NEEW Benefits Fund – Local 7

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 (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 (800) 832-6538 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: No Deductible Out-of-Network: $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: Med / In-Network: Rx / Out Ind. $5,400 / $1,200 / N/A Family $10,800 / $2,400 / 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 (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	$0/visit	50% of "Reasonable and Customary" amount	None
	Specialist visit	$0 /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)	No copayment	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	Copayments Retail: $0; Mail: $0 Walk-in Retail: $0	Not Covered	Retail: 30 day; Mail: 90 day Walk-in Retail: 90 day Some prescriptions require Pre-Authorization.
	Preferred brand drugs	Copayments Retail: $25; Mail: $25 Walk-in Retail: $50	Not Covered	Retail: 30 day; Mail: 90 day Walk-in Retail: 90 day Some prescriptions require Pre-Authorization.
	Non-preferred brand drugs	Copayments Retail: $60; Mail: $90 Walk-in Retail: $120	Not Covered	Retail: 30 day; Mail: 90 day Walk-in Retail: 90 day Some prescriptions require Pre-Authorization.
	Specialty drugs	Copayments Retail: $60; Mail: $90 Walk-in Retail: $120	Not Covered	Retail: 30 day; Mail: 90 day Walk-in Retail: 90 day 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	$20 copayment	$20 copayment	None
	Urgent care	$50 copayment	50% of "Reasonable and Customary" amount	None

* For more information about limitations and exceptions, see the plan, which you can receive from the Fund Office.

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 (800) 810-2583 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	$0 copayment	50% of "Reasonable and Customary" amount	None
	Inpatient services	$100 copayment	50% of "Reasonable and Customary" amount	Pre authorization required. Call LHV EAP (800) 327-2799
If you are pregnant	Office visits	$0 /visit	50% of "Reasonable and Customary" amount	None
	Childbirth/delivery professional services	$0 /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): 48 hours (vaginal birth) 96 hours (cæsarean section). Call Anthem (800) 810-2583
If you need help recovering or have other special health needs	Home health care	$0 copayment	50% of "Reasonable and Customary" amount	Maximum 80 visits per year
	Rehabilitation services	$5 copayment	50% of "Reasonable and Customary" amount	Maximum 30 visits PT/OT/ST/Massage per year
	Habilitation services	$5 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	$20 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 Preventive services: 1 every 5 months

* For more information about limitations and exceptions, see the plan, which you can receive from the Fund Office.

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.	• Hearing aids – Services from one of the four participating Universities	• Acupuncture
• Bariatric Surgery – when reviewed and determined to be medically necessary	• Infertility Treatment (subject to Plan limitations)	• Chiropractic Care
• Routine foot care ONLY when related to diabetes		• 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 (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 Fund Office at (800) 832-6538.

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 (800) 832-6538.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 832-6538.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码(800) 832-6538.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 832-6538.

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, which you can receive from the Fund Office.

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]*	$0
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

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	**$12700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

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]*	0
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

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	**$5600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$320**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist *[cost sharing]*	$0
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

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	**$2800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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