**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.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call your Local Fund Office. 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 your Local Fund Office to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$500**/person/calendar year; **$1,000**/family/calendar year | Generally, you must pay all of the costs from providers up to the deductible amount. If you have other family members on the plan, the plan begins to pay for one individual once that person satisfies the $500 individual deductible. The plan begins to pay for other family members once any combination of family members satisfies the remaining $500 deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care, prescription drugs, emergency room care and routine vision services 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 www.healthcare.gov/coverage/preventive-care-benefits/ |
| **Are there other deductibles for specific services?** | No. | You do not have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Medical: **$1,250**/person/calendar year; **$3,250**/family/calendar year (includes deductible)<br>Prescription drugs: **$5,350**/person/calendar year; **$9,950**/family/calendar year | 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?** | Balance-billing charges, penalties for failure to obtain precertification 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 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 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 **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/visit<br>Deductible does not apply. | $25 copay/visit<br>Deductible does not apply. | Telemedicine visits: $25 copay/visit then covered at 100% of allowable expense. |
| | Specialist visit | $35 copay/visit<br>Deductible does not apply. | $35 copay/visit<br>Deductible does not apply. | Telemedicine visits: $35 copay/visit then covered at 100% of allowable expense. |
| | Preventive care/screening/ immunization | No charge. Deductible does not apply. | No charge. Deductible does not apply. | You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have test** | Diagnostic test (x-ray, blood work) | 10% coinsurance | 10% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 10% 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) | |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.myallegiantrx.com | Generic drugs | Retail: $10 copay/prescription<br>Mail order: $15 copay/prescription<br>Deductible does not apply. | Not covered | Retail 30-day maximum, 90-day maximum through CVS Saver Plus Network; mail order 90-day maximum.<br>Some prescription drugs may be subject to mandatory mail order, precertification and/or high utilization monitoring programs.<br>Preferred brand drugs are brand name drugs where no generic equivalent is available.<br>Non-preferred drugs are covered only when your prescription is written as "dispense as written" or "DAW." You are responsible for the generic copay per prescription plus the difference in cost between the brand name drug and generic drug.<br>Generic contraceptives covered without copay. |
| | Preferred brand drugs | Retail: $20 copay/prescription<br>Mail order: $35 copay/prescription<br>Deductible does not apply. | Not covered | |
| | Non-preferred brand drugs | Retail: $10 copay/prescription plus difference between the cost of generic and brand name.<br>Mail order: $15 copay/prescription plus difference between the cost of generic and brand name.<br>Deductible does not apply. | Not covered | |
| | Specialty drugs | Retail: $20 copay/ prescription<br>Mail order: $35 copay/prescription<br>Deductible does not apply. | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 10% coinsurance | Precertification required to avoid penalty equal to 20% reduction of benefits. |
| | Physician/surgeon fees | 10% coinsurance | 10% coinsurance | Precertification required to avoid penalty equal to 20% reduction of benefits. |
| **If you need immediate medical attention** | Emergency room care | $50 copay/visit<br>Deductible does not apply. | $50 copay/visit<br>Deductible does not apply. | None |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance | Must be a local service. Transportation must be to nearest facility. Must be medically necessary. |
| | Urgent care | 10% coinsurance | 10% 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) | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 10% coinsurance | Precertification required to avoid penalty equal to 20% reduction of benefits. |
| | Physician/surgeon fees | 10% coinsurance | 10% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge for first 3 visits, then 10% coinsurance. | No charge for first 3 visits, then 10% coinsurance. | Telemedicine visits subject to deductible & coinsurance. |
| | Inpatient services | 10% coinsurance | 10% coinsurance | Precertification required to avoid penalty equal to 20% reduction of benefits. |
| **If you are pregnant** | Office visits | 10% coinsurance | 10% coinsurance | Medically necessary genetic testing is limited and precertification is required to avoid penalty equal to 20% reduction of benefits.<br>Cost sharing does not apply for preventive services. |
| | Childbirth/delivery professional services | 10% coinsurance | 10% coinsurance | Precertification required for stays in excess of government mandated-minimum (48/96 hours) to avoid penalty equal to 20% reduction of benefits. |
| | Childbirth/delivery facility services | 10% coinsurance | 10% 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 help recovering or have other special health needs** | Home health care | 10% coinsurance | 10% coinsurance | Limited to post-hospitalization and terminal conditions.<br>Precertification required to avoid penalty of 20% reduction of benefits. |
| | Rehabilitation services | Inpatient: 10% coinsurance<br>Outpatient: $25 copay/visit, deductible does not apply. | Inpatient: 10% coinsurance<br>Outpatient: $25 copay/visit, deductible does not apply. | Chiropractic care limit of 40 visits/calendar year.<br>Physical therapy limit of 60 visits/calendar year.<br>Medical massage and acupuncture combined limit of 24 visits/calendar year (must be prescribed). |
| | Habilitation services | Not covered | Not covered | You must pay 100% of this service, even in-network. |
| | Skilled nursing care | 10% coinsurance | 10% coinsurance | Precertification required to avoid a penalty equal to 20% reduction of benefits. |
| | Durable medical equipment | 10% coinsurance | 10% coinsurance | Precertification may be required to avoid a penalty equal to 20% reduction of benefits. |
| | Hospice services | 10% coinsurance | 10% coinsurance | Precertification required to avoid a penalty equal to 20% reduction of benefits.<br>Must be diagnosed as terminally ill with a life expectancy of less than 6 months. |

| 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 your child needs dental or eye care** | Children's eye exam | No charge for well vision exam.<br>Deductible does not apply. | Not covered | Limit one per 12 months. |
| | Children's glasses | Frames: No charge up to $300 ($320 for Feature Frame Brands through VSP), then 80%.<br>Lenses: No charge for single vision lenses, lined bifocal and lined trifocal lenses, impact-resistant lenses, and standard progressive lenses.<br>Deductible does not apply. | Not covered | Limit one per 12 months. |
| | Children's dental check-up | No charge | No charge | Limit two per calendar year. Coverage based on fee schedule. |

## 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.) | | |
|---|---|---|
| • Habilitation services<br>• Infertility treatment | • Long-term care<br>• Private-duty nursing | • Routine foot care |

| Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.) | | |
|---|---|---|
| • Acupuncture (24 visits/year combined with medical massage)<br>• Bariatric surgery (one/lifetime)<br>• Chiropractic care (40 visits/calendar year) | • Cosmetic surgery (only following injury, illness or mastectomy, or for correction of congenital functional abnormality)<br>• Dental care (Adult)<br>• Hearing aids ($2,500 per ear/3 years) | • Non-emergency care when traveling outside the U.S. (see www.Anthem.com)<br>• Routine eye care (Adult) (no charge for well vision exam and for certain lenses and frames)<br>• Weight loss programs (limited to $350 per calendar year through Fitness Awareness and to programs required to be covered under the Affordable Care Act) |

**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. 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 your Local Fund Office. 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 does not 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 copayment** | **$35** |
| **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** | **$12,700** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $10 |
| Coinsurance | $750 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,320** |

### 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 copayment** | **$35** |
| **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** | **$5,600** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $550 |
| **The total Joe would pay is** | **$1,350** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$500** |
| **Specialist copayment** | **$35** |
| **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** | **$2,800** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $160 |
| Coinsurance | $170 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$830** |

**NOTE:** These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your cost. For more information about the wellness program, please call your Local Fund Office.

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