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 1-800-255-3340. 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 1-800-255-3340 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$250** person/**$750** family; Non-Network: **$500** person/**$1,500** family (January 1 – December 31)	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. Wellness benefits (preventive services) up to $300 per person per calendar year, Doctor on Demand, emergency room care, prescription drugs, vision care, and dental care 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.
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?	Network: **$1,500** person/**$3,000** family; Non-Network: **$3,000** person/**$6,000** family (January 1 – December 31)	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, deductible, prescription drugs, dental care, vision care, emergency room copayments, care that is not precertified when required, penalty amounts for not obtaining precertification, 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.anthem.com or call 833-952-2061 for a list of network providers. See www.deltadentalwi.com or call 800-236-3712 for a list of dental 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)	Non-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	10% coinsurance	20% coinsurance	Telemedicine available through Doctor on Demand at no charge and the deductible does not apply.
	Specialist visit	10% coinsurance	10% coinsurance for chiropractic, acupuncture, and massage therapy; 20% coinsurance all other services	Chiropractic care limited to 36 visits per person per calendar year. $1,500 massage therapy limit per person per calendar year.
	Preventive care/screening/ immunization	No deductible and no charge up to $300 per person per calendar year, then deductible and 10% coinsurance apply to excess amount	No deductible and no charge up to $300 per person per calendar year, then deductible and 10% coinsurance apply to excess amount	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)	10% coinsurance	20% coinsurance	Precertification required to avoid benefit reduction.
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-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 www.savrx.com.	Generic drugs	30% coinsurance (retail and mail order). Deductible does not apply.	30% coinsurance (retail) plus balance of cost of the fill. Deductible does not apply.	Supply: 30-day retail and 90-day mail order Cost sharing for prescriptions drugs does not count toward the out-of-pocket limit.
	Brand Name drugs	30% coinsurance (retail and mail order) plus the difference between brand and generic if not specified as medically necessary. Deductible does not apply.	30% coinsurance (retail) plus the difference between brand and generic if not specified as medically necessary. Deductible does not apply.	
	Specialty drugs	30% coinsurance (retail and mail order). Deductible does not apply.	30% coinsurance (retail) plus balance of cost of the fill. Deductible does not apply.	Specialty drugs will be delivered exclusively though the Sav-Rx Specialty Pharmacy after an initial retail fill.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	Precertification required for surgery to avoid benefit reduction.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	$50 copayment/visit, then 10% coinsurance. Deductible does not apply.	$50 copayment/visit, then 10% coinsurance. Deductible does not apply.	Your copayments do not count toward the out-of-pocket limit.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	10% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Precertification required to avoid benefit reduction.
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	Telemedicine available through Doctor on Demand at no charge and the deductible does not apply.
	Inpatient services			Precertification required to avoid benefit reduction.
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Precertification required to avoid benefit reduction after a hospital stay of not less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section unless the mother has consented.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance for custodial care and 20% coinsurance for all other care	Precertification required to avoid benefit reduction. $10,000 lifetime maximum on custodial care.
	Rehabilitation services	10% coinsurance	20% coinsurance	Precertification required to avoid benefit reduction. Reviewed after 120 visits for continued medical necessity.
	Habilitation services	10% coinsurance	20% coinsurance	Precertification required to avoid benefit reduction. Reviewed after 120 visits for continued medical necessity.
	Skilled nursing care	10% coinsurance	20% coinsurance	Precertification required to avoid benefit reduction.
	Durable medical equipment	10% coinsurance	20% coinsurance	Precertification required for charges over $1,000 to avoid benefit reduction. Equipment rental is covered up to purchase price of equipment.
	Hospice services	No charge	20% coinsurance	Precertification for in-home services is required to avoid benefit reduction.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	No charge up to $35. Deductible does not apply.	One routine exam every twelve months. Vision benefits administered separately through EyeMed.
	Children's glasses	No charge for lenses; no charge up to $150 for frames; no charge up to $125 for conventional contacts; and no charge for medically necessary contacts. Deductible does not apply.	No charge up to $40 per single vision lenses, $60 for bifocal lenses, $80 for trifocal lenses, $32 for frames, $176 for medically necessary contacts, and $72 for conventional and disposable contacts. Deductible does not apply.	Routine care once every twelve months. Vision benefits administered separately through EyeMed.
	Children's dental check-up	No charge. Deductible does not apply.	20% coinsurance. Deductible does not apply.	Routine cleaning two times per twelve-month period. Dental benefits administered separately through Delta Dental of Wisconsin.

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 (except treatment for endogenous obesity if medically necessary)
- Cosmetic surgery (except reconstructive surgery due to an injury, infection, or disease resulting from a congenital anomaly, or following mastectomy)
- Infertility treatment (except diagnostic testing or services)
- Long-term care
- Private-duty nursing
- 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 (Limited to 36 visits per person per calendar year)
- Dental care (Adult) ($3,000 lifetime orthodontia maximum)
- Hearing aids (one per ear per 36-month period)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care

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: the 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 Milwaukee Drivers Health and Welfare Fund at 1-800-255-3340. You may also 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.

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 network pre-natal care and a hospital delivery)

The plan's overall deductible	**$250**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**30%**

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	$250
Copayments	$0
Coinsurance	$1,230
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,540**

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

The plan's overall deductible	**$250**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**30%**

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	$250
Copayments	$0
Coinsurance	$1,370
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	**$1,660**

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

The plan's overall deductible	**$250**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**30%**

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	$250
Copayments	$50
Coinsurance	$250
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

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