ADMINISTRATIVE OFFICES

ELECTRICAL WORKERS LOCAL 332 TRUST FUNDS

MAILING ADDRESS: P.O. BOX 5057, SAN JOSE, CA 95150-5057 • PHONE (408) 288-4400

December 2019

TO: ALL ACTIVE PARTICIPANTS OF THE I.B.E.W. LOCAL 332 HEALTH & WELFARE PLAN

RE: 2020 Open Enrollment – READ CAREFULLY
ALL CHANGES ARE EFFECTIVE JANUARY 1, 2020

The Annual Open Enrollment will be held from December 1, 2019 through December 27, 2019. All enrollment changes will be effective January 1, 2020.

Each year, the Board of Trustees carefully evaluates proposals from various insurance providers, as well as projected costs for the Trust's self-funded medical, prescription drug, dental, short-term disability and vision benefits. As a result of this year's review, the Trustees determined that there will be no changes to the Trust's self-funded benefits or to the Kaiser HMO plan option for 2020.

To help you in your decision-making process, the enclosed Benefit Summary Comparison Chart compares some of the most important benefit features of the Kaiser HMO plan option as well as the Trust Self-Funded Medical Indemnity PPO plan option. Naturally, the comparison chart cannot show every benefit or every limitation or exclusion. If you are interested in changing your Medical Plan option for 2020, a complete benefit informational packet for the Kaiser HMO plan option is available from the Trust Office (UAS). Benefits provided by the Trust Self-Funded Medical Indemnity PPO plan option are fully described in the Plan's Summary Plan Description (SPD) benefit booklet which can be viewed online at **ibew332benefits.com**.

To change your Medical Plan Option, you may either:

1) Complete the enclosed "**Medical Plan Option Change Request Form**" and mail or fax it to the Trust Office, and they will send you new enrollment forms; or
2) Contact the Trust Office directly and notify them of the Medical Plan Option change you wish to make, and they will send you new enrollment forms.

If you have any questions or need more information, please contact the Trust Office (UAS) at (408) 288-4433 or toll-free at 1-877-827-4239.

If you are currently enrolled in Kaiser HMO plan option or the Trust Self-Funded Medical Indemnity PPO plan option as a Participant and you wish to remain with your current plan option for 2020, no action is required on your part.

If you want to enroll an eligible dependent during open enrollment you must complete a new enrollment form and return it to the Trust Office no later than December 27, 2019. If you have questions regarding who qualifies as a dependent, please contact the Trust Office.

You must complete new enrollment forms to change your medical plan option. <u>All enrollment forms must be returned to the Trust Office (UAS) by December 27, 2019.</u>

BENEFIT MODIFICATIONS FOR 2020

Trust Self-Funded Medical/Rx Plan Benefit Modifications

There will be no changes to benefits for 2020.

Kaiser HMO/Rx Plan Benefit Modifications

There will be no changes to benefits for 2020.

2020 Summary of Benefits and Coverage (SBC)

The SBC is a required notice created to provide you with a standardized summary about the Plan's medical benefits and coverage. You are receiving SBCs for all of the benefit options available under the Plan. You may not be eligible for each of these benefit options based on where you work or reside. If you would like a copy of the Glossary of Terms, you will find a link to the document on the group website at soundcommbenefits.com. If you do not have access to the website, you may request a copy at no charge. For additional copies, or if you have questions about the SBC or the Glossary of Terms referred to in the SBC, please contact the Trust office at (408) 288-4433 or toll-free at 1-877-827-4239.

I.B.E.W. LOCAL 332 HEALTH & WELFARE PLAN
ACTIVE PLAN – 2020 MEDICAL PLAN OPTIONS
BENEFIT SUMMARY COMPARISON

Two Medical plan options are offered: 1) The Trust Self-Funded Medical Indemnity Plan (a PPO Plan) and 2) Kaiser Permanente (an HMO Plan). With two options, you are able to select the plan that works best for your needs.

