
 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, go to www.ibew153.benefits.org or call 1-877-244-9473. 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.com or call 1-855-756-4448 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible ? | \$400/Individual or \$1,200/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 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 primary care services 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? | No, there are no other deductibles. | You don't have to meet other specific deductibles for specific services |
| What is the out-of-pocket limit for this plan ? | For network providers \$1,000 individual / \$2,000 family; for out-of-network providers \$1,500 individual / \$4,000 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 ? | Copayments for certain services, 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 www.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 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. |

 Some [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 | \$30 copay /office visit and 0% coinsurance for other outpatient services; deductible does not apply | 30% coinsurance | Out-of-network providers may balance bill. |
| | Specialist visit | \$30 copay /visit | 30% coinsurance | Out-of-network providers may balance bill. |
| | Preventive care/screening/immunization | No charge | Not Covered | You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | 10% co-insurance after the deductible | 30% coinsurance after the deductible | Out-of-network providers may balance bill |
| | Imaging (CT/PET scans, MRIs) | 10% co-insurance after the deductible | 30% coinsurance after the deductible | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.humana.com | Generic drugs (Tier 1) | \$5 copay /prescription (1-30 days) \$10 copay (31-90 days) (retail & mail order) | \$5 copay /prescription (1-30 days) \$10 copay (31-90 days) (retail & mail order) | Covers up to a 30-day supply (retail & mail order); 31-90 day supply (retail & mail order prescription). The out-of-pocket limit for Rx is \$3,000 per person and \$6,000 per family |
| | Preferred brand drugs (Tier 2) | \$30 copay /prescription (1-30 days) \$60 copay (31-90 days) (retail & mail order) | \$30 copay /prescription (1-30 days) \$60 copay (31-90 days) (retail & mail order) | |
| | Non-preferred brand drugs (Tier 3) | \$50 copay /prescription (1-30 days) \$100 copay (31-90 days) (retail & mail order) | \$50 copay /prescription (1-30 days) \$100 copay (31-90 days) (retail & mail order) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance after deductible | 30% coinsurance after deductible | Preauthorization is required for in-patient services only. If you do not get preauthorization , benefits could be reduced. |
| | Physician/surgeon fees | 10% coinsurance after the deductible | 30% coinsurance after deductible | Out-of-network may balance bill. |

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| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need immediate medical attention | Emergency room care | \$150 copay | \$150 copay | Copay waived if admitted or for an accidental injury. Transportation must be medically necessary. Out-of-network providers may balance bill. |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance after the deductible | |
| | Urgent care | \$30 copay/visit | 30% coinsurance after the deductible | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance after the deductible | 30% coinsurance after the deductible | Preauthorization is required for in-patient services. Please contact Hines & Associates at 888-236-2652. Out-of-network may balance bill. |
| | Physician/surgeon fees | 10% coinsurance after the deductible | 30% coinsurance after the deductible | Out-of-network may balance bill. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 10% coinsurance after the deductible | 30% coinsurance after the deductible | Out-of-network may balance bill. Pre-authorization is required for in-patient services. Contact Hines & Assoc. at 888-236-2652. |
| | Inpatient services | 10% coinsurance after the deductible | 30% coinsurance after the deductible | |
| If you are pregnant | Office visits | 0% coinsurance | 30% coinsurance after the deductible | Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 10% coinsurance after the deductible | 30% coinsurance after the deductible | |
| | Childbirth/delivery facility services | 10% coinsurance after the deductible | 30% coinsurance after the deductible | |
| If you need help recovering or have other special health needs | Home health care | 10% coinsurance after the deductible | 10% coinsurance after the deductible | Out-of-network may balance bill. Must be medically necessary. |
| | Rehabilitation services | 10% coinsurance after the deductible | 30% coinsurance after the deductible | Out-of-network may balance bill |
| | Habilitation services | 10% coinsurance after the deductible | 30% coinsurance after the deductible | |
| | Skilled nursing care | 10% coinsurance after the deductible | 10% coinsurance after the deductible | Out-of-network may balance bill. |
| | Durable medical equipment | 10% coinsurance | 10% coinsurance | Out-of-network may balance bill. |
| | Hospice services | 0% coinsurance | 0% coinsurance | Provided through a participating program only. |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | -----none----- |
| | Children's glasses | Not covered | Not covered | -----none----- |
| | Children's dental check-up | Not covered | Not covered | -----none----- |

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
- Dental Care
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss programs

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

- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Non-emergency care when traveling outside of the U.S.
- Private duty nursing

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, Employee Benefits Security Administration 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 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: www.153benefits.org or 1-877-244-9473. You may also contact the Department of Laborer Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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 Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 877-244-9473

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-244-9473

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 877-244-9473

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 877-244-9473

————— *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 | \$400 |
| ■ Specialist copayment | \$30 |
| ■ 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 | \$20,000 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$400 |
| Copayments | \$00 |
| Coinsurance | \$1,000 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$1,400 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|-------|
| ■ The plan's overall deductible | \$400 |
| ■ Specialist copayment | \$30 |
| ■ 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 | \$3,000 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|--------------|
| Deductibles* | \$400 |
| Copayments | \$60 |
| Coinsurance | \$100 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$560 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|-------|
| ■ The plan's overall deductible | \$400 |
| ■ Specialist copayment | \$30 |
| ■ 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 | \$4,000 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|--------------|
| Deductibles* | \$000 |
| Copayments | \$150 |
| Coinsurance | \$00 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$150 |

*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.