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 In-Network: $250 Individual/ $500 Family Out-of-Network: $2,000 Individual/ $5,000 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. Emergency room care, in-network preventive care and in-network diagnostic tests 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?	Medical In-Network: $1,850 Individual / $3,700 Family Prescription Drugs In-Network: $7,600 Individual / $15,200 Family Medical Out-of-Network: $6,000 Individual / $15,000 Family	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, balance-billed charges, penalties for failure to obtain preauthorization, your cost sharing and costs paid by drug manufacturers for certain non-essential specialty drugs, 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. For a list of in-network providers for hospital & medical benefits, visit www.anthem.com or call 1-800-810-Blue. For Prescription drug benefits, visit www.express-scripts.com. For Vision benefits, visit www.e-nva.com.	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 copay/visit	40% coinsurance	None
	Specialist visit	$40 copay/visit	40% coinsurance	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	40% coinsurance	Age and frequency limits apply. 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)	10% coinsurance; deductible does not apply	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
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	Retail: 15% coinsurance ($5 minimum payment); Mail Order: 15% coinsurance ($5 minimum payment) *Brand name drugs are only covered if no generic is available.	Not covered	30-day supply retail and 90-day supply home delivery pharmacy service (mail order program) or 90-day supply filled at a Smart90 retail pharmacy. 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.
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs	No charge for specialty drugs on the SaveonSP Specialty Drug List if you enroll in that program. You pay the full copay indicated on that list if you do not enroll in that program.		*The SaveonSP Specialty Drug List is available at www.saveonsp.com/local338. Your cost sharing for these "non-essential" specialty drugs, as well as any amount paid by the drug manufacturer through its copay assistance program, do not count toward your out-of-pocket limit or deductible. Prescriptions for inflammatory conditions and multiple sclerosis products must be filled exclusively through Accredo specialty pharmacy.

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay/visit; deductible does not apply	$150 copay/visit; deductible does not apply	Copayment waived if admitted within 24 hours.
	Emergency medical transportation	No charge	No charge	In- and Out-of-Network: Limited to $2,000 maximum per trip. Air Ambulance covered subject to medical necessity and subject to No Surprises Act. For more information, contact the Fund Office.
	Urgent care	Office visit: $20 copay/visit ER visit: $150 copay/visit; deductible does not apply	40% coinsurance	There is no special benefit for urgent care. It will be billed as either an office visit or ER visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: $20 copay/visit Outpatient facility: 10% coinsurance	40% coinsurance	Failure to obtain preauthorization for intensive outpatient treatment and partial hospitalization program may result in non-coverage or reduced coverage.
	Inpatient services	10% coinsurance	40% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you are pregnant	Office visits	10% coinsurance	40% coinsurance	Cost sharing does not apply for preventive screenings.
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	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% coinsurance	40% coinsurance	

*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 you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	Limited to 200 visits per calendar year. Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Rehabilitation services	Outpatient: $20 copay/visit Inpatient: 10% coinsurance	40% coinsurance	Limited to 30 visits per calendar year combined in home, office, or outpatient facility. Inpatient limited to 30 days. Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Habilitation services	Outpatient: $20 copay/visit Inpatient: 10% coinsurance	40% coinsurance	Limited to 30 visits per calendar year combined in home, office, or outpatient facility. Inpatient limited to 30 days.
	Skilled nursing care	10% coinsurance	40% coinsurance	Limited to 60 days per calendar year. Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Durable medical equipment	10% coinsurance	40% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Hospice services	10% coinsurance	40% coinsurance	Limited to 210 days per lifetime. Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If your child needs dental or eye care	Children's eye exam	No charge if within Schedule of Benefits	Charges over Plan Allowance	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 Plan Allowance	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 Plan Schedule of Benefits	Charges over Plan Schedule of Benefits	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.).

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

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
- 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 plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Infertility treatment*
- Non-emergency care when traveling outside the United States (See www.bcbsglobalcore.com)
- 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, kwiijigo holne' (855) 412-3797

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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

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	**$250**
Specialist copay	**$40**
Hospital (facility) coinsurance	**10%**
Diagnostic tests copay	**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	$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 deductible	**$250**
Specialist copay	**$40**
Hospital (facility) coinsurance	**10%**
Diagnostic Tests copay	**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	$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 deductible	**$250**
Specialist copay	**$40**
Hospital (facility) coinsurance	**10%**
Diagnostic tests copay	**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	$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.