/**$25** (outpatient) for Non-PPO Hospital services; **$250** for emergency room services (after first visit). There are 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?	**$2,500** per person/**$3,750** per family per calendar year for medical expenses.	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?	Non-PPO **deductibles** (except for emergency care); **prescription drug copays**; non-essential health benefit dental expense payments; **premiums**; **balance-billing** charges; 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 anthem.com or call 1-800-810-2583 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 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**		30% **coinsurance**	----------none----------**
	Specialist visit	20% **coinsurance**		30% **coinsurance**	Chiropractic care limited to 12 visits per person per calendar year; excludes laboratory services.**
	Preventive care/screening/ immunization	No charge; **deductible** does not apply		30% **coinsurance**	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)	20% **coinsurance**		30% **coinsurance**	**Pre-authorization** required through Carelon program for imaging services.**
	Imaging (CT/PET scans, MRIs)				
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.		**Retail**	**Mail**		
	Generic drugs	$15 **copay**	$37.50 **copay**	Not covered	**$6,950** per person/**$15,150** per family out-of-pocket maximum per calendar year. Retail order supply is limited to 34 days; mail order supply is limited to 90 days;
	Formulary brand drugs	$25 **copay**	$62.50 **copay**	Not covered	
	Non-Formulary brand drugs	$50 **copay**	$125 **copay**	Not covered	

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**; $150 maximum	Not covered	90 day supply at retail for maintenance drugs. You pay difference in cost between brand-name and generic when a brand-name drug is requested and a generic equivalent is available.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **coinsurance**	30% **coinsurance**	----------none----------**
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	20% **coinsurance**	20% **coinsurance**	$250 **deductible** for each **emergency room** visit during the calendar year (after the first visit) that does not result in an inpatient admission.**
	Emergency medical transportation	20% **coinsurance**	30% **coinsurance**, except air ambulance services covered at 20% **coinsurance**	Coverage limited to first trip to the Hospital for any one Sickness or for all injuries sustained in any one Accident.**
	Urgent care	20% **coinsurance**	30% **coinsurance**	----------none----------**
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **coinsurance**	30% **coinsurance**	$200 Non-PPO Hospital **deductible** for each non-emergency inpatient confinement of at least one day; $25 Non-PPO Hospital **deductible** for each non-emergency outpatient treatment; **pre-authorization** required.**
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% **coinsurance**	30% **coinsurance**	----------none----------**
	Inpatient services			**Pre-authorization** required.** No coverage for Non-PPO residential treatment facilities.**

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 are pregnant	Office visits Childbirth/delivery professional services Childbirth/delivery facility services	20% **coinsurance**	30% **coinsurance**	Excludes dependent children except as required under federal law. **Cost sharing** does not apply for **preventive services**.**
If you need help recovering or have other special health needs	Home health care	20% **coinsurance**	30% **coinsurance**	**Home health care** must be provided by or through a Home Health Agency as defined by the **Plan**; must be in lieu of Hospital confinement; services must cost less to **Plan** than if provided by a Hospital; **pre-authorization** required.**
	Rehabilitation services	20% **coinsurance**	30% **coinsurance**	Speech therapy limited to 120 visits per calendar year; must be ordered by a Physician with specific instructions as to the type and duration of therapy.** Occupational and physical therapy limited to 50 visits per calendar year (combined; visits over limit subject to medical review); must be administered in accordance with a Physician's instructions as to the type and duration of therapy.** **Pre-authorization** required.**
	Habilitation services	20% **coinsurance**	30% **coinsurance**	
	Skilled nursing care	20% **coinsurance**	Not covered	Confinement must begin within 14 days after a Hospital admission of at least 3 days duration; 100 days per confinement maximum; **pre-authorization** required.**
	Durable medical equipment	20% **coinsurance**	30% **coinsurance**	**Pre-authorization** required.**

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)	
	Hospice services	20% **coinsurance**	30% **coinsurance**	**Pre-authorization** required.**
If your child needs dental or eye care	Children's eye exam	No charge	No charge	No charge for one eye exam per calendar year.**
	Children's glasses	Not covered	Not covered	No coverage unless eyeglasses are required to correct impairment caused by an ocular Accident or by intra-ocular surgery where such expenses are incurred no later than 6 months after the injury is sustained or the surgery is performed.**
	Children's dental check-up	20% **coinsurance**	20% **coinsurance**	----------none----------**

**Amounts paid by an Eligible Employee or Eligible Retiree for Covered HRA Expenses (as defined by the Plan) may be reimbursed from an HRA account.

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
- Infertility treatment (unless diagnostic infertility testing, if such tests are performed for the Physician to make an initial diagnosis)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care (unless individual is under active treatment for a metabolic or peripheral vascular disease such as diabetes)
- Weight loss program

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

- Bariatric surgery (limited to one treatment per lifetime (member and spouse only))
- Chiropractic care (limited to 12 visits per person per calendar year (excludes laboratory services))
- Dental care (Adult) ($700 per person per calendar year maximum; $100 per person calendar year **deductible**)
- Hearing aids (20% **coinsurance** up to $2,500 (PPO); 20% **coinsurance** up to $1,500 (Non-PPO); limited to once per ear every 36 months)
- Private-duty nursing (limited to 60 days per confinement)
- Routine eye care (Adult) (No charge up to $100 maximum benefit per calendar year)

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 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 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 Plan at 1-877-389-5398. 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.**
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	$500
Specialist coinsurance	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	$10
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,570**

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

The plan's overall deductible	$500
Specialist coinsurance	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 *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$880
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,460**

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

The plan's overall deductible	$500
Specialist coinsurance	20%
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 *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$260
Coinsurance	$410
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,170**

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