# NEEW Benefits Fund – Local 104

**Coverage for:** Individual / Family | **Plan Type:** PPO

**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 the Fund Office at 1-800-832-6538. 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 by calling 1-800-832-6538 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network: No Deductible<br>Out-of-Network:<br>$400 Individual / $800 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, 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?** | There no deductibles in-network. All in-network services are covered. | This plan covers all items and services without a deductible amount. For example, this plan covers certain preventive services without cost-sharing. 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-pocke limit for this plan?** | In-Network: Ind. Med $5,400; Ind. Rx $1,200; Ind. Out N/A<br>In-Network: Family Med $10,800; Family Rx $2,400; Family Out N/A | 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, 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. Go to www.anthem.com or call 1-800-810-2583 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 don't need a referral to see a specialist. | You can see the specialist you choose without permission from this plan. |

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/visit | 50% of "Reasonable and Customary" amount | None |
| | Specialist visit | $30 /visit | 50% of "Reasonable and Customary" amount | Preauthorization is required. If you don't get preauthorization, benefits could be reduced. |
| | Preventive care/screening/ Immunization | No charge | 50% of "Reasonable and Customary" amount | 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) | $30/ test | 50% of "Reasonable and Customary" amount | None |
| | Imaging (CT/PET scans, MRIs) | $125 /test | 50% of "Reasonable and Customary" amount | None |
| **If you need drugs to treat your illness or condition.** More information about **prescription drug coverage** is available by calling the Fund Office | Generic drugs | Retail: $10 copayment<br>Mail: $10 copayment | Not Covered | Retail: 30 day; Mail: 90 day<br>Some prescriptions require Pre-Authorization. |
| | Preferred brand drugs | Retail: $25 copayment<br>Mail: $25 copayment | Not Covered | Retail: 30 day; Mail: 90 day<br>Some prescriptions require Pre-Authorization. |
| | Non-preferred brand drugs | Retail: $60 copayment<br>Mail: $90 copayment | Not Covered | Retail: 30 day; Mail: 90 day<br>Some prescriptions require Pre-Authorization. |
| | Specialty drugs | Retail: $60 copayment<br>Mail: $90 copayment | Not Covered | Retail: 30 day; Mail: 90 day<br>Some prescriptions require Pre-Authorization. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $125 copayment | 50% of "Reasonable and Customary" amount | None |
| | Physician/surgeon fees | No payment; included in Facility Fee | 50% of "Reasonable and Customary" amount | None |
| **If you need immediate medical attention** | Emergency room care | $150 copayment | $150 copayment | None |
| | Emergency medical transportation | $30 copayment | $30 copayment | None |
| | Urgent care | $50 copayment | 50% of "Reasonable and Customary" amount | None |

* For more information about limitations and exceptions, see the plan or policy document by calling the Fund Office at 1-800-832-6538.

| 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) | $200 copayment | 50% of "Reasonable and Customary" amount | Pre authorization required. Call Anthem 1-800-810-2583<br>Max copay/family per year: 6 days ($1200). |
| | Physician/surgeon fees | No payment; included in Facility Fee | 50% of "Reasonable and Customary" amount | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $30 copayment | 50% of "Reasonable and Customary" amount | None |
| | Inpatient services | $200 copayment | 50% of "Reasonable and Customary" amount | Pre authorization required.<br>Call LHV EAP 800-327-2799 |
| **If you are pregnant** | Office visits | $30 /visit | 50% of "Reasonable and Customary" amount | None |
| | Childbirth/delivery professional services | $30 /visit | 50% of "Reasonable and Customary" amount | None |
| | Childbirth/delivery facility services | $200 / day | 50% of "Reasonable and Customary" amount | Minimum stay (mother and baby):<br>48 hrs. vaginal birth. 96 hrs. caesarean birth. Call Anthem 1-800-810-2583 |
| **If you need help recovering or have other special health needs** | Home health care | $30 copayment | 50% of "Reasonable and Customary" amount | Maximum 80 visits per year |
| | Rehabilitation services | $10 copayment | 50% of "Reasonable and Customary" amount | Maximum 30 visits PT/OT/ST/Massage per year |
| | Habilitation services | $10 copayment | 50% of "Reasonable and Customary" amount | Maximum 30 visits PT/OT/ST/Massage per year |
| | Skilled nursing care | $100 copayment | 50% of "Reasonable and Customary" amount | Maximum 120 days/year |
| | Durable medical equipment | $30 copayment | 50% of "Reasonable and Customary" amount | Rental price will not exceed purchase price of item |
| | Hospice services | $100 copayment (one time) | 50% of "Reasonable and Customary" amount | Terminally ill patient with 6 months or less life expectancy |
| **If your child needs dental or eye care** | Children's eye exam | Anthem Blue View Vision | Anything over Plan benefit: $60 | Once per calendar year |
| | Children's glasses | Anthem Blue View Vision | Anything over Plan benefits $65 lens/$100 frames | Once per calendar year |
| | Children's dental check-up | No Charge | Amounts over "Reasonable and Customary | Anthem Dental Network<br>Preventive services: 1 every 5 months |

* For more information about limitations and exceptions, see the plan or policy document by calling the Fund Office at 1-800-832-6538.

## 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 | • Private-duty nursing | • Routine foot care |
| • Long Term Care | • Weight Loss Programs | |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Coverage provided outside the United States.<br>• Bariatric Surgery – when reviewed and determined to be medically necessary<br>• Routine foot care ONLY when related to diabetes | • Hearing aids – Services from one of the four participating Universities<br>• Infertility Treatment (subject to Plan limitations) | • Acupuncture<br>• Chiropractic Care<br>• Dental and Routine Vision (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 1-866-444-3272 or www.dol.gov/ebsa. 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 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 the Fund Office at 1-800-832-6538.

**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.

*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 the plan or policy document by calling the Fund Office at 1-800-832-6538.

## 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 | $0 |
| Specialist *[cost sharing]* | $30 |
| Hospital (facility) *[cost sharing]* | $200/day |
| Other *[cost sharing]* | -- |

**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** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $560 |
| Coinsurance | 0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$620** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist *[cost sharing]* | $30 |
| Hospital (facility) *[cost sharing]* | $200/day |
| Other *[cost sharing]* | -- |

**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** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $1,115 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$1,170** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist *[cost sharing]* | $30 |
| Hospital (facility) *[cost sharing]* | $200/day |
| Other *[cost sharing]* | -- |

**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** | **$1,900** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $480 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$480** |

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