

Cleveland-Cliffs Steel LLC VEBA Trust

2023 Summary of Benefits (Basic Enhanced Medical Plan)

PPO Plan 5LD

[Anthem.com](https://www.Anthem.com)

Anthem Blue Cross and Blue Shield gives you the tools and resources you need to make the best decisions for your health, like this summary of benefits. It's a snapshot of your plan's covered benefits and services and what they cost. For more details about your benefits and services, please review your Evidence of Coverage (EOC).

The benefits and description of covered services within this summary are pending CMS approval and may change. Any changes will be shared with you.

Medicare & You 2023 resource: For more information, we encourage you to read Medicare & You 2023. This booklet is mailed to people with Medicare every year in the fall. It has a summary of Medicare benefits, rights, and protections. It also includes answers to the most frequently asked questions. If you don't have a copy of this booklet, request one at www.medicare.gov or call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

How much is the monthly premium? Contact your group plan benefit administrator to determine your actual premium amount, if applicable.

	In-network:	Out-of-network:
Annual medical deductible:	\$0	\$250
Maximum out-of-pocket responsibility: (Does not include prescription drugs)	\$3,400	\$5,450
Covered medical benefits	In-network, members pay:	Out-of-network, members pay:
Inpatient hospital care*	\$200 copay per day for days 1-7 per admission	\$200 copay per day for days 1-7 per admission

Covered medical benefits	In-network, members pay:	Out-of-network, members pay:
Outpatient Hospital Care Facility or ambulatory surgical center visit for surgery*	\$185 copay Per Visit	\$185 copay Per Visit
Observation Room	\$185 copay Per Visit	\$185 copay Per Visit
Primary care office visit	\$5 copay Per Visit	\$15 copay Per Visit
Specialty care office visit	\$40 copay Per Visit	\$40 copay Per Visit
Video doctor visits LiveHealth Online	\$0 copay Per Visit	
Preventive care	\$0 copay Per Visit	\$0 copay Per Visit
Emergency room visit	\$75 copay Per Visit, 72 hours cost share waived if admitted for the same condition	
Urgently needed services	\$50 copay Per Visit, 72 hours cost share waived if admitted for the same condition	
Diagnostic services, labs, and imaging Diagnostic lab services*	\$0 copay Per Visit	\$0 copay Per Visit
Diagnostic radiology services, such as MRIs and CT scans*	\$200 copay Per Visit	\$200 copay Per Visit
Outpatient X-rays*	\$35 copay Per Visit	\$35 copay Per Visit
Hearing services Medicare-covered diagnostic hearing and balance evaluations*	\$40 copay Per Visit	\$40 copay Per Visit
Medicare Covered Dental Non-routine care covered by Medicare*	\$40 copay Per Visit	\$40 copay Per Visit
Vision services Medicare-covered exams given by a specialist to diagnose and treat eye diseases and conditions	\$40 copay Per Visit	\$40 copay Per Visit
Medicare-covered eyewear following cataract surgery	20% coinsurance	20% coinsurance
Routine vision eye exam	\$0 copay Per Visit, 1 Visit every 12 months, \$70 every 12 months	\$0 copay Per Visit, 1 Visit every 12 months, \$70 every 12 months

Covered medical benefits	In-network, members pay:	Out-of-network, members pay:
Mental Health Services Inpatient visit *	\$200 copay per day for days 1-7 per admission	\$200 copay per day for days 1-7 per admission
Outpatient group therapy professional visit	\$40 copay Per Visit	\$40 copay Per Visit
Outpatient individual therapy professional visit	\$40 copay Per Visit	\$40 copay Per Visit
Professional partial hospitalization*	\$40 copay Per Visit	\$40 copay Per Visit
Skilled nursing facility (SNF)*	Tier 1 \$0 copay Per Day, 1-20 Days Per Benefit Period	Tier 1 \$0 copay Per Day, 1-20 Days Per Benefit Period
	Tier 2 \$125 copay Per Day, 21-100 Days Per Benefit Period	Tier 2 \$125 copay Per Day, 21-100 Days Per Benefit Period
Outpatient rehabilitation services Physical, occupational, and speech therapy visits*	\$40 copay Per Visit	\$40 copay Per Visit
Ambulance services	\$100 copay Per One Way Trip	
Part B Drugs Medicare-covered*	20% coinsurance	20% coinsurance
Chiropractic services*	\$20 copay Per Visit	\$20 copay Per Visit
Acupuncture for chronic low back pain	\$5 copay Per Visit	\$15 copay Per Visit
Diabetes management Supplies, including blood glucose test strips, lancet devices, lancets, and glucose control solutions	\$0 copay Per Visit, 30 days per supply	\$0 copay Per Visit, 30 days per supply
Blood glucose monitor	\$0 copay Per Purchase	\$0 copay Per Purchase
Therapeutic shoes	\$0 copay Per Purchase	\$0 copay Per Purchase
Self-management training	\$0 copay Per Visit	\$0 copay Per Visit
Continuous glucose monitor*	\$0 copay Per Purchase	\$0 copay Per Purchase
Durable medical equipment (DME)*	20% coinsurance	20% coinsurance
Podiatry services	\$5 copay Per Visit	\$15 copay Per Visit
Routine foot care	\$5 copay Per Visit, 12 Visits Per Year	\$15 copay Per Visit, 12 Visits Per Year
Home health care*	\$0 copay Per Visit	\$0 copay Per Visit

Additional supplemental benefits, services, and discounts

Additional covered benefits and services	Members pay:
Foreign travel emergency (outside U.S. territories) Emergency care	\$75 copay Per Visit, 72 hours cost share waived if admitted for the same condition
Urgently needed services	\$50 copay Per Visit, 72 hours cost share waived if admitted for the same condition
Inpatient emergency care	\$200 copay per day for days 1-7 days per admission 60 days per lifetime
Health and wellness programs SilverSneakers® Take virtual fitness classes at home or visit us at a participating gym.	\$0 copay Per Visit
Healthy Meals Meals delivered after being discharged from inpatient hospital visit or for members living with a chronic condition*	\$0 copay Per Qualifying Event, 14 Meals Per Qualifying Event, four (4) Events Per Year, 56 Meals In Total
Healthy Pantry Monthly nutritional counseling and delivery of pantry items*	\$0 copay Per Year
Over-the-counter (OTC) items	This plan provides coverage up to \$30 every quarter.
Medicare Community Resource Support	\$0 copay Per Visit
Compression Stockings	\$0 copay for compression stockings, 4 per calendar year

*Benefit requires physician referral or prior authorization.

This document reflects cost shares only.

Some of the benefits listed above are combined in-network and out-of-network.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply. If there is a difference between this document and the *Evidence of Coverage* (EOC), the EOC is considered correct.

Benefits, premiums and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.