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 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 deductible?	$250 Individual or $500 family *Certain Out-of-Network claims are treated as In-Network claims as required by the No Surprises Act*	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 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?	Yes. $100 for prescription drug coverage.	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?	For network providers $3,000 individual; for out-of-network providers $6,000 individual *Certain Out-of-Network claims are treated as In-Network claims as required by No Surprises Act*	The out-of-pocket limit is the most you could pay in a year for covered services.
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. *Out-of-Network providers may be treated as In-Network providers as required by No-Surprises Act.*	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.	

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	15% coinsurance	30% coinsurance	None
	Specialist visit	15% coinsurance	30% coinsurance	None
	Preventive care/screening/ immunization	No charge	No Charge	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 (blood work)	15% coinsurance	30% coinsurance	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% coinsurance.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.iuoe132.org	Generic drugs (Tier 1)	10% of cost ($7.50 minimum / $100 maximum) $20 for 90-day supply		Covers up to a 30-day supply (retail subscription); Covers from 31-90 day supply (mail order prescription) at any Optum RX or the Optum RX Mail Service Pharmacy.
	Preferred brand drugs (Tier 2)	20% of cost ($20 minimum / $100 maximum) $40 for 90-day supply		
	Non-preferred brand drugs (Tier 3)	30% of cost ($35 minimum / $100 maximum) $80 for 90-day supply		
	Specialty drugs (Tier 4)	Dependent on if specialty drug is generic, brand or non-preferred brand		Requires preauthorization and the use of the Optum RX Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	30% coinsurance unless otherwise required by No Surprises Act	None
	Physician/surgeon fees	15% coinsurance	30% coinsurance unless otherwise required by No Surprises Act	None
If you need immediate medical attention	Emergency room care	15% coinsurance	30% coinsurance unless otherwise required by No Surprises Act	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)	
	Emergency medical transportation	15% coinsurance	30% coinsurance unless otherwise required by No Surprises Act	
	Urgent care	15% coinsurance	30% coinsurance unless otherwise required by No Surprises Act	
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	30% coinsurance unless otherwise required by No Surprises Act	Preauthorization is not required.
	Physician/surgeon fees	15% coinsurance	30% coinsurance unless otherwise required by No Surprises Act	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	30% coinsurance unless otherwise required by No Surprises Act	None
	Inpatient services	15% coinsurance	100% coinsurance unless otherwise required by No Surprises Act	No benefits are payable for services provided by an out-of-network residential treatment facility.
If you are pregnant	Office visits	15% coinsurance	30% coinsurance unless otherwise required by No Surprises Act	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			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	15% coinsurance	30% coinsurance	None
	Habilitation services	15% coinsurance	30% coinsurance	None
	Rehabilitation services	15% coinsurance	100% coinsurance	No benefits are payable for services provided by an out-of-network residential treatment facility.
	Skilled nursing care	15% coinsurance	100% coinsurance	
	Durable medical equipment	15% coinsurance	30% coinsurance	None
	Hospice services	15% coinsurance	30% coinsurance	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Bariatric surgery (if BMI less than 40) • Cosmetic Surgery	• Hearing Aids • Infertility Treatments	• 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.)		
• Acupuncture (if prescribed for rehabilitation purposes) • Chiropractic Care (up to $1,000 per year or twenty visits, whichever occurs first)	• Dental Care (Adult or Child) • Long Term Care • Non-emergency care when traveling outside the U.S.	• Private Duty Nurse • Routine eye care (Adult or Child)

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, or the U.S. Department of Health and Human Services at 1-8977-267-2323, extension 61565 or 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 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, kwiijigo 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)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$283
Copayments	$0
Coinsurance	$1,761
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,104

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)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$350
Copayments	$0
Coinsurance	$1,203
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,608

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)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$289
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$539

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