**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 or call 1-800-397-3373 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | PPO: **$300** Person or **$600** Family.<br>Non-PPO: **$600** Person or **$1,200** Family.<br>(January 1 – December 31) | 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. PPO preventive services, PPO medical office visits, and PPO and Non-PPO mental health/substance use disorder office visits are 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. **$300** Person for Organ Transplant. 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?** | Medical: PPO: **$4,500** per Person or Family; Non-PPO **$10,000** per Person or Family. (January 1 – December 31)<br>Prescription drugs: **$4,600** per Person or **$13,700** per Family.<br>(January 1 – December 31) | 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. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is not included in the out-of-pocket limit?** | Medical: Premiums, prescription drug copayments, balance billing charges, and health care this plan does not cover.<br>Prescription drugs: Premiums, medical expenses, SaveOnSP specialty drug copayments, balance billing charges and health care this plan does not 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 for a list of PPO 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 |
|---|---|---|---|---|
| | | PPO Provider (You will pay the least) | Non-PPO 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 | $15 copayment/visit. Deductible does not apply. | 40% coinsurance | No charge for LiveHealth Online. |
| | Specialist visit | $15 copayment/visit. Deductible does not apply. | 40% coinsurance | 50% coinsurance applies for TMJ services. |
| | 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. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | PPO Provider (You will pay the least) | Non-PPO Provider (You will pay the most) | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance; no charge for chiropractic x-rays | 40% coinsurance | Genetic testing limited to diagnostic testing with a $2,500 annual maximum per person. Annual maximum does not apply to preventive services, such as genetic testing for breast cancer. |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 40% coinsurance | None |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.express-scripts.com. | Generic drugs | $8 copayment/fill retail; $16 copayment/fill mail order | $8 copayment/fill retail plus amounts over PPO provider cost | 30-day supply retail; 90-day supply Walgreens or ESI mail order; maintenance medications must be filled through Walgreens or the ESI mail order program.<br>Immunosuppressive drugs covered under the Transplant Benefit should be filled through ESI mail order program; cost sharing for retail immunosuppressive drugs will be determined on a case-by-case basis.<br>Certain drugs require prior authorization for coverage.<br>No charge for network FDA-approved generic preventive care drugs (or brand name if a generic is medically inappropriate).<br>No amounts paid for SaveOnSP specialty drugs apply toward the out-of-pocket limit. |
| | Formulary brand drugs | $25 copayment/fill retail; $50 copayment/fill mail order, plus the difference in cost between the brand name and generic, if generic is available | $25 copayment/fill retail plus the difference in cost between the brand name and generic, if generic is available, plus amounts over PPO provider cost | |
| | Non-formulary brand drugs | $40 copayment/fill retail; $80 copayment/fill mail order, plus the difference in cost between the brand name and generic, if generic is available | $40 copayment/fill retail plus the difference in cost between the brand name and generic, if generic is available, plus amounts over PPO provider cost | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 40% coinsurance | None |
| | Physician/surgeon fees | 10% coinsurance | 40% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | PPO Provider (You will pay the least) | Non-PPO Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | $300 copayment plus 10% coinsurance | $300 copayment plus 10% coinsurance | $300 copayment waived if referred to emergency room by LiveHealth Online or if admitted as bed patient for at least 1 day within the three consecutive-day period after visiting the emergency room. |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance | None |
| | Urgent care | 10% coinsurance | 40% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 40% coinsurance | Coverage is for a semi-private room unless the patient's condition requires a private room. Orthognathic surgery, 50% coinsurance with $10,000 lifetime maximum per person. Surgical treatment for morbid obesity limited to once per lifetime — preauthorization is required for coverage. |
| | Physician/surgeon fees | 10% coinsurance | 40% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office visits: No charge. Deductible does not apply. All other outpatient services: 10% coinsurance after deductible | Office visits: No charge. Deductible does not apply. All other outpatient services: 40% coinsurance after deductible | No charge for LiveHealth Online. |
| | Inpatient services | Mental health: 10% coinsurance. Substance use disorder: no charge for first occurrence, 10% coinsurance for second and subsequent occurrences. Deductible does not apply. | 40% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | PPO Provider (You will pay the least) | Non-PPO Provider (You will pay the most) | |
| **If you are pregnant** | Office visits | $15 copayment/visit. Deductible does not apply. | 40% coinsurance | Cost sharing does not apply to preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | 10% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 10% coinsurance | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 40% coinsurance | Limited to 40 visits in a 12-consecutive month period; weekly costs not to exceed weekly cost for confinement in a skilled nursing facility. |
| | Rehabilitation services | 10% coinsurance for outpatient services. Inpatient services are not covered. | 40% coinsurance 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. |
| | Habilitation services | Not covered | Not covered | You must pay 100% of this service, even in-network. |
| | Skilled nursing care | 10% coinsurance | 40% coinsurance | Limited to 60 days per confinement. |
| | Durable medical equipment | 10% coinsurance | 40% coinsurance | Rentals not to exceed purchase price of equipment. |
| | Hospice services | No charge | No charge | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | PPO Provider (You will pay the least) | Non-PPO Provider (You will pay the most) | |
| **If your child needs dental or eye care** | Children's eye exam | No charge. Deductible does not apply. | Reimbursed up to $45; deductible does not apply | None; separately administered by EyeMed (866-800-5457). |
| | Children's glasses | Frames: No charge up to $130, 20% discount on balance over $130; Lenses: No charge standard/ polycarbonate non-progressive; deductible does not apply | Frames: Reimbursed up to $65; Lenses: Reimbursed up to $25 single vision and $24 polycarbonate; deductible 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 | Not covered | Not covered | You must pay 100% of this service, even in-network. |

## 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)
- Dental care (Adult and Child) (Covered only through insured plan and only if Retiree elects and pays for dental benefits)
- 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)
- 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. 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 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.

**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, kwiijigo 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 plan's overall deductible | $300 |
| Specialist copayment | $15 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 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** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $60 |
| Coinsurance | $1,080 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Peg would pay is** | **$1,460** |

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

| | |
|---|---|
| The plan's overall deductible | $300 |
| Specialist copayment | $15 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 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** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $120 |
| Copayments | $770 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$890** |

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

| | |
|---|---|
| The plan's overall deductible | $300 |
| Specialist copayment | $15 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 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** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $300 |
| Copayments | $370 |
| Coinsurance | $180 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$850** |

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.

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