

 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 [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call your Local Fund Office to request a copy.

| Important Questions   | Answers  | Why This Matters:  |
|---|--|--|
| What is the overall <u>deductible</u> ?                             | \$150/person/calendar year;<br>\$300/family/calendar year  | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount. If you have other family members on the plan, the <u>plan</u> begins to pay for one individual once that person satisfies the \$150 individual <u>deductible</u> . The <u>plan</u> begins to pay for other family members once any combination of family members satisfies the remaining \$150 <u>deductible</u> .  |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Preventive care</u> , <u>prescription drugs</u> , <u>emergency room care</u> , routine vision services and the first \$250 of <u>diagnostic tests</u> and imaging 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.  |
| Are there other <u>deductibles</u> for specific services?           | No.  | You don't have to meet <u>deductibles</u> for specific services.   |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | Yes. \$400/person/calendar year.   | The <u>out-of-pocket limit</u> is the most each person could pay in a year for covered services.   |
| What is not included in the <u>out-of-pocket limit</u> ?            | <u>Balance billing</u> charges, health care this <u>plan</u> doesn't cover, <u>copayments</u> , <u>deductible</u> and penalties for failure to obtain precertification for services.   | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .   |
| Will you pay less if you use a <u>network provider</u> ?            | Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 800-810-2583 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. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?          | No.  | You can see the <u>specialist</u> you choose without a <u>referral</u> .   |



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<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)                                     |  |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | 20% <u>coinsurance</u>   | 20% <u>coinsurance</u>   | None   |
|   | <u>Specialist</u> visit                          | 20% <u>coinsurance</u>   | 20% <u>coinsurance</u>   | None   |
|   | <u>Preventive care/screening/immunization</u>    | No charge. <u>Deductible</u> does not apply.   | No charge. <u>Deductible</u> does not apply.   | 1 physical exam/year.<br>1 mammogram/year/ages 40+.<br>Well child: 3 visits/birth-6months; 4 visits/9-18 months; 1 visit/year thereafter.<br>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. |
| If you have a test  | <u>Diagnostic test</u> (x-ray, blood work)       | First \$250: no charge; then subject to <u>deductible</u> and 20% <u>coinsurance</u> . | First \$250: no charge; then subject to <u>deductible</u> and 20% <u>coinsurance</u> . | None   |
|   | Imaging (CT/PET scans, MRIs)                     |  |  |  |



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   |
|--|--|---|---|--|
|  |  | <u>Network Provider</u><br>(You will pay the least)   | <u>Out-of-Network Provider</u><br>(You will pay the most) |  |
| <p><b>If you need drugs to treat your illness or condition</b><br/>More information about <b>prescription drug coverage</b> is available at <a href="http://www.myalleghiantrx.com">www.myalleghiantrx.com</a></p> | Generic drugs                                  | Retail: \$10 <u>copay</u> /prescription.<br>Mail order: \$15 <u>copay</u> /prescription.<br><u>Deductible</u> does not apply.   | Not covered   | <p>Retail: 30-day maximum; mail order: 90-day maximum</p> <p>Some <u>prescription drugs</u> may be subject to mandatory mail order, precertification and/or high utilization monitoring programs.</p> <p>Preferred brand drugs are brand names where no generic equivalent is available.</p> <p>Non-preferred drugs are covered only when your prescription is written as "dispense as written" or "DAW."</p> <p><u>Copayments</u> are not included in the <u>out-of-pocket limit</u>.</p> |
|  | Preferred brand drugs                          | Retail: \$20 <u>copay</u> /prescription.<br>Mail order: \$35 <u>copay</u> /prescription.<br><u>Deductible</u> does not apply.   | Not covered   |  |
|  | Non-preferred brand drugs                      | Retail: \$10 <u>copay</u> /prescription plus difference between the cost of generic and brand name.<br>Mail order: \$15 <u>copay</u> /prescription plus difference between the cost of generic and brand name.<br><u>Deductible</u> does not apply. | Not covered   |  |
|  | <u>Specialty drugs</u>                         | Retail: \$20 <u>copay</u> /prescription.<br>Mail order: \$35 <u>copay</u> /prescription.<br><u>Deductible</u> does not apply.   | Not covered   |  |
| <p><b>If you have outpatient surgery</b></p>   | Facility fee (e.g., ambulatory surgery center) | No charge   | No charge   | Precertification required to avoid penalty equal to 20% reduction in benefits.   |
|  | Physician/surgeon fees                         | No charge   | No charge   | Precertification required to avoid penalty equal to 20% reduction in benefits.   |



