




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 1-800-397-3373. 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](http://www.dol.gov/ebsa/healthreform) or call 1-800-397-3373 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<b>\$300</b> Person or <b>\$600</b> Family. (January 1 – December 31)	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> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>PPO preventive services</u> , <u>PPO office visits</u> , <u>outpatient mental health/substance use disorder services</u> , and <u>PPO inpatient mental health/substance use disorder services</u> are covered before you meet your <u>deductible</u> .	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other deductibles for specific services?</b>	Yes. <b>\$300</b> Person for Organ Transplant; <b>\$25</b> Person or <b>\$75</b> Family for Dental. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	Medical: <u>PPO</u> : <b>\$4,500</b> Person or Family; <u>Non-PPO</u> <b>\$10,000</b> Person or Family. (January 1 – December 31) <u>Prescription drugs</u> : <b>\$4,600</b> Person or <b>\$13,700</b> Family (January 1 – December 31)	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.
<b>What is not included in the out-of-pocket limit?</b>	Medical: <u>Premiums</u> , <u>prescription drug copayments</u> , <u>balance billing</u> charges, and health care this <u>plan</u> does not cover. <u>Prescription drugs</u> : <u>Premiums</u> , medical expenses, <u>SaveOnSP specialty drug copayments</u> , <u>balance billing</u> charges and health care this <u>plan</u> does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.anthem.com">www.anthem.com</a> for a list of <u>PPO providers</u> .	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.
Do you need a <u>referral to see a 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
		<u>PPO Provider</u> (You will pay the least)	<u>Non-PPO Provider</u> (You will pay the most)	
If you visit a <u>health care provider's office or clinic</u>	Primary care visit to treat an injury or illness	\$15 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	No charge for LiveHealth Online.
	<u>Specialist</u> visit	\$15 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	50% <u>coinsurance</u> applies for TMJ services.
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	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 <u>test</u>	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u> ; no charge for chiropractic x-rays	40% <u>coinsurance</u>	Genetic testing limited to <u>diagnostic testing</u> with a \$2,500 annual maximum per person. Annual maximum does not apply to <u>preventive services</u> , such as genetic testing for breast cancer.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>PPO Provider</u> (You will pay the least)	<u>Non-PPO Provider</u> (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> .	Generic drugs	\$8 <u>copayment</u> /fill retail; \$16 <u>copayment</u> /fill mail order	\$8 <u>copayment</u> /fill retail plus amounts over <u>PPO provider</u> cost	30-day supply retail; 90-day supply Walgreens or ESI mail order; non-specialty maintenance medications must be filled through Walgreens or the ESI mail order program. Immunosuppressive drugs covered under the transplant benefit should be filled through ESI mail order program; <u>cost sharing</u> for retail immunosuppressive drugs will be determined on a case-by-case basis. Certain drugs require <u>prior authorization</u> for coverage. No charge for <u>PPO</u> FDA-approved generic <u>preventive care</u> drugs (or brand name if a generic is medically inappropriate). No amounts paid for SaveOnSP <u>specialty drugs</u> apply toward the <u>out-of-pocket limit</u> .
	<u>Formulary</u> brand drugs	\$25 <u>copayment</u> /fill retail; \$50 <u>copayment</u> /fill mail order, plus the difference in costs between the brand name and generic, if generic is available	\$25 <u>copayment</u> /fill retail plus the difference in costs between the brand name and generic, if generic is available, plus amounts over <u>PPO provider</u> cost	
	<u>Non-formulary</u> brand drugs	\$40 <u>copayment</u> /fill retail; \$80 <u>copayment</u> /fill mail order, plus the difference in costs between the brand name and generic, if generic is available	\$40 <u>copayment</u> /fill retail; plus the difference in costs between the brand name and generic, if generic is available, plus amounts over <u>PPO provider</u> cost	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$100 <u>copayment</u> plus 10% <u>coinsurance</u>	\$100 <u>copayment</u> plus 10% <u>coinsurance</u>	\$100 <u>copayment</u> waived if admitted as bed patient for at least 1 day within the three consecutive-day period after visiting the emergency room.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
	<u>Urgent care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>PPO Provider</u> (You will pay the least)	<u>Non-PPO Provider</u> (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>	Coverage is for a semi-private room unless the patient's condition requires a private room. Orthognathic surgery, 50% <u>coinsurance</u> with \$10,000 lifetime maximum per person. Surgical treatment for morbid obesity limited to once per lifetime — <u>preauthorization</u> is required for coverage.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	No charge for LiveHealth Online.
	Inpatient services	Mental health: 10% <u>coinsurance</u> Substance use disorder: no charge for first occurrence, 10% <u>coinsurance</u> for second and subsequent occurrences. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	None
If you are pregnant	Office visits	\$15 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>PPO Provider</u> (You will pay the least)	<u>Non-PPO Provider</u> (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 40 visits in a 12-consecutive month period; weekly costs not to exceed weekly cost for confinement in a skilled nursing facility.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u> for outpatient services. Inpatient services are not covered.	40% <u>coinsurance</u> for outpatient services. Inpatient services are not covered.	Coverage is provided for physical, respiratory, occupational and speech therapies. Outpatient visits are limited to 30 combined visits per lifetime.
	<u>Habilitation services</u>	Not covered	Not covered	You must pay 100% of this service, even <u>in-network</u> .
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 60 days per confinement.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Rentals not to exceed purchase price of equipment.
	<u>Hospice services</u>	No charge	No charge	None
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge. <u>Deductible</u> does not apply.	Reimbursed up to \$45; <u>deductible</u> does not apply	None; separately administered by EyeMed (866-800-5457).
	Children's glasses	Frames: No charge up to \$130, 20% discount off balance over \$130; Lenses: No charge standard/ polycarbonate non-progressive; <u>deductible</u> does not apply	Frames: Reimbursed up to \$65; Lenses: Reimbursed up to \$25 single vision and \$24 polycarbonate; <u>deductible</u> does not apply	Lenses and frames covered once every 24 months; separately administered by EyeMed (866-800-5457). Fund Office administers reimbursement of out-of-pocket vision costs up to \$250 per person per year.
	Children's dental check-up	No charge. Dental <u>deductible</u> does not apply.	Delta Dental: No charge. Dental <u>deductible</u> does not apply. CarePlus: Not covered.	None; separately administered by Delta Dental (800-236-3712) or CarePlus (800-318-7007).

