


\*This Plan covers Employees only. Spouses are covered for Dental and Vision benefits only.



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, 1-800-522-0456. 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.associated-admin.com](http://www.associated-admin.com) or call 1-800-522-0456 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$5,600/per calendar year.	The Fund pays the 1 <sup>st</sup> \$400 @ 100% of the Anthem allowance for all eligible expenses, then <b><u>deductible</u></b> is applied. Generally, you must pay all of the costs from <b><u>providers</u></b> up to the <b><u>deductible</u></b> amount before this <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <b><u>Preventive</u></b> care and the 1 <sup>st</sup> \$400 @ 100% of the Anthem allowance for all eligible expenses	For example, this <a href="#">plan</a> covers certain <b><u>preventive services</u></b> without <b><u>cost-sharing</u></b> and before you meet your <b><u>deductible</u></b> . See a list of covered <b><u>preventive services</u></b> 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?	No	You don't have to meet <b><u>deductibles</u></b> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For Medical Benefits \$5,600, for Prescription Drug Benefits \$1,000	The <b><u>out-of-pocket limit</u></b> 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> ?	<b><u>Copayments</u></b> on certain services, <b><u>premiums</u></b> , <b><u>balance-billing</u></b> charges, and health care this <a href="#">plan</a> doesn't cover	Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b> .
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-BLUE for a list of <b><u>network providers</u></b>	This plan uses a <b><u>provider network</u></b> . You will pay less if you use a <b><u>provider</u></b> in the <b><u>plan's network</u></b> . You will pay the most if you use an <b><u>out-of-network provider</u></b> . Be aware your <b><u>network provider</u></b> might use an <b><u>out-of-network provider</u></b> for some services (such as lab work). Check with your <b><u>provider</u></b> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <b><u>specialist</u></b> you choose without a <b><u>referral</u></b> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	No charge	Not Covered	None
	<a href="#">Specialist</a> visit	No charge	Not Covered	None
	<a href="#">Preventive care/screening/immunization</a>	No charge. <b>Deductible</b> does not apply	Not Covered	None
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	<b>Preauthorization</b> required. Failure may result in a denial or penalty of 50% up to \$500
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.Express-Scripts.com">www.Express-Scripts.com</a>	Generic drugs	Retail: 20% up to \$20; Mail: 20% up to \$40	Not Covered	Retail limited to 34-day supply; mail order limited to 90 day supply. If you can obtain a brand name medication when a generic equivalent is available, you pay the generic <b>co-insurance</b> plus the difference between the cost of the brand name drug and the generic. Utilization Management Program in effect. <b>Preauthorization</b> required for some drugs. Failure to do so may result in a denial of benefits. For more information contact Express Scripts at 1-877-861-8145
	Preferred brand drugs	Retail: 20% up to \$30; Mail: 20% up to \$60	Not Covered	
	Non-preferred brand drugs	Retail: 20% up to \$60; Mail: 20% up to \$120	Not Covered	
	<a href="#">Specialty drugs</a>	Same as non-preferred	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	<b>Preauthorization</b> required for certain services. Failure may result in a denial or penalty of 50% up to \$500
	Physician/surgeon fees	No Charge	Not Covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 <b>copayment</b>	\$100 <b>copayment</b> and balance between charge and <b>In-network rate</b>	<b>Copayment</b> waived if admitted. Limited to initial visit for <b>Emergency Medical Conditions</b> as defined by the Summary Plan Description
	<a href="#">Emergency medical transportation</a>	No Charge	Balance between charge <b>and In-network rate</b>	If air ambulance, condition must warrant air ambulance services
	<a href="#">Urgent care</a>	No Charge	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered – except in emergencies. Balance between charge <b>and In-network rate</b>	<b>Preauthorization</b> required. Failure may result in a denial or penalty of 50% up to \$500. Semi-private room and board allowed only
	Physician/surgeon fees	No Charge	Not Covered	<b>Preauthorization</b> required for certain services. Failure may result in a denial or penalty of 50% up to \$500

\* For more information about limitations and exceptions, see the plan or policy document at [www.associated-admin.com](http://www.associated-admin.com)

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 mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	Not Covered	None
	Inpatient services	No Charge	Not Covered	<b>Preauthorization</b> required. Failure may result in a denial or penalty of 50% up to \$500. Semi-private room and board allowed only
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	No Charge	Not Covered	<b>Preauthorization</b> should be obtained within first 3 months of pregnancy, but not required
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No Charge	Not Covered	200 visits/year. 40 visits/year without prior hospitalization not to exceed 200 visit/year combined maximum. <b>Preauthorization</b> required. Failure may result in a denial or penalty of 50% up to \$500
	<a href="#">Rehabilitation services</a>	No Charge	Not Covered	30 visits/year for each service.
	<a href="#">Habilitation services</a>	No Charge	Not Covered	<b>Preauthorization</b> required. Failure may result in a denial or penalty of 50% up to \$500
	<a href="#">Skilled nursing care</a>	No Charge	Not Covered	60 days/year. <b>Preauthorization</b> required. Failure may result in a denial or penalty of 50% up to \$500
	<a href="#">Durable medical equipment</a>	No Charge	Not Covered	<b>Preauthorization</b> required. Failure may result in a denial or penalty of 50% up to \$500
	<a href="#">Hospice services</a>	No Charge	Not Covered	210 days/lifetime. <b>Preauthorization</b> required. Failure may result in a denial or penalty of 50% up to \$500
If your child needs dental or eye care	Children's eye exam	Not covered for children	Not covered for children	
	Children's glasses	Not covered for children	Not covered for children	
	Children's dental check-up	Not covered for children	Not covered for children	

## 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
- Hearing Aids
- Infertility Treatment
- Long-term care
- No coverage for spouse, except Dental and Vision benefits
- 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
- Bariatric Surgery
- Chiropractic care
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)

**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: U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA(3272) or [www.dol.gov/ebsa/healthreform](http://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](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 **plan** at 1-800-522-0456. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or [www.dol.gov/ebsa/healthreform](http://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 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 1-800-522-0456 Ext. 1336

————— *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](#) \$5,600
- [Specialist \[cost sharing\]](#) \$0
- Hospital (facility) [\[cost sharing\]](#) 0%
- Other [\[cost sharing\]](#) 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,600
Copayments	\$20
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$200
<b>The total Peg would pay is</b>	<b>\$5,820</b>

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

- The [plan's](#) overall [deductible](#) \$5,600
- [Specialist \[cost sharing\]](#) \$0
- Hospital (facility) [\[cost sharing\]](#) 0%
- Other [\[cost sharing\]](#) 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$200
<b>The total Joe would pay is</b>	<b>\$2,700</b>

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

- The [plan's](#) overall [deductible](#) \$5,600
- [Specialist \[cost sharing\]](#) \$0
- Hospital (facility) [\[cost sharing\]](#) 0%
- Other [\[cost sharing\]](#) 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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,500</b>