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<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)  |   |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                | Injury: no charge<br>Illness: \$50 <u>copay</u> /visit<br><u>Deductible</u> does not apply. | Injury: no charge<br>Illness: \$50 <u>copay</u> /visit<br><u>Deductible</u> does not apply. | <u>Copayments</u> are not included in the <u>out-of-pocket limit</u> .<br><u>Copayment</u> is waived if admitted.   |
|   | <u>Emergency medical transportation</u>   | 20% <u>coinsurance</u>  | 20% <u>coinsurance</u>  | Must be a local service. Transportation must be to nearest facility. Must be <u>medically necessary</u> .   |
|   | <u>Urgent care</u>                        | No charge   | No charge   | None  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)        | No charge   | No charge   | Precertification required to avoid penalty equal to 20% reduction of benefits.  |
|   | Physician/surgeon fees                    | Physician: 20% <u>coinsurance</u><br>Surgeon: No charge                                     | Physician: 20% <u>coinsurance</u><br>Surgeon: No charge                                     |   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | No charge for first 3 visits; 20% <u>coinsurance</u> thereafter.                            | No charge for first 3 visits; 20% <u>coinsurance</u> thereafter.                            | None  |
|   | Inpatient services                        | No charge   | No charge   | Precertification required to avoid penalty equal to 20% reduction of benefits.  |
| If you are pregnant   | Office visits                             | 20% <u>coinsurance</u>  | 20% <u>coinsurance</u>  | <u>Medically necessary</u> genetic testing is limited, and precertification is required to avoid penalty equal to 20% reduction of benefits.<br><u>Cost sharing</u> does not apply for <u>preventive services</u> . |
|   | Childbirth/delivery professional services | No charge   | No charge   | 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     | No charge   | No charge   |   |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                   | No charge   | No charge   | Limited to post-hospitalization and terminal conditions.<br>Precertification required to avoid penalty of 20% reduction of benefits.  |



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  |
|---|----------------------------------|--|--|---|
|   |                                  | <u>Network Provider</u><br>(You will pay the least)  | <u>Out-of-Network Provider</u><br>(You will pay the most)                    |   |
|   | <u>Rehabilitation services</u>   | No charge  | No charge  | Chiropractic care limit: 40 visits/calendar year.<br>Physical therapy limit: 60 visits/calendar year.<br>Medical massage and acupuncture combined limit: 24 visits/calendar year. |
|   | <u>Habilitation services</u>     | Not covered  | Not covered  | You must pay 100% of these expenses, even in-network.   |
|   | <u>Skilled nursing care</u>      | No charge  | No charge  | Precertification required to avoid penalty equal to 20% reduction of benefits.  |
|   | <u>Durable medical equipment</u> | No charge on certain equipment. 20% <u>coinsurance</u> otherwise applicable.   | No charge on certain equipment. 20% <u>coinsurance</u> otherwise applicable. | Precertification may be necessary to avoid penalty equal to 20% reduction of benefits.  |
|   | <u>Hospice services</u>          | No charge  | No charge  | Precertification may be necessary to avoid penalty equal to 20% reduction of benefits. Must be diagnosed as terminally ill with a life expectancy of less than 6 months.          |
| <b>If your child needs dental or eye care</b> | Children's eye exam              | Region I: No charge<br>Region II: \$20 <u>copay/exam</u><br>Region III: \$30 <u>copay/exam</u><br>Region IV: \$43 <u>copay/exam</u><br><u>Deductible</u> does not apply. | Not covered  | Limit one per 12 months   |



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 |
|----------------------|----------------------------|---|---|--|
|                      |                            | <u>Network Provider</u><br>(You will pay the least)   | <u>Out-of-Network Provider</u><br>(You will pay the most) |  |
|                      | Children's glasses         | No charge for regular glasses with standard lenses.<br>Hi-index: \$55 <u>copay/frame</u><br>Polarized: \$75 <u>copay/frame</u><br><u>Copay</u> varies for anti-reflective coating<br>Disposable contacts: \$35 <u>copay/6-month</u> supply.<br><u>Deductible</u> does not apply | Not covered   | Limit one per 12 months                                |
|                      | Children's dental check-up | No charge   | No charge   | 1 visit/6 months                                       |

## 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
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care

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

- Acupuncture (24 visits/calendar year combined with medical massage)
- Bariatric surgery (one/lifetime)
- Chiropractic care (40 visits/calendar year)
- Cosmetic surgery (only following injury, illness or mastectomy, or for correction of congenital functional abnormality)
- Dental care (Adult)
- Hearing aids (\$2,500 per ear/5 years)
- Non-emergency care when traveling outside the U.S. (See: [www.anthem.com](http://www.anthem.com))
- Routine eye care (Adult) (no charge for exam in Region I; copayment for Regions II, III, and IV and for certain lenses and frames)
- Weight loss programs

**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 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 an 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 or appeal for any reason to your plan. For more information about your rights, this notice, or assistance, call 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](http://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 \$300
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 0%
- 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <u>Cost Sharing</u>               |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$300        |
| <u>Copayments</u>                 | \$40         |
| <u>Coinsurance</u>                | \$400        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$60         |
| <b>The total Peg would pay is</b> | <b>\$800</b> |

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

- The plan's overall deductible \$150
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 0%
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$150          |
| <u>Copayments</u>                 | \$890          |
| <u>Coinsurance</u>                | \$150          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$260          |
| <b>The total Joe would pay is</b> | <b>\$1,450</b> |

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

- The plan's overall deductible \$150
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 0%
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <u>Cost Sharing</u>               |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$150        |
| <u>Copayments</u>                 | \$0          |
| <u>Coinsurance</u>                | \$40         |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$190</b> |

**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.