## 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 (with certain exceptions)
- Habilitation services
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs (except as required by the health reform law)

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

- Acupuncture (for certain diagnoses)
- Bariatric surgery (one surgery per lifetime, preauthorization required)
- Chiropractic care (no charge up to \$75/visit; 26 visits per person per calendar year)
- Dental care (Adult) (Delta Dental: \$2,000 calendar year maximum per person; CarePlus: \$2,500 calendar year maximum per person)
- Hearing aids (\$2,000 per person every 5 years)
- Non-emergency and emergency care when traveling outside the U.S. or Canada
- Private-duty nursing (only with hospice care)
- Routine eye care (Adult) (separately administered by EyeMed; Fund Office administers reimbursement of out-of-pocket costs up to \$250 per person per year)

**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](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 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 Administrator, Wisconsin Laborers' Health Fund, Benefit Plan Administrators, 4633 LIUNA Way, Suite 201, DeForest, WI 53532-2514, Telephone 1-800-397-3373. 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

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 1-800-397-3373.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-397-3373.

*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 <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist copayment</u>	\$15
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</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*)

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

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$60
<u>Coinsurance</u>	\$1,080
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$1,460</b>

### Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist copayment</u>	\$15
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$120
<u>Copayments</u>	\$770
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$890</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist copayment</u>	\$15
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$170
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$670</b>

NOTE: A Health Reimbursement Arrangement (HRA) is also available under this plan. The HRA generally covers expenses that qualify as allowable "medical care" by the IRS and satisfy any requirements imposed by the plan. You may be eligible to file for reimbursement of some of these expenses, as permitted by the plan's Health Reimbursement Arrangement. These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your cost. For more information about the wellness program, please contact: 800-397-3373.

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