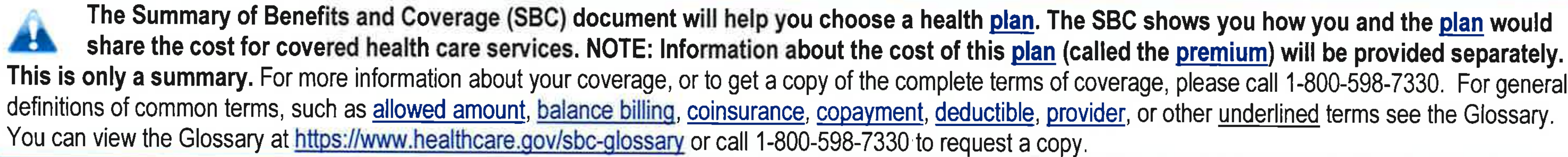

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. 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 providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes	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?	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: In-Network: **$6,550** per person; Out-of-Network: **$7,500** per person Prescription Drug: In-Network: **$1,600** per person; Out-of-Network: No limit.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance billing 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 out-of-pocket limit.
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 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.

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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	20% coinsurance	40% coinsurance	$10 penalty for out-of-network office visits.
	Specialist visit	20% coinsurance	40% coinsurance	$10 penalty for out-of-network office visits.
	Preventive care/screening/ immunization	0% coinsurance	40% coinsurance	Services required by the ACA are provided. See Summary Plan Description at page 26
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	--------------------none--------------------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	--------------------none--------------------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.envisionrx.com** Prescription benefits have separate Out of Pocket maximum of $1,600.	Generic drugs	$15 retail co-payment $30 mail order co-payment	N/A	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	$40 retail co-payment $80 mail order co-payment	N/A	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Non-preferred brand drugs	$75 retail co-payment $150 mail order co-payment	N/A	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Specialty drugs	$15 generic co-payment $40 preferred brand co-payment $75 non-preferred brand co-payment	N/A	Certain drugs require prior authorization
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	$250 **copayment** per visit 20% coinsurance	$250 **copayment** per visit 20% coinsurance	$250 **copayment** waived if there is hospital inpatient admission or treatment at urgent care center/doctor's office for same/related diagnosis within 24 hours of ER visit.
	Emergency medical transportation	20% coinsurance	40% coinsurance	--------------------none--------------------
	Urgent care	20% coinsurance	40% coinsurance	--------------------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)	20% coinsurance	40% coinsurance	Out-of-Network Inpatient Services must be obtained within a 200-mile radius of your primary residence to be covered
	Physician/surgeon fees	20% coinsurance	40% 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	20% coinsurance	40% coinsurance	--------------------none--------------------
	Inpatient services	20% coinsurance	40% 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	20% coinsurance	40% coinsurance	--------------------none--------------------
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	--------------------none--------------------
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Out-of-Network Services must be obtained within a 200-mile radius of your primary residence to be covered
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	120 visits per calendar year, payable at 4 hours per visit
	Rehabilitation services	20% coinsurance	40% coinsurance	--------------------none--------------------
	Habilitation services	20% coinsurance	40% coinsurance	--------------------none--------------------
	Skilled nursing care	20% coinsurance	40% coinsurance	1st 60 days after confinement, see Summary Plan Description pages 35-36
	Durable medical equipment	20% coinsurance	40% coinsurance	Paid as rental up to purchase price
	Hospice services	20% coinsurance	40% 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

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.

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

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	20%
Hospital (facility) co-insurance	20%
Other co-insurance	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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$60
Coinsurance	$2,520
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,140**

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	20%
Hospital (facility) co-insurance	20%
Other co-insurance	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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$990
Coinsurance	$590
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,140**

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

The plan's overall deductible	$500
Specialist co-insurance	20%
Hospital (facility) co-insurance	20%
Other co-insurance	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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$250
Coinsurance	$390
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,140**

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