MEDICAL

PLAN FEATURES	TRUST SELF-FUNDED MEDICAL INDEMNITY PLAN		KAISER HMO PLAN Group #780
	In-Network	Out-of-Network	
Provider Network	Anthem Blue Cross PPO	Use Any Provider	Kaiser Permanente
Network Service Area	California		California
Who Provides Care	To receive the highest level of benefits, use an Anthem Blue Cross PPO network provider. Note: If you are referred to an out-of-network provider by an in-network provider, out-of-network benefits still apply.		Kaiser Permanente doctors and facilities only
Calendar-Year Deductible	$250 per person, up to $750 per family	$250 per person, up to $750 per family	None
Calendar-Year Out-of-Pocket Maximum for Covered Expenses	$3,000 per person, up to $6,000 per family	$6,000 per person, up to $13,000 per family	$1,500 per person, up to $3,000 per family
Medical Plan Annual Maximum	Unlimited		Unlimited
Medical Plan Lifetime Maximum	Unlimited		Unlimited
Eligibility Age Limits for Dependent Children	Under age 26		Same
Preauthorization Requirements	Your physician is responsible for obtaining any required preauthorization through Anthem Blue Cross.	You or your physician must contact Anthem Blue Cross at least seven days before: • Hospital admission • Use of outpatient facility • Certain diagnostic procedures • Outpatient surgery	All preauthorizations must be coordinated through your Kaiser primary care physician.

MEDICAL

PLAN FEATURES	TRUST SELF-FUNDED MEDICAL INDEMNITY PLAN		KAISER HMO PLAN Group #780
	In-Network	Out-of-Network	
Benefits for Most Covered Services	After calendar-year deductible, plan pays:		You pay $15 copay per visit. No benefits are payable at non-Kaiser facilities, except in case of emergency.
	80% of Anthem Blue Cross negotiated rate.	60% of usual, customary and reasonable charges.	
Preventative Care Benefits – Preventative Physical Exams	100% of eligible expenses for annual preventative physical exam in an Anthem Blue Cross network provider doctor's office. Age frequency applies. No deductible applies.	No benefit provided out-of-network.	Plan pays 100%. Annual routine physical examinations for employment, sports, college entrance, etc. not covered.
Well Baby Care	80% of Anthem Blue Cross negotiated rate. Preventive Care is paid at 100% of eligible expenses (see Preventive Care Benefits – Preventive Physical Exams). (Infants through age 36 months) No deductible applies.	No benefit provided out-of-network	Plan pays 100%. (Infants through age 23 months)
Immunizations and Vaccinations	100% of eligible expenses for adults and children for physician-recommended immunizations and vaccinations.	No benefit provided out-of-network	Plan pays 100%. For children under 2 years of age, refer to Well Baby Care.
Diagnostic Test (X-Ray, Blood Work)	100% of Anthem Blue Cross PPO network provider services. Calendar-year deductible is waived.	60% of usual, customary and reasonable charges after calendar-year deductible is applied.	Plan pays 100%.
Imaging (CT / PET scans, MRI's)	80% of Anthem Blue Cross negotiated rate.	60% of usual, customary and reasonable charges after calendar-year deductible is applied.	Plan pays 100%.

All information contained in this Benefit Summary Comparison has been designed to give you a general overview of the Medical plan options and the Medical benefits provided effective January 1, 2020. It does not, however, attempt to explain all the details, provisions, limitations, restrictions and exclusions of the Plan's Medical benefits. The Board of Trustees reserves the right to change or terminate the Plan or specific provisions of the Plan at any time. If there is any conflict between this benefit summary and the Plan's Summary Plan Description (SPD), the SPD prevails. For additional information about the Plan's benefits, please contact the Plan Administrator, United Administrative Services: (408) 288-4433 or toll-free, 1-877-827-4239.

