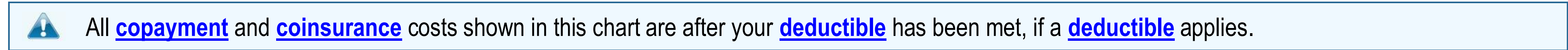
This is only a summary. If you want more detail about your coverage and costs, you can get that complete terms in the policy or plan documents at http://www.ohiolaborers.com/ or by calling 1-800-236-6437. If you would like a copy of the Uniform Glossary, please visit https://www.healthcare.gov/sbc-glossary/ or call 1-866-444-3272.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$400/individual or $800/family (network) $800/individual or $1,600/family (out-of-network)	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.	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 do not need to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $3,975 individual /$7,950 family For out-of-network providers $7,950 individual /$15,900 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?	Penalties, premiums, balance-billing charges, 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. See www.anthem.com to plan specific provider directory or call 1-888-878-0128 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.


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/visit	$20/visit then 40% coinsurance	Additional charges for after-hours/weekend office visits will be covered up to $30 per occurrence.
	Specialist visit	$30/visit	$30/visit then 40% coinsurance	None
	Preventive care/screening/ immunization	No charge	40% coinsurance No charge for influenza virus vaccine	Preventive care covered under the Patient Protection and Affordable Care Act and the following routine/preventive tests are covered once per calendar year: EKG, chest x-ray, complete blood count, digital rectal exam, cholesterol screening, prostate specific antigen (PSA), comprehensive metabolic panels, and urinalysis. 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)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Precertification is required. If not precertified and later determined it was not medically necessary, the plan will not cover the charges.

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 drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.ohiolaborers.com/ or by calling 1-800-361-4542	Generic drugs (Tier 1)	$10/prescription (retail) $25/prescription (mail order)	$10/prescription (retail) $25/prescription (mail order)	Retail prescriptions are up to a 30-day supply, 360 tabs, 150 grams, or 4,000 ML. Mail order prescriptions are up to a 90-day supply, 1,080 tabs, 450 grams, or 12,000 ML. Limits may vary for narcotics and certain other drugs. If a brand name drug is requested when a generic drug is available, the cost difference between the generic and brand name drug in addition to the brand name drug copayment will be charged. Certain drugs require prior authorization from a physician before the drug can be dispensed. Certain drugs are subject to step therapy. There is a maximum out-of-pocket limit of $4,550 individual /$9,100 family. Limit does not include penalties, ingredient charges, premiums, and prescriptions this plan does not cover. Certain Drugs may be excluded due to formulary.
	Preferred brand drugs (Tier 2)	$30/prescription (retail) $25/prescription (mail order)	$30/prescription (retail) $25/prescription (mail order)	
	Non-preferred brand drugs (Tier 3)	$50/prescription (retail) $125/prescription (mail order)	$50/prescription (retail) $125/prescription (mail order)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Charges for blood, autotransfusions, or cell saver transfusions are not covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$150/visit	$150/visit	Copayment applies to room charges only. Other covered charges are subject to 20% coinsurance, but not subject to deductible.
	Emergency medical transportation	20% coinsurance	40% coinsurance	Transportation services provided by an ambulette or a wheelchair van are not covered.
	Urgent care	$50/visit	$50/visit then 40% coinsurance	Applies to the cost of office visit only. All other covered charges are subject to deductible and coinsurance.

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 a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Inpatient admissions must be precertified. If out-of-network admission is not precertified and it is later determined it was not medically necessary or not covered, the plan will not cover the charges.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20/visit	$20/visit then 40% coinsurance	Inpatient admissions (including residential care rendered by a residential treatment facility) must be precertified, except for emergency admission. If out-of-network admission is not precertified and it is later determined it was not medically necessary or not covered, the plan will not cover the charges.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	$20/visit	$20/visit then 40% coinsurance	Expenses associated with a pre-planned home birth with an attending health care provider or doula are not covered. Depending on the type of services, a copayment, coinsurance or deductible may apply.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Home health care and skilled nursing care services must be medically necessary and certified by a physician initially, and when requested by the plan, that the care is skilled, and not custodial. Inpatient admissions must be precertified. If out-of-network admission is not precertified and it is later determined it was not medically necessary or not covered the plan will not cover the charges.
	Rehabilitation services	20% coinsurance	40% coinsurance	

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)	
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	Custodial care, rest care, or care which is only for someone's convenience is not covered.
If your child needs dental or eye care	Children's eye exam	$5/visit	Reimbursed up to $30/visit	Limited to every 2 calendar years
	Children's glasses	No charge for lenses. Reimbursed up to $40 wholesale for frames.	Lenses reimbursed up to $75. Frames reimbursed up to $25.	Limited to every 2 calendar years. Additional charges for non-standard lenses. Single vision lenses reimbursed up to $25, bifocal up to $35, and trifocal up to $45 for out-of-network claims.
	Children's dental check-up	Not covered	Not covered	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Experimental and investigational care or items (excluding clinical trials)
- Genetic testing (unless mandated by Federal Law)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight Loss Programs

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

- Chiropractic care (combined 50 visits maximum with physical therapy and outpatient occupation therapy)
- Hearing aids ($1,200 per year every 36 months
- Long-term care (if medically necessary)
- Private-duty nursing (if medically necessary)
- Routine eye care (Adult) (every two calendar years)

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 are the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the 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: [insert applicable contact information from instructions].

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.

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

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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** **$400**
- **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	$400
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,810**

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

- **The plan's overall deductible** **$400**
- **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*	$100
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,400**

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

- **The plan's overall deductible** **$400**
- **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*	$400
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**