
 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 1-888-466-9094. 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 <https://www.cms.gov/ccio/index.html> or call 1-888-466-9094 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers \$1,050 individual /\$3,150 family; for out-of-network providers \$2,100 individual/ \$6,300 family.	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. Preventive care services and prescription drugs 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers \$6,600 individual/ \$13,200 family; for out-of-network providers unlimited.	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.
What is not included in the out-of-pocket limit?	Premiums , penalties for non-compliance, charges over allowed amount, and health care this plan doesn't 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 or call 1-800-810-blue for a list of network 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
		Network Provider (You will pay the least)	Out-of-Network 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% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/immunization	No charge	100% of cost	No benefits are payable for charges from an out-of-network provider or for treatment of an illness or injury.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization may be required for some tests.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.savrx.com . 1-866-233-IBEW	Generic drugs	10% copay /prescription (retail); \$15 copay /prescription (mail order)	100% of cost	\$10 minimum (retail); \$100 maximum (retail)
	Preferred brand drugs	20% copay /prescription (retail); 20% copay /prescription (mail order)	100% of cost	\$15 minimum (retail); \$40 minimum (mail order); \$100 maximum (retail); \$200 maximum (mail order). Step therapy program may apply.
	Non-preferred brand drugs	30% copay /prescription (retail); 30% copay /prescription (mail order)	100% of cost	\$30 minimum (retail); \$60 minimum (mail order); \$100 maximum (retail); \$200 maximum (mail order). Step therapy program may apply
	Specialty drugs	30% copay /prescription (retail); 30% copay /prescription (mail order)	100% of cost	May be limited to a 30-day supply by Sav-Rx.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	40% coinsurance	First \$300 paid at 100% per accident
If you have a	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	None

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)	
hospital stay	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply to certain 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). Applies to female employee or spouse only.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	None
	Rehabilitation services	20% coinsurance	40% coinsurance	None
	Habilitation services	20% coinsurance	40% coinsurance	None
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to \$50,000 for attendance of a registered graduate nurse in the home
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	Amount charged above \$30	Limited to 1 exam per calendar year
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	No charge	No charge	Limited to 2 exams per calendar year

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](#).)

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|---|---|--|
| <ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery, unless necessary to correct a • Birth deformity or the result of an accidental injury | <ul style="list-style-type: none"> • Infertility Treatment • Long-term care | <ul style="list-style-type: none"> • Routine foot care • Weight loss program |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric surgery to treat morbid obesity
- Chiropractic care, limited to \$500 per calendar year
- Dental care for adults
- Hearing aids for children less than 18, Limited to \$1,500 lifetime
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing Care
- Routine eye care (adult examination)

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 Health and Human Services at 1-877-267-2323 ext. 61565. 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 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 Fund Office at 1-888-466-9094 or visit www.4thdistricthealthfund.com.

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: See Addendum

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	\$1,050
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	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*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,050
Copayments	\$40
Coinsurance	\$2,343
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,493

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1,050
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	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*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,050
Copayments	\$505
Coinsurance	\$558
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$2,169

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Mia's Simple Fracture

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

- The plan's overall deductible \$1,050
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 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*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,050
Copayments	\$0
Coinsurance	\$385
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,435

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