
 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, please contact the IUOE Local 132 Health & Welfare Fund at 1-304-525-0482 or 1-800-642-3525. 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 1-800-642-3525 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                       | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$250 Individual or \$500 family                                                                                                                                              | Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .                                                                   | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | Yes. \$100 for <a href="#">prescription drug coverage</a> .                                                                                                                   | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For <a href="#">network providers</a> \$3,000 individual; for <a href="#">out-of-network providers</a> \$6,000 individual                                                     | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Copayments</a> for certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover. | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-810-2583 for a list of <a href="#">network providers</a> .                                          | This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

 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<br>(You will pay the least)                            | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                 |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                    | Primary care visit to treat an injury or illness       | 15% <a href="#">coinsurance</a>                                         | 30% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                            |
|                                                                                                                                                                           | <a href="#">Specialist</a> visit                       | 15% <a href="#">coinsurance</a>                                         | 30% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                            |
|                                                                                                                                                                           | <a href="#">Preventive care/screening/immunization</a> | No charge                                                               | No Charge                                          | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.    |
| If you have a test                                                                                                                                                        | <a href="#">Diagnostic test</a> (blood work)           | 15% <a href="#">coinsurance</a>                                         | 30% <a href="#">coinsurance</a>                    | Must be a free-standing laboratory for the Participating Provider charges to be paid at 100%, if it is not a free-standing laboratory, Participating Provider charges require 15% <a href="#">coinsurance</a> . |
|                                                                                                                                                                           | Imaging (CT/PET scans, MRIs)                           | 15% <a href="#">coinsurance</a>                                         | 30% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                            |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.iuoe132.org</a> | Generic drugs (Tier 1)                                 | 10% of cost (\$7.50 minimum / \$100 maximum)<br>\$20 for 90-day supply  |                                                    | Covers up to a 30-day supply (retail subscription);                                                                                                                                                             |
|                                                                                                                                                                           | Preferred brand drugs (Tier 2)                         | 20% of cost (\$20 minimum / \$100 maximum)<br>\$40 for 90-day supply    |                                                    | Covers from 31-90 day supply (mail order prescription) at any Optum RX or the Optum RX Mail Service Pharmacy.                                                                                                   |
|                                                                                                                                                                           | Non-preferred brand drugs (Tier 3)                     | 30% of cost (\$35 minimum / \$100 maximum)<br>\$80 for 90-day supply    |                                                    |                                                                                                                                                                                                                 |
|                                                                                                                                                                           | <a href="#">Specialty drugs</a> (Tier 4)               | Dependent on if specialty drug is generic, brand or non-preferred brand |                                                    | Requires <a href="#">preauthorization</a> and the use of the Optum RX Specialty Pharmacy.                                                                                                                       |
|                                                                                                                                                                           | Facility fee (e.g., ambulatory surgery center)         | 15% <a href="#">coinsurance</a>                                         | 30% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                            |
|                                                                                                                                                                           | Physician/surgeon fees                                 | 15% <a href="#">coinsurance</a>                                         | 30% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                            |
| If you need immediate medical attention                                                                                                                                   | <a href="#">Emergency room care</a>                    | 15% <a href="#">coinsurance</a>                                         | 30% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                            |
|                                                                                                                                                                           | <a href="#">Emergency medical transportation</a>       | 15% <a href="#">coinsurance</a>                                         | 30% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                 |
|                                                                                                                                                                           | <a href="#">Urgent care</a>                            | 15% <a href="#">coinsurance</a>                                         | 30% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                 |
| If you have a hospital stay                                                                                                                                               | Facility fee (e.g., hospital room)                     | 15% <a href="#">coinsurance</a>                                         | 30% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is not required.                                                                                                                                                               |
|                                                                                                                                                                           | Physician/surgeon fees                                 | 15% <a href="#">coinsurance</a>                                         | 30% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                            |

