**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 or call 1-833-767-0172. 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 drugs 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<br><br>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 | Not covered | Not covered | No coverage for vision care. |
| | Children's glasses | Not covered | Not covered | No coverage for vision care. |
| | Children's dental check-up | Not covered | Not covered | No coverage for dental care. |

## 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)
- Dental care (adult or child)
- Habilitation services
- Hearing aids
- Infertility treatment (except diagnostic infertility testing if such tests are performed for the Physician to make an initial diagnosis)
- Long-term care (unless Skilled Nursing Facility; pre-certification required ($250 penalty
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult or child)
- 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<br>• 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))<br>• 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'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** | **$3,570** |

### 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.

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

Questions: Call 1-833-767-0172 or visit www.ualocal172benefits.org