




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- 866-697-5750. 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](http://www.dol.gov/ebsa/healthreform) or call 1-866-697-5750 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$150 per person/\$450 per family.	Generally, you must pay all of the costs from <a href="#">provider</a> up to the <a href="#">deductible</a> amount before this plan begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Covered in-network preventive care, prescription drugs, and dental services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this plan covers certain <a href="#">preventive services</a> without cost sharing and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Medical: \$5,300 per person / \$10,000 per family. Prescription Drugs: \$700 per person / \$2,000 per family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billed</a> charges, charges in excess of allowed amounts, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.premiera.com/sharedadmin">www.premiera.com/sharedadmin</a> or call 1-800-810-2583 for a list of <a href="#">network providers</a> . To locate a preferred vision provider, see <a href="http://www.vsp.com">www.vsp.com</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> 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 <a href="#">provider's office</a> or <a href="#">clinic</a>	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /visit, deductible and 20% <a href="#">coinsurance</a>	\$40 <a href="#">copay</a> /visit, deductible and 50% <a href="#">coinsurance</a>	Chiropractor office visits limited to 24 per year. No coverage for work related illnesses or injuries or for naturopath office visits.  You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
	<a href="#">Specialist</a> visit			
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">Deductible</a> does not apply.	\$40 <a href="#">copay</a> /visit, deductible and 50% <a href="#">coinsurance</a>	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Diagnostic services provided by an out-of-network provider at an in-network facility will be covered as though in-network.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Diagnostic services provided by an out-of-network provider at an in-network facility will be covered as though in-network.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com/oe_chi/landing">www.optumrx.com/oe_chi/landing</a>	Generic drugs	Retail: \$10 <a href="#">copay</a> /prescription Mail order: \$10 <a href="#">copay</a> /prescription	Retail: \$25 <a href="#">copay</a> /prescription Mail order: \$10 <a href="#">copay</a> /prescription	Covers up to a 30-day supply for a retail brand prescription and 31-90 day supply for a retail generic prescription, generic mail order prescription, or brand mail order prescription.  The maximum you will pay for prescription drugs through OptumRx is \$700 per person and \$2,000 per family.  Non-formulary drugs may not be covered without approval through the prior-authorization process."
	Preferred brand drugs	Retail: \$35 <a href="#">copay</a> /prescription Mail order: \$45 <a href="#">copay</a> /prescription	Retail: \$35 <a href="#">copay</a> /prescription Mail order: \$45 <a href="#">copay</a> /prescription	
	Non-preferred brand drugs	Retail: \$50 <a href="#">copay</a> /prescription Mail order: \$60 <a href="#">copay</a> /prescription	Retail: \$50 <a href="#">copay</a> /prescription Mail order: \$60 <a href="#">copay</a> /prescription	
	<a href="#">Specialty drugs</a>	<a href="#">Copay</a> is the same as for generic or brand name drugs, whichever applies.	<a href="#">Copay</a> is the same as for generic or brand name drugs, whichever applies.	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.agc-iuoe701trusts.com](http://www.agc-iuoe701trusts.com)

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)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	If you receive services from a non-network provider at an in-network facility, the Plan will provide benefits as though the provider was in-network.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$50 <a href="#">copay</a> /visit, deductible and 20% <a href="#">coinsurance</a>	\$50 <a href="#">copay</a> /visit, deductible and 20% <a href="#">coinsurance</a>	<a href="#">Copay</a> waived if admitted to hospital. Emergency services provided in response to an emergent condition will be covered as at in-network or out-of-network facilities.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after deductible for non-emergency ambulance services when using a <a href="#">Non-Preferred Network provider</a> .
	<a href="#">Urgent care</a>	\$30 <a href="#">copay</a> /visit, deductible and 20% <a href="#">coinsurance</a>	\$40 <a href="#">copay</a> /visit, deductible and 50% <a href="#">coinsurance</a>	Emergency services provided at an out-of-network Urgent Care facility will be covered as though in-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Benefit reduced by \$150 per stay if not pre-certified at least 48 hours before stay begins.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	If you receive services from a non-network provider at an in-network facility, the Plan will provide benefits as though the provider was in-network.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	If you receive services from a non-network provider at an in-network facility, the Plan will provide benefits as though the provider was in-network.
	Inpatient services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Benefit reduced by \$150 per admission if not precertified at least 48 hours before admission. If you receive services from a non-network provider at an in-network facility, the Plan will provide benefits as though the provider was in-network.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.agc-iuoe701trusts.com](http://www.agc-iuoe701trusts.com)

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 are pregnant	Office visits	\$30 <a href="#">copay</a> /visit and 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	\$40 <a href="#">copay</a> /visit and 50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Dependent coverage limited to treatment of emergent conditions and preventive services as outlined by the Affordable Care Act..
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Stays in excess of 48 hours for vaginal delivery and 96 hours for cesarean delivery should be precertified..
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Limited to 50 visits per year per condition. Benefit reduced by \$150 per treatment if not precertified at least 48 hours before treatment begins.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Prescription and treatment plan required if more than 30 visits in 12 month period.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Standard coinsurance, copays and deductibles apply. Limited to dependents age 12 and under. No limit for treatment of developmental disorders classified as mental disorders in the ICD and DSM.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Limited to 120 days per condition. Benefit reduced by \$150 per admission if not pre-certified at least 48 hours before stay begins.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Limited to 180 days. Benefit reduced by \$150 per admission if not precertified at least 48 hours before stay begins.
If your child needs dental or eye care	Children's eye exam	No charge	Excess of \$45	Limited to one exam every 12 months.
	Children's glasses	Lenses: \$20 <a href="#">copay</a> (single vision, bifocal, trifocal)	Fees in excess of the VSP benefit schedule	Lenses limited to one pair every 12 months. Frames limited to one set every 24 months.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.agc-iuoe701trusts.com](http://www.agc-iuoe701trusts.com)

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)	
		Up to \$150 for contact lenses Frames: included with \$20 <a href="#">copay</a> .		Vision coverage is provided through VSP. Charges from a non-VSP doctor must be paid in full and member must file a claim with VSP.
	Children's dental check-up	30% <a href="#">coinsurance deductible</a> does not apply.	30% <a href="#">coinsurance</a>	None.

## 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
- Long-term care
- Routine foot care
- Infertility Treatment
- Work related injuries

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

- Acupuncture (precertification required)
- Dental care (Adult, if participant is not retired)
- Non-emergency care when traveling outside the U.S.
- Bariatric Surgery
- Hearing aids (not covered for dependents)
- Routine eye care (Adult)
- Spinal manipulations (up to 24 office visits/year)

**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](http://www.dol.gov/ebsa/healthreform) and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). You may also contact the Trust Administration Office at 1-866-697-5750.

### 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 1-866-697-5750.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-697-5750.

*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](#) \$150
- [Specialist copayment](#) \$30
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$150
<a href="#">Copayments</a>	\$70
<a href="#">Coinsurance</a>	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,780</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$150
- [Specialist copayment](#) \$30
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$150
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,470</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$150
- [Specialist copayment](#) \$30
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$150
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$850</b>

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