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, visit www.tristatewelfarefund.com or call 1-844-395-4467. 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 the Benefit Office at 1-844-395-4467 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300** per person or **$600** per family	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes, preventive care is 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?	**$5,000** per person or **$10,000** per family for network providers; **No Limit** for out-of-network providers	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-billing charges, out-of-network expenses, 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, visit www.anthem.com or call (800) 810-2583 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% coinsurance	40% coinsurance	None.
	Specialist visit	20% coinsurance	40% coinsurance	None.
	Preventive care/screening/ Immunization	No charge; deductible does not apply.	No charge; deductible does not apply.	You may have to pay for services that aren't preventive care. 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	40% coinsurance	Pursuant to the No Surprises Act, in some circumstances, you may only be responsible for the network rate for certain charges from out-of-network providers when received at a network facility or during an emergency medical condition. For more information, contact the Fund Office.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	Therapeutic class: No charge (retail/mail order); Other drugs: $7.50 copay (retail)/$15 copay (mail order)	Full price of the prescription minus amount the network pharmacy would have paid	Retail: 34-day supply or 100 units Mail Order:90-day supply
	Preferred brand drugs	Therapeutic class: $10 copay (retail)/$20 copay (mail); Other drugs: 20% coinsurance up to $50 (retail)/$100 (mail)	Full price of the prescription minus amount the network pharmacy would have paid	Retail: 34-day supply/100 units; Mail Order: 90-day supply. You must pay the difference between the brand name and generic plus the brand name copay if a generic is available.
	Non-preferred brand drugs	Therapeutic class: $20 copay (retail)/$40 copay (mail); Other drugs: 30% coinsurance up to $75 (retail)/ $150 (mail)	Full price of the prescription minus amount the network pharmacy would have paid	Retail: 34-day supply/100 units; Mail Order: 90-day supply. You must pay the difference between the brand name and generic plus the brand name copay if a generic is available.
	Specialty drugs	Same cost sharing as generic, preferred brand, and non-preferred brand drugs, depending on the type of specialty drugs	Full price of the prescription minus amount the network pharmacy would have paid	Retail: 34-day supply or 100 units Mail Order: 90-day supply

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	40% coinsurance	Pursuant to the No Surprises Act, in some circumstances, you may only be responsible for the network rate for certain charges from out-of-network providers when received at a network facility or during an emergency medical condition. For more information, contact the Fund Office.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$50 copayment/visit	$50 copayment/visit	Copayment waived if admitted. Pursuant to the No Surprises Act, in some circumstances, you may only be responsible for the network rate for certain charges from out-of-network providers when received at a network facility or during an emergency medical condition. For more information, contact the Fund Office.
	Emergency medical transportation	20% coinsurance	40% coinsurance, except 20% coinsurance for air ambulance services	Pursuant to the No Surprises Act, in some circumstances, you may only be responsible for the network rate for certain charges from out-of-network providers when received at a network facility or during an emergency medical condition. For more information, contact the Fund Office.
	Urgent care	20% coinsurance	40% coinsurance	Pursuant to the No Surprises Act, in some circumstances, you may only be responsible for the network rate for certain charges from out-of-network providers when received at a network facility or during an emergency medical condition. For more information, contact the Fund Office.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Failure to obtain pre-approval results in $200 penalty, except when admitted for an emergency medical condition. Private rooms are covered only if medically necessary. Pursuant to the No Surprises Act, in some circumstances, you may only be responsible for the network rate for certain charges from out-of-network providers when received at a network facility or during an emergency medical condition. For more information, contact the Fund Office.
	Physician/surgeon fees	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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits, intensive outpatient services, and partial hospitalization: 20% coinsurance	Office visits, intensive outpatient services, and partial hospitalization: 40% coinsurance	None.
	Inpatient services	Acute inpatient admission and residential treatment facilities: 20% coinsurance	Acute inpatient admission and residential treatment facilities: 40% coinsurance	Failure to obtain pre-approval results in $200 penalty, except when admitted for an emergency medical condition. Private rooms are covered only if medically necessary. Pursuant to the No Surprises Act, in some circumstances, you may only be responsible for the network rate for certain charges from out-of-network providers when received at a network facility or during an emergency medical condition. For more information, contact the Fund Office.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance or a deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Private rooms are covered only if medically necessary.
	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	Coverage is limited to 100 visits per calendar year.
	Rehabilitation services	20% coinsurance	40% coinsurance	None.
	Habilitation services	20% coinsurance	40% coinsurance	Speech Therapy is limited to 20 visits per year.
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage is limited to 120 days per calendar year. Failure to obtain preauthorization will result in a $200 penalty.
	Durable medical equipment	20% coinsurance	40% coinsurance	None.
	Hospice services	20% coinsurance	40% coinsurance	Must be diagnosed as terminally ill with a life expectancy of 6 months or less. Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	You must pay 100% of this service.
	Children's glasses	Not covered.	Not covered.	You must pay 100% of this service.
	Children's dental check-up	Not covered.	Not covered.	You must pay 100% of this service.

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.)

- Bariatric surgery
- Cosmetic surgery (except for injury and reconstructive care following mastectomy.)
- Dental care (Adult and Child)
- Long-term care
- Non-emergency care when traveling outside of U.S.
- Routine eye care (Adult and Child
- 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.)

- Acupuncture
- Chiropractic care
- Hearing benefits (Max of $2,500/ear or $5,000 per pair every 36 months)
- Infertility treatment
- Private-duty nursing

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 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: the 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.
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 1-844-395-4467.

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	**$300**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$10
Coinsurance	$2,380
What isn't covered:	
Limits or Exclusions	$60
The total Peg would pay is	**$2,750**

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

The Plan's overall deductible	**$300**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$90
Coinsurance	$940
What isn't covered:	
Limits or Exclusions	$70
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	**$300**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$60
Coinsurance	$430
What isn't covered:	
Limits or Exclusions	$0
Total	**$790**