MEDICAL

PLAN FEATURES	TRUST SELF-FUNDED MEDICAL INDEMNITY PLAN		KAISER HMO PLAN Group #780
	In-Network	Out-of-Network	
Inpatient Hospital and Outpatient Facility Services	After calendar-year deductible, plan pays:		Inpatient – Plan pays 100% after you pay $100 copay per admission. Outpatient – Plan pays 100% after you pay $15 copay per procedure.
	80% of Anthem Blue Cross negotiated rate.	60% of usual, customary and reasonable charges.	
Emergency Room Facility Charges	80% of Anthem Blue Cross negotiated rate. No deductible applies.	Greatest of: (1) 80% of the Anthem Blue Cross negotiated rate; (2) 80% of the amount that would be paid under Medicare; or (3) 80% of UCR. No deductible applies.	Plan pays 100% after you pay $100 copay per emergency room visit. Copay is waived if you are admitted to hospital as inpatient.
Urgent Care Center Services	80% of Anthem Blue Cross negotiated rate.	60% of usual, customary and reasonable charges.	Plan pays 100% after you pay $15 copay.
Ambulance	80% of Anthem Blue Cross negotiated rate.	60% of usual, customary and reasonable charges.	Plan pays 100% after you pay $50 copay.
Infertility Treatment	No benefit provided.		Limited benefits. Contact Kaiser for specific coverage.
Chiropractic and Acupuncture Services	Regular in- and out-of-network benefits apply for up to 30 visits per calendar year.		You pay $15 copay per visit for up to 30 visits per calendar year.
Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST)	80% of Anthem Blue Cross negotiated rates.	60% of usual, customary and reasonable charges.	You pay $15 copay per visit.

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MEDICAL

PLAN FEATURES	TRUST SELF-FUNDED MEDICAL INDEMNITY PLAN		KAISER HMO PLAN Group #780
	In-Network	Out-of-Network	

<table>
<tr><td>Mental / Behavioral Health Services</td><td colspan="2">MENTAL HEALTH BENEFIT</td><td rowspan="5"><u>Mental Health</u>
Outpatient:
$15 copay per visit (individual basis) or $7 copay per visit (group basis) at Kaiser facilities.
Inpatient:
$100 copay per admission at Kaiser facilities.

<u>Chemical Dependency</u>
Detox: $100 copay per admission at Kaiser facilities.
Outpatient: $15 copay per visit (individual basis) or $5 copay per visit (group basis) at Kaiser facilities.
Additional Coverage:
Supplemental coverage is provided by Beat It! for Chemical Dependency <u>after Kaiser benefits are exhausted.</u></td></tr>
<tr><td rowspan="4"></td><td colspan="2">Contact Anthem Blue Cross’s Utilization Review department by calling 1-800-274-7767 for mental health services. Anthem Blue Cross works with a network of counseling and treatment providers throughout California.
These include psychologists, psychiatrists, marriage and family counselors and social workers where needed, inpatient and outpatient hospitals, and facilities for mental health treatment.</td></tr>
<tr><td colspan="2">After calendar-year deductible, plan pays:</td></tr>
<tr><td>Outpatient:
80% of Anthem Blue Cross’s negotiated rate.</td><td>60% of usual, customary and reasonable charges.</td></tr>
<tr><td>Inpatient:
80% of Anthem Blue Cross’s negotiated rate.</td><td>If for emergency services, 80% of greater of: (1) 80% of the Anthem Blue Cross negotiated rate; (2) 80% of the amount that would be paid under Medicare; or (3) 80% of UCR.
Non-emergency, 60% of usual, customary and reasonable charges.</td></tr>
<tr><td>Psychiatric Residential Care benefits:
80% of Anthem Blue Cross’s negotiated rate.</td><td>If for emergency services, 80% of greater of: (1) 80% of the Anthem Blue Cross negotiated rate; (2) 80% of the amount that would be paid under Medicare; or (3) 80% of UCR.
Non-emergency, 60% of usual, customary and reasonable charges.</td></tr>
<tr><td>Substance Abuse Disorder Services</td><td colspan="3">BEAT IT! PROGRAM FOR ALCOHOL AND SUBSTANCE ABUSE</td></tr>
<tr><td></td><td colspan="3">Beat It! Is a specialty program for the treatment of alcohol and substance abuse. This program is available to all eligible participants and their dependents, including members who have chosen the Kaiser HMO plan for medical coverage.
This benefit covers inpatient treatment and outpatient counseling. Inpatient treatment at a facility approved by Beat It! is covered at 80% of covered charges of the first $3,000 ($6,000 per family unit) of eligible expenses and 100% (instead of 80%) of covered charges for the remainder of the calendar year. Outpatient counseling by an approved counselor provided by Beat It! is covered at 80% of covered charges after the applicable annual deductible (currently $250 per person or a maximum of $750 per family unit) has been satisfied.
Inpatient treatment and outpatient counseling provided by an out-of-network provider is covered at 60% of all usual, customary, and reasonable charges in excess of the applicable annual deductible and coinsurance amounts.</td></tr>
</table>