| 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 mental health, behavioral health, or substance abuse services | Outpatient services                       | 15% <a href="#">coinsurance</a>                                                                               | 30% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                   |
|                                                                           | Inpatient services                        | 15% <a href="#">coinsurance</a>                                                                               | 100% <a href="#">coinsurance</a>                   | No benefits are payable for services provided by an out-of-network residential treatment facility.                                                                                                                                                                     |
| If you are pregnant                                                       | Office visits                             | 15% <a href="#">coinsurance</a>                                                                               | 30% <a href="#">coinsurance</a>                    | <a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                           | Childbirth/delivery professional services | 15% <a href="#">coinsurance</a>                                                                               | 30% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                        |
|                                                                           | Childbirth/delivery facility services     | 15% <a href="#">coinsurance</a>                                                                               | 30% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                        |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | 15% <a href="#">coinsurance</a>                                                                               | 30% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                   |
|                                                                           | <a href="#">Habilitation services</a>     | 15% <a href="#">coinsurance</a>                                                                               | 30% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                   |
|                                                                           | <a href="#">Rehabilitation services</a>   | 15% <a href="#">coinsurance</a>                                                                               | 100% <a href="#">coinsurance</a>                   | No benefits are payable for services provided by an out-of-network residential treatment facility.                                                                                                                                                                     |
|                                                                           | <a href="#">Skilled nursing care</a>      | 15% <a href="#">coinsurance</a>                                                                               | 100% <a href="#">coinsurance</a>                   | No benefits are payable for services provided by an out-of-network residential treatment facility.                                                                                                                                                                     |
|                                                                           | <a href="#">Durable medical equipment</a> | 15% <a href="#">coinsurance</a>                                                                               | 30% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                   |
|                                                                           | <a href="#">Hospice services</a>          | 15% <a href="#">coinsurance</a>                                                                               | 30% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                   |
| If your child needs dental or eye care                                    | Children's eye exam                       | For children age 19 or less, the oral/vision care benefit pays 100% of the first \$1,500, then 50% thereafter |                                                    | For adults, the oral/vision care benefit is limited to a maximum of \$1,500 per calendar year.                                                                                                                                                                         |
|                                                                           | Children's glasses                        |                                                                                                               |                                                    |                                                                                                                                                                                                                                                                        |
|                                                                           | Children's dental check-up                |                                                                                                               |                                                    |                                                                                                                                                                                                                                                                        |

### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)      |                                                                                                                                                                    |                                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Bariatric surgery (if BMI less than 40)</li> <li>Cosmetic Surgery</li> </ul>                                                                                    | <ul style="list-style-type: none"> <li>Hearing Aids</li> <li>Infertility Treatments</li> </ul>                                                                     | <ul style="list-style-type: none"> <li>Routine Foot Care</li> <li>Weight Loss Programs</li> </ul>               |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                           |                                                                                                                                                                    |                                                                                                                 |
| <ul style="list-style-type: none"> <li>Acupuncture (if prescribed for rehabilitation purposes)</li> <li>Chiropractic Care (up to \$1,000 per year or twenty visits, whichever occurs first)</li> </ul> | <ul style="list-style-type: none"> <li>Dental Care (Adult or Child)</li> <li>Long Term Care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>Private Duty Nurse</li> <li>Routine eye care (Adult or Child)</li> </ul> |

**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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272, or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-8977-267-2323, extension 61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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 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 Fund Office at 1-304-525-0482 or 1-800-642-3525.

**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 1-800-642-3525.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-642-3525.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-642-3525.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-642-3525.]

-----*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](#) \$250
- [Specialist copayment](#) \$0
- Hospital (facility) [coinsurance](#) 15%
- Other [coinsurance](#) 15%

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:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$283          |
| Copayments                        | \$0            |
| Coinsurance                       | \$1,761        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,104</b> |

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$0
- Hospital (facility) [coinsurance](#) 15%
- Other [coinsurance](#) 15%

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:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$350          |
| Copayments                        | \$0            |
| Coinsurance                       | \$1,203        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$55           |
| <b>The total Joe would pay is</b> | <b>\$1,608</b> |

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$0
- Hospital (facility) [coinsurance](#) 15%
- Other [coinsurance](#) 15%

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:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$250        |
| Copayments                        | \$0          |
| Coinsurance                       | \$289        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$539</b> |