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 or call 1-866-697-5750 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$150** per person/$**450** per family.	Generally, you must pay all of the costs from provider 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. Covered in-network preventive care, prescription drugs, and dental services 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: **$5,300** per person / $**10,000** per family. Prescription Drugs: **$700** per person / **$2,000** per 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, 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 out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes**. See www.premera.com/sharedadmin or call 1-800-810-2583 for a list of network providers. To locate a preferred vision provider, see www.vsp.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	$30 copay/visit, deductible and 20% coinsurance	$40 copay/visit, deductible and 50% coinsurance	Chiropractor office visits limited to 24 per year. No coverage for work related illnesses or injuries or for naturopath office visits.
	Specialist visit			
	Preventive care/screening/ immunization	No charge Deductible does not apply.	$40 copay/visit, deductible and 50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	50% coinsurance after deductible	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% coinsurance after deductible	50% coinsurance after deductible	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 **prescription drug coverage** is available at www.optumrx.com/oe_chi/landing	Generic drugs	Retail: $10 copay/prescription Mail order: $10 copay/prescription	Retail: $25 copay/prescription Mail order: $10 copay/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 copay/prescription Mail order: $45 copay/prescription	Retail: $35 copay/prescription Mail order: $45 copay/prescription	
	Non-preferred brand drugs	Retail: $50 copay/prescription Mail order: $60 copay/prescription	Retail: $50 copay/prescription Mail order: $60 copay/prescription	
	Specialty drugs	Copay is the same as for generic or brand name drugs, whichever applies.	Copay is the same as for generic or brand name drugs, whichever 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% coinsurance after deductible	None.
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	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	Emergency room care	$50 copay/visit, deductible and 20% coinsurance	$50 copay/visit, deductible and 20% coinsurance	Copay 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.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible for non-emergency ambulance services when using a Non-Preferred Network provider.
	Urgent care	$30 copay/visit, deductible and 20% coinsurance	$40 copay/visit, deductible and 50% coinsurance	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% coinsurance after deductible	50% coinsurance after deductible	Benefit reduced by $150 per stay if not pre-certified at least 48 hours before stay begins.
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	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% coinsurance after deductible	50% coinsurance after deductible	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% coinsurance after deductible	50% coinsurance after deductible	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.

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 copay/visit and 20% coinsurance after deductible	$40 copay/visit and 50% coinsurance after deductible	Cost-sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance after deductible	50% coinsurance after deductible	Dependent coverage limited to treatment of emergent conditions and preventive services as outlined by the Affordable Care Act..
	Childbirth/delivery facility services	20% coinsurance after deductible	50% coinsurance after deductible	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	Home health care	20% coinsurance after deductible	50% coinsurance after deductible	Limited to 50 visits per year per condition. Benefit reduced by $150 per treatment if not precertified at least 48 hours before treatment begins.
	Rehabilitation services	20% coinsurance after deductible	50% coinsurance after deductible	Prescription and treatment plan required if more than 30 visits in 12 month period.
	Habilitation services	20% coinsurance after deductible	50% coinsurance after deductible	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.
	Skilled nursing care	20% coinsurance after deductible	50% coinsurance after deductible	Limited to 120 days per condition. Benefit reduced by $150 per admission if not pre-certified at least 48 hours before stay begins.
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	None.
	Hospice services	20% coinsurance after deductible	50% coinsurance after deductible	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 copay (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

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 copay.		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% coinsurance deductible does not apply.	30% coinsurance	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 • Infertility Treatment	• Long-term care	• Routine foot care • 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) • Bariatric Surgery • Spinal manipulations (up to 24 office visits/year)	• Dental care (Adult, if participant is not retired) • Hearing aids (not covered for dependents)	• Non-emergency care when traveling outside the U.S. • 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$150
Copayments	$70
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,780**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

he 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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$150
Copayments	$900
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,470**

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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$150
Copayments	$200
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$850**

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