MEDICAL

PLAN FEATURES	TRUST SELF-FUNDED MEDICAL INDEMNITY PLAN		KAISER HMO PLAN Group #780
	In-Network	Out-of-Network	
Prescription Drugs **Maxor Plus as of July 1, 2019**	**Retail Drugs** (up to 30-day supply) – **Only at participating pharmacies** • Generic – You pay $10 copay. • Preferred Brand – You pay 20%; $15 minimum up to a $25 maximum copay. • Non-Preferred Brand – You pay 30%; $30 minimum up to a $75 maximum copay. **Mail Order Drugs** (up to 90-day supply) – **Only through MXP Pharmacy** • Generic – You pay $20 copay. • Preferred Brand – You pay 20%; $40 minimum up to a $75 maximum copay. • Non-Preferred Brand – You pay 30%; $75 minimum up to a $150 maximum copay. **Some drugs require preauthorization.** Medical plan deductible and coinsurance amounts do not apply to this benefit feature.		**Retail Drugs** (up to 30-day supply) – **Only at Kaiser pharmacy** • Generic – You pay $10 copay. • Brand – You pay $25 copay. **Mail Order Drugs** refills only (up to 100-day supply) – **Only through Kaiser Mail Order Service** • Generic – You pay $20 copay. • Brand – You pay $50 copay. • Not all drugs are available through mail order. **Specialty Drugs** (up to 30-day supply) – • You pay up to a maximum copay of $200.

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PROVIDER CONTACT INFORMATION

	TRUST SELF-FUNDED MEDICAL INDEMNITY PLAN	KAISER GROUP #780
Member / Customer Service Phone, Email	**United Administrative Services (Plan Administrator)** (408) 288-4400 1-877-827-4239 www.uastpa.com **Anthem Blue Cross Preferred Provider Organization (PPO)** (Refer to Group #170017) (408) 288-4400 1-877-827-4239 www.anthem.com/ca	1-800-464-4000 www.kaiserpermanente.org

VISION SERVICE PLAN	BEAT IT! (Alcohol and Substance Abuse)	ANTHEM BLUE CROSS DENTAL PPO
1-800-877-7195 www.vsp.com	1-800-828-3939 www.beatiteap.com	(408) 288-4400 1-800-541-8059 www.anthem.com/ca

MaxorPlus (Pharmacy Benefit Manager)	MXP Pharmacy (Mail Order Rx)
1-800-687-0707 www.maxorplus.com	1-800-687-8629 www.maxorplus.com

