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 1-800-765-4239. 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 http://www.healthcare.gov/sbc-glossary or call 1-800-765-4239 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** Individual/**$3,000** Family *Certain out-of-network claims are treated as in-network claims (see page 2).*	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. Prescription drugs, Teladoc visits, GLP-1 drugs for obesity, and in-network preventive 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.
Are there other deductibles for specific services?	Yes. **$50** non-accident emergency room deductible after first 2 visits.	You must pay all of the costs for these specific 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?	**Medical Coinsurance Out-of-Pocket Maximum:** **$3,000** Individual/**$6,000** Family **Maximum PPO Out-of-Pocket Limit:** **Medical: $4,600** Individual/**$9,200** Family **Prescription: $4,600** Individual/**$9,200** Family **Non-PPO Out-of-Pocket Limit: No limit** *Certain medical out-of-network claims are treated as medical in-network claims (see page 2).*	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?	**Medical Coinsurance Out-of-Pocket Maximum:** Premiums, balance-billing charges, deductibles, office visit copayments, prescription drugs, non-accident emergency room deductible, chiropractic services, coinsurance for Non-Centers of Excellence organ transplant benefits, cost sharing for hearing aids, and health care that this plan doesn't cover. **PPO Out-of-Pocket Limit:** Premiums, balance-billing charges, expenses for Non-PPO Providers, GLP-1 drugs for obesity, and health care that 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 https://www.whyuhc.com/uhss or contact the Fund Office at 1-800-765-4239 for a list of PPO providers. **Out-of-network providers* may be treated as *network providers* for *cost-sharing* purposes for out-of-network emergency services*, *out-of-network providers* at in-network facilities, and *out-of-network* air ambulance costs for *emergencies*.	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: PPO Provider (You will pay the least)	What You Will Pay: Non-PPO Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment/visit	$20 copayment/visit	Certain services are available through Teladoc. There is no copayment, deductible, or coinsurance for a virtual visit through Teladoc.
	Specialist visit	$20 copayment/visit. 50% coinsurance for chiropractic care.	$20 copayment/visit. 50% coinsurance for chiropractic care.	Chiropractic care limited to 48 visits per individual per calendar year. Certain services are available through Teladoc. There is no copayment, deductible, or coinsurance for a virtual visit through Teladoc.
	Preventive care/screening/ immunization	No charge	40% coinsurance	Certain services are available through Teladoc. There is no copayment, deductible, or coinsurance for a virtual visit through Teladoc. 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. See https://www.healthcare.gov/coverage/preventive-care-benefits/ for covered preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)			None

Common Medical Event	Services You May Need	What You Will Pay: PPO Provider (You will pay the least)	What You Will Pay: Non-PPO Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medimpact.com	Generic drugs	$25 copayment/fill (retail) and $50 copayment/fill (mail order). Medical deductible does not apply.	50% coinsurance (retail). Medical deductible does not apply.	34-day supply (retail); 90-day supply (mail order) Maintenance medications limited to 3 fills at a retail pharmacy, then fills must be through mail order. 90-day supply for maintenance drugs available through CVS Mandatory Choice90 (retail and mail order). Your cost sharing applies toward the prescription out-of-pocket limit. Individuals age 19 and younger subject to opioid utilization program, which includes limiting members new to therapy to a 3-day supply. Drugs considered preventive services under the ACA are covered at 100% and not subject to prescription drug copayments. Specialty drugs included on the Select Drugs and Products List that are administered by a healthcare provider in a hospital, clinic or facility and those self-administered are subject to precertification for medical necessity and participation in the Select Drugs and Products Program. Gene and Cellular Therapy Products are not covered by this plan. Humira, Skyrizi, and Rinvoq are not covered by this plan. All covered persons receiving specialty drugs included on the Select Drugs and Products List must enroll in the Select Drugs and Products Program. Specialty drugs are subject to prior authorization, step-therapy, and administrative review that may require specific drug distribution channels be used. Failure to obtain prior authorization may result in a cost containment penalty equal to 100% reduction in benefits payable. GLP-1 drugs for obesity are 1) subject to 50% coinsurance, 2) subject to a lifetime limit of 18 months, 3) subject to prior authorization, and 4) not subject to the Plan's annual Rx out-of-pocket limit or deductible.
	Preferred brand drugs	$40 copayment/fill (retail) and $80 copayment/fill (mail order) plus the difference between generic and brand when generic is available. Medical deductible does not apply.		
	Non-Preferred brand drugs	$50 copayment/fill (retail) and $100 copayment/fill (mail order) plus the difference between generic and brand when generic is available. Medical deductible does not apply.