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, visit www.ualocal172benefits.org. 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.healthcare.gov/sbc-glossary or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$800/individual or $1,600/family for in-network; $1,200/individual or $2,400/family for out-of-network.	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 is 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/individual or $200/family for prescription drug and $100 for emergency room. There are no other specific deductibles.	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 $5,000 individual/$10,000 family; for out- of-network providers $10,000 per person.	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?	Out-of-network deductibles (except for emergency); prescription drug copayments; 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.

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	$20 copay/office visit and 20% coinsurance for other outpatient services	40% coinsurance	None
	Specialist visit	$20 copay/visit	40% coinsurance	Chiropractic care limited to 20 visits per calendar year (excludes x-rays or lab service).
	Preventive care/screening/ immunization	No charge; deductible does not apply	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com.		**Retail (30-day)**	**Mail (90-day)**	**$100**/individual or **$200**/family per calendar year prescription drug deductible. **$4,100**/individual or **$8,200**/family per calendar year prescription drug out-of-pocket maximum.
	Generic drugs	$15 copay	$30 copay	Not covered
	Preferred brand drugs	$40 copay	$80 copay	Not covered
	Non-preferred brand drugs	$60 copay	$120 copay	Not covered
	Specialty drugs	20% coinsurance ($150 max); 30% coinsurance ($150 max with copay assistance)		Not covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Ambulatory surgery center must be licensed; pre-certification required for outpatient surgical procedures (**$250** penalty).
	Physician/surgeon fees	20% coinsurance	40% 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 immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Notification of emergency hospitalization is required within one business day following admission. **$100** per visit emergency room deductible. If admitted to hospital, the emergency room deductible is waived.
	Emergency medical transportation	20% coinsurance	40% of UCR for ground transportation 20% of the lesser of the amount billed or the QPA for air ambulance	None
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-certification required ($250 penalty).
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Pre-certification required ($250 penalty).
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Pre-certification required ($250 penalty).
If you are pregnant	Office visits	$20 copay/office visit	40% coinsurance	**Cost sharing** does not apply for **preventive services**. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Pre-certification required ($250 penalty).
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Pre-certification required ($250 penalty).

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	20% coinsurance	40% coinsurance	Coverage limited to 40 visits/calendar year. Pre-certification required ($250 penalty).
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical therapy must be administered in accordance with a Physician's instructions as to the type and duration; speech therapy and occupational therapy must be required as a direct result of an Accident or Sickness.
	Habilitation services	Not covered	Not covered	No coverage for habilitation services.
	Skilled nursing care	20% coinsurance	40% coinsurance	Pre-certification required ($250 penalty).
	Durable medical equipment	20% coinsurance	40% coinsurance	Pre-certification required ($250 penalty).
	Hospice services	20% coinsurance	40% coinsurance	Care must be rendered by a licensed Hospice Care Agency as defined by the Plan and coverage person must elect to use the Hospice Care Program. Pre-certification required ($250 penalty).
If your child needs dental or eye care	Children's eye exam	No charge	No charge for dependent children under age 19; Balance over $35 for dependent children age 19 and older	Vision and Dental coverage are an optional benefit for Pre-Medicare Retirees and a separate premium is required.
	Children's glasses	No charge for one pair of lenses (every calendar year); 50% of balance over $187.50 for frames (every other calendar year)	50% of balance over: $60 for single vision lenses; $80 for lined bifocal lenses; $95 for lined trifocal lenses; $70 for frames (every other calendar year)	
	Children's dental check-up	No charge	No charge	

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.)

- Cosmetic surgery (except to correct damage caused by Accident or Sickness or congenital deformities of a Dependent child)
- Habilitation services
- Hearing aids
- Infertility treatment (except diagnostic infertility testing if such tests are performed for the Physician to make an initial diagnosis)
- Non-emergency care when traveling outside the U.S.
- Long-term care (unless Skilled Nursing Facility; pre-certification required ($250 penalty
- Routine foot care (unless Medically Necessary)
- Weight Loss programs

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

- Acupuncture
- Bariatric surgery (limited to treatment/ surgery for one occurrence of morbid obesity for covered Participants and Dependents over 18 years of age; pre-certification required ($250 penalty))
- Chiropractic care (limited to 20 visits per calendar year (excludes x-rays or laboratory services))
- Dental care (Adult) ($1,250 per person maximum (PPO); $1,000 per person maximum (Premier and Non-PPO);optional benefit for Pre-Medicare Retirees and separate premium required)
- Private-duty nursing
- Routine eye care (Adult) ($35 per person maximum for Non-PPO; optional benefit for Pre-Medicare Retirees and separate premium required)

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's Employees 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 the plan at 1-833-767-0172. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit 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 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 1-833-767-0172

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	$800
Prescription deductible	$100
Specialist copayment	$20
Hospital (facility) coinsurance	20%
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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$810
Copayments	$300
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

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

The plan's overall deductible	$800
Prescription deductible	$100
Specialist copayment	$20
Hospital (facility) coinsurance	20%
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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$450
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,570**

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

The plan's overall deductible	$800
Prescription deductible	$100
Specialist copayment	$20
Hospital (facility) coinsurance	20%
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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$810
Copayments	$60
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,270**

*Note: This plan may have other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above. For Active Employees, these numbers do not consider any possible reimbursement from your Dollar Bank Account. The plan would be responsible for the other costs of these EXAMPLE covered services.