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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, go to www.ibew332benefits.com or call in San Jose (408) 288-4433 or toll-free at 1-877-827-4239. 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.cciio.cms.gov or call 1-800-878-4445 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 person / $750 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?	Yes. Most network provider preventive care services 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. 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?	There are no other medical plan deductibles. Dental benefit deductible: $50 person / $150 family	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-pocket limit for this plan?	For network providers: $3,000 person / $6,000 family (including deductible and Rx) For out-of-network providers: $6,000 person / $13,000 family (including deductible and Rx)	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?	Deductibles, 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, this plan uses network providers. If you use a non-network provider your cost may be more. For a list of network providers, see www.anthem.com/ca or call the Member Service number listed on the back of your ID card for a list of Anthem BlueCross PPO 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 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	20% coinsurance after deductible	40% coinsurance after deductible	None
	Specialist visit	20% coinsurance after deductible	40% coinsurance after deductible	None
	Preventive care/screening/ immunization	No charge	Not covered	Deductible does not apply. 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)	20% coinsurance after deductible	40% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.maxorplus.com.	Preferred and non-preferred generic drugs	Retail: $10 copay/prescription; Mail order: $20 copay/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	Retail: 20% coinsurance/prescription; Mail order: 20% coinsurance/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Responsible for difference in cost between brand drug and generic, if generic equivalent available. Retail: $15 minimum up to $25 maximum coinsurance. Mail Order: $40 minimum up to $75 maximum coinsurance.
	Non-preferred brand drugs/all other drugs	Retail: 30% coinsurance/prescription Mail order: 30% coinsurance/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Responsible for difference in cost between brand drug and generic, if generic equivalent available. Retail: $30 minimum up to $75 maximum coinsurance. Mail Order: $75 minimum up to $150 maximum

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)	
				coinsurance.
	Specialty drugs	Retail: 30% coinsurance/prescription Mail order: 30% coinsurance/prescription	Not covered	Must use the MXP Pharmacy Specialty Mail-Order Pharmacy. Maximum 30-day supply. Retail: $30 minimum up to $75 maximum coinsurance. Mail Order: $75 minimum up to $150 maximum coinsurance.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	None
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	20% coinsurance, $0 deductible	40% coinsurance after deductible	Out-of-network provider emergency service are paid by the Plan at 80% of greater of: (1) 80% of the network provider rate; (2) 80% of the amount that would be paid under Medicare; or (3) 80% of UCR.
	Emergency medical transportation	20% coinsurance, $0 deductible	40% coinsurance after deductible	Limited to the U.S. and Canada.
	Urgent care	20% coinsurance after deductible	40% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required except in an emergency. See your plan document for details.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required except in an emergency. See your plan document for details.
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required except in an emergency. See your plan document for details.
If you are pregnant	Office visits	20% coinsurance after deductible	40% coinsurance after deductible	Coinsurance applies to provider delivery charges.
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	

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 help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Medical treatment only.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	None
	Habilitation services	Not covered	Not covered	No coverage for Habilitation services.
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Routine custodial care excluded. Limitations apply – See your plan document.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required.
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	None
If your child needs dental or eye care	Children's eye exam	$10 copay/visit	Limited to $50	Limited to 1 exam every calendar year.
	Children's glasses	$25 copay	Various reimbursement amounts. Refer to Plan Document.	Lenses limited to once in a calendar year. Frames limited to once every two calendar years.
	Children's dental check-up	No charge	No charge	Limited to 2 exams in any calendar year.

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 is general excluded except as required by Women's Health and Cancer Rights Act, due to an accidental bodily injury, or due to a birth defect.
- Habilitation Services
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- 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 Services
- Bariatric Surgery
- Chiropractic Care
- Dental Care
- Hearing Aids
- Routine Eye 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or http://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 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: For more information about your coverage, contact I.B.E.W. Local 332 Health & Welfare Plan in San Jose at (408) 288-4438 or toll-free at 1-877-827-4239. 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**.
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 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 1-800-547-4457.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-547-4457.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-800-547-4457.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-547-4457.

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	$250
Specialist copayment	$0
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$2,510
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,760**

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

The plan's overall deductible	$250
Specialist copayment	$0
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$1,430
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,680**

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

The plan's overall deductible	$500
Specialist copayment	$0
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$330
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$580**