



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, call Associated Administrators, LLC toll free at (855) 412-3797. 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.dol.gov/ebsa/healthreform or call (855) 412-3797 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Medical <u>In-Network</u> : \$250 Individual/ \$500 Family <u>Out-of-Network</u> : \$2,000 Individual/ \$5,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Emergency room care</u> , <u>in-network preventive care</u> and <u>in-network diagnostic tests</u> are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Medical <u>In-Network</u> : \$1,500 Individual / \$3,000 Family <u>Prescription Drugs In-Network</u> : \$4,650 Individual/ \$8,050 Family <u>Medical Out-of-Network</u> : \$6,000 Individual / \$15,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billed</u> charges, penalties for failure to obtain <u>preauthorization</u> , your <u>cost sharing</u> and costs paid by drug manufacturers for certain non-essential <u>specialty drugs</u> , and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. For a list of <u>in-network providers</u> for hospital & medical benefits, visit www.anthem.com or call 1-800-810-Blue. For <u>Prescription drug</u> benefits, visit www.express-scripts.com . For <u>Vision</u> benefits, visit www.e-nva.com .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Age and frequency limits apply. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Failure to obtain <u>preauthorization</u> may result in non-coverage or reduced coverage.

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 drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com .	Generic drugs	Retail: 15% <u>coinsurance</u> (\$5 minimum payment); Mail Order: 15% <u>coinsurance</u> (\$5 minimum payment) *Brand name drugs are only covered if no generic is available. No charge for <u>specialty drugs</u> on the SaveonSP Specialty Drug List if you enroll in that program. You pay the full <u>copay</u> indicated on that list if you do not enroll in that program.	Not covered	30-day supply retail and 90-day supply home delivery pharmacy service (mail order program). Contraceptives and certain preventive medications are available at no cost. In accordance with the Affordable Care Act, certain over-the-counter (OTC) drugs are payable at no charge when prescribed by a Physician. *Brand name drugs are only covered if no generic is available. *The SaveonSP <u>Specialty Drug List</u> is available at www.saveonsp.com/local338 . Your <u>cost sharing</u> for these “non-essential” <u>specialty drugs</u> , as well as any amount paid by the drug manufacturer through its <u>copay</u> assistance program, do not count toward your <u>out-of-pocket limit</u> or <u>deductible</u> .
	Preferred brand drugs			
	Non-preferred brand drugs			
	<u>Specialty drugs</u>			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Failure to obtain <u>preauthorization</u> may result in non-coverage or reduced coverage.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> /visit; <u>deductible</u> does not apply	\$150 <u>copay</u> /visit; <u>deductible</u> does not apply	<u>Copayment</u> waived if admitted within 24 hours.
	<u>Emergency medical transportation</u>	No charge	No charge	<u>In- and Out-of-Network</u> : Limited to \$2,000 maximum per trip.
	<u>Urgent care</u>	Office visit: \$20 <u>copay</u> /visit ER visit: \$150 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	There is no special benefit for <u>urgent care</u> . It will be billed as either an office visit or ER visit.

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 have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Failure to obtain <u>preauthorization</u> may result in non-coverage or reduced coverage.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: \$20 <u>copay</u> Outpatient facility: 10% <u>coinsurance</u>	40% <u>coinsurance</u>	Failure to obtain <u>preauthorization</u> for intensive outpatient treatment and partial hospitalization program may result in non-coverage or reduced coverage.
	Inpatient services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Failure to obtain <u>preauthorization</u> may result in non-coverage or reduced coverage.
If you are pregnant	Office visits	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for preventive screenings.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Must notify if stay will exceed 48 hours (regular delivery) or 96 hours (c-section). Failure to notify may result in non-coverage or reduced benefits.
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 200 visits per calendar year. Failure to obtain <u>preauthorization</u> may result in non-coverage or reduced coverage.
	<u>Rehabilitation services</u>	Outpatient: \$20 <u>copay</u> /visit Inpatient: 10% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 30 visits per calendar year combined in home, office or outpatient facility. Inpatient limited to 30 days. Failure to obtain <u>preauthorization</u> may result in non-coverage or reduced coverage.
	<u>Habilitation services</u>	Outpatient: \$20 <u>copay</u> /visit Inpatient: 10% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 30 visits per calendar year combined in home, office or outpatient facility. Inpatient limited to 30 days.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 60 days per calendar year. Failure to obtain <u>preauthorization</u> may result in non-coverage or reduced coverage.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Failure to obtain <u>preauthorization</u> may result in non-coverage or reduced coverage.
	<u>Hospice services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 210 days per lifetime. Failure to obtain <u>preauthorization</u> may result in non-coverage or reduced coverage.

*For more information about limitations and exceptions, see the Summary of Benefits section of the plan document, available from (855) 412-3797.

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 your child needs dental or eye care	Children's eye exam	No charge if within Schedule of Benefits	Charges over <u>Plan Allowance</u>	Limited to one exam and lenses every 12 months. Frames covered once every 24 months. Optical benefits are separately administered by National Vision Administrators (NVA).
	Children's glasses	No charge	Charges over <u>Plan Allowance</u>	Limited to one exam and lenses every 12 months. Frames covered once every 24 months. Optical benefits are separately administered by National Vision Administrators (NVA).
	Children's dental check-up	Charges over <u>Plan Schedule of Benefits</u>	Charges over <u>Plan Schedule of Benefits</u>	Oral exam & cleaning limited to twice per year. Fluoride treatment up to age 19, maximum two applications per year. Sealant per tooth: permanent posterior teeth to age 15 & max one application per lifetime. Dental benefits are separately administered by Self-Insured Dental Services (ASO/SIDS.).

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)		
• Cosmetic surgery • Hearing aids • Long-term care	• Private-duty nursing • Routine foot care	• Weight loss programs (except as required by the Affordable Care Act)
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
• Acupuncture • Bariatric surgery • Chiropractic care	• Dental care (Adult) • Infertility treatment*	• Non-emergency care when traveling outside the United States (See www.BCBS.com/bluecardworldwide) • 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: the Department of Labor's Employee 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: Associated Administrators, LLC toll free at (855) 412-3797. 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.

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 (855) 412-3797

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (855) 412-3797

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (855) 412-3797

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (855) 412-3797

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 <u>deductible</u>	\$250
■ <u>Specialist copay</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	10%
■ Diagnostic tests <u>copay</u>	10%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$1,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,510

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$250
■ <u>Specialist copay</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	10%
■ Diagnostic Tests <u>copay</u>	10%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$160
Coinsurance	\$650
What isn't covered	
Limits or exclusions	\$230
The total Joe would pay is	\$1,290

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$250
■ <u>Specialist copay</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	10%
■ Diagnostic tests <u>copay</u>	10%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$390
Coinsurance	\$20
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$660

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