



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.healthcare.gov/sbc-glossary or call 1-800-397-3373 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<u>PPO</u> : \$350 Person or \$700 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> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>PPO preventive services</u> , <u>PPO</u> medical office visits, and <u>PPO</u> and <u>Non-PPO</u> mental health/substance use disorder office visits are covered before you meet your <u>deductible</u> .	This plan 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 plan 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 <u>deductibles</u> for specific services?	Yes. \$300 per Person for Organ Transplant. 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.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>Medical</u> : <u>PPO</u> : \$6,600 Person or \$13,200 Family; <u>Non-PPO</u> : \$25,000 Person or Family. (January 1 – December 31) <u>Prescription drugs</u> : \$2,500 Person or \$5,000 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.
What is not included in the <u>out-of-pocket limit</u>?	<u>Medical</u> : <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 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	\$20 copayment /visit. Deductible does not apply.	40% coinsurance	No charge for LiveHealth Online.
	Specialist visit	\$20 copayment /visit. Deductible does not apply.	40% coinsurance	None
	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)	30% coinsurance	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)	30% coinsurance	40% coinsurance	Preauthorization required. Call Telligen at 888-348-9330.

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 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	\$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>network</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> . You must enroll in the SaveOnSP program to be reimbursed by the <u>specialty drugs</u> manufacturer at no cost to you. The SaveOnSP Drug List and <u>copayment</u> amounts are available by contacting SaveOnSP at 1-800-683-1074 or online at www.express-scripts.com .
	<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	
	Non- <u>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	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	30% <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 need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copayment</u> plus 30% <u>coinsurance</u>	\$100 <u>copayment</u> plus 30% <u>coinsurance</u>	\$100 <u>copayment</u> 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.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Urgent care</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <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 is not covered. Surgical treatment for morbid obesity limited to once per lifetime — <u>preauthorization</u> is required for coverage.
	Physician/surgeon fees	30% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: No charge. <u>Deductible</u> does not apply. All other outpatient services: 30% <u>coinsurance</u> after <u>deductible</u>	Office visits: No charge. <u>Deductible</u> does not apply. All other outpatient services: 40% <u>coinsurance</u> after <u>deductible</u>	No charge for LiveHealth Online.
	Inpatient services	Mental health: 25% <u>coinsurance</u> Substance use disorder: no charge for first occurrence, 25% <u>coinsurance</u> for second and subsequent occurrences. <u>Deductible</u> does not apply.	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 are pregnant	Office visits	\$20 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <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	30% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <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>	30% <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.
	<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>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 60 days per confinement.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	Rentals not to exceed purchase price of equipment.
	<u>Hospice services</u>	Not covered	Not covered	You must pay 100% of this service, even <u>in-network</u> .
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of this service, even <u>in-network</u> .
	Children's glasses	Not covered	Not covered	You must pay 100% of this service, even <u>in-network</u> .
	Children's dental check-up	Not covered	Not covered	You must pay 100% of this service, even <u>in-network</u> .

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
• Chiropractic care • Cosmetic surgery (with certain exceptions) • Dental care (Adult and Child) • <u>Habilitation services</u>	• Hearing aids • <u>Hospice services</u> • Infertility treatment • Long-term care • Routine foot care	• Private-duty nursing • Routine eye care (Adult and Child) • Weight loss programs (except Teladoc management program or 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 <u>plan</u> document.)		
• Acupuncture (for certain diagnoses)	• Bariatric surgery (one surgery per lifetime, <u>preauthorization</u> required)	• Non-emergency and emergency care when traveling outside the U.S. or Canada

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, 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>	\$350
■ <u>Specialist</u> copayment	\$20
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

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	
<u>Deductibles</u>	\$350
<u>Copayments</u>	\$60
<u>Coinsurance</u>	\$3,240
What isn't covered	
Limits or exclusions	\$20
The total Peg would pay is	\$3,670

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>	\$350
■ <u>Specialist</u> copayment	\$20
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

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	
<u>Deductibles</u>	\$120
<u>Copayments</u>	\$820
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$940

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$350
■ <u>Specialist</u> copayment	\$20
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

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	
<u>Deductibles</u>	\$350
<u>Copayments</u>	\$190
<u>Coinsurance</u>	\$590
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,130

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.