

! 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, please call 1-800-598-7330. 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.healthcare.gov/sbc-glossary> or call 1-800-598-7330 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$500 per person Out-of-Network: \$1,500 per person	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.
Are there services covered before you meet your deductible?	Yes	This <u>plan</u> 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?	There are no other specific deductibles.	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 out-of-pocket limit for this plan?	Medical: In-Network: \$6,550 per person; Out-of-Network: \$7,500 per person Prescription Drug: In-Network: \$1,600 per person	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, <u>balance billing</u> charges, contributions, dental benefits administered separately by Delta Dental, vision and non-covered services	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call 1-800-676-BLUE (or 1-800-810-BLUE for coverage while traveling) for a list of <u>network providers</u>	This plan 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 provider for the difference between the provider's charge and what your plan pays (<u>balance billing</u>). 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 <u>specialist</u> 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
		In 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	30% <u>coinsurance</u>	50% <u>coinsurance</u>	\$10 penalty for <u>out-of-network</u> office visits.
	Specialist visit	30% <u>coinsurance</u>	50% <u>coinsurance</u>	\$10 penalty for out of network office visits.
If you have a test	<u>Preventive care/screening/immunization</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	Services required by ACA are provided. See Summary Plan Description at page 26
	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	Generic drugs	\$15 retail <u>co-payment</u> \$30 mail order <u>co-payment</u>	N/A	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.envisionrx.com Prescription benefits have separate Out of Pocket maximum of \$1,600.	Preferred brand drugs	\$40 retail <u>co-payment</u> \$80 mail order <u>co-payment</u>	N/A	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Non-preferred brand drugs	\$75 retail <u>co-payment</u> \$150 mail order <u>co-payment</u>	N/A	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	<u>Specialty drugs</u>	\$15 generic <u>co-payment</u> \$40 preferred brand <u>co-payment</u> \$75 non-preferred brand <u>co-payment</u>	N/A	Certain drugs require prior authorization
	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you have outpatient surgery	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copayment</u> per visit 30% <u>coinsurance</u>	\$250 <u>copayment</u> per visit 30% <u>coinsurance</u>	\$250 <u>copayment</u> waived if there is hospital inpatient admission or treatment at urgent care center/doctor office for same/related diagnosis within 24 hrs of ER visit.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	<u>Urgent care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----

* For more information about limitations and exceptions, see Plan or call 1-800-598-7330.

If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Out-of-Network Inpatient Services must be obtained within a 200-mile radius of your primary residence to be covered
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Out-of-Network Inpatient physician/surgeon fees must be obtained within a 200-mile radius of your primary residence to be covered
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	-----none-----
	Inpatient services	30% coinsurance	50% coinsurance	Out-of-Network Inpatient Services must be obtained within a 200-mile radius of your primary residence to be covered
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	-----none-----
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	-----none-----
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	Out-of-Network Services must be obtained within a 200-mile radius of your primary residence to be covered
	Home health care	30% coinsurance	50% coinsurance	120 visits per calendar year payable at 4 hours per visit
If you need help recovering or have other special health needs	Rehabilitation services	30% coinsurance	50% coinsurance	-----none-----
	Habilitation services	30% coinsurance	50% coinsurance	-----none-----
	Skilled nursing care	30% coinsurance	50% coinsurance	1 st 60 days after confinement, see Summary Plan Description pages 35-36
	Durable medical equipment	30% coinsurance	50% coinsurance	Paid as rental up to purchase price
	Hospice services	30% coinsurance	50% coinsurance	-----none-----
If your child needs dental or eye care	Children's eye exam	N/A	N/A	N/A Retiree plan; children not eligible
	Children's glasses	N/A	N/A	
	Children's dental check-up	N/A	N/A	N/A Retiree plan; children not eligible

* For more information about limitations and exceptions, see Plan or call 1-800-598-7330.

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.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Private-Duty Nursing
- Treatments that are investigational/experimental
- Routine Foot Care
- Infertility Treatment
- Non-Emergency Care when traveling outside of the U.S.
- Weight Loss Programs
- Adult Dental Care
- Routine Eye Care
- Long Term Care
- Treatment for TMJ
- Services for Seasonal Affective Light Disorder
- Hearing Aids

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

- Home Health Care (limitations apply)
- Speech and Physical Therapy
- Chiropractic Care
- Orthotics and orthopedic appliances
- Most coverage provided outside the United States. See SPD or contact Fund Office or www.cignasharedadministration.com

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 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 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: 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

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:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (502) 839-8166.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1 (502) 839-8166。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1 (502) 839-8166.

————— 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 **\$500**
- Specialist co-insurance **30%**
- Hospital (facility) co-insurance **30%**
- Other co-insurance **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 **\$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$160
Coinsurance	\$3,780
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,500

Managing Joe's type 2 Diabetes

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

- The plan's overall deductible **\$500**
- Specialist co-insurance **30%**
- Hospital (facility) co-insurance **30%**
- Other co-insurance **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 **\$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$2,220
Coinsurance	\$880
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$3,660

Mia's Simple Fracture

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

- The plan's overall deductible **\$500**
- Specialist co-insurance **30%**
- Hospital (facility) co-insurance **30%**
- Other co-insurance **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 **\$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$250
Coinsurance	\$580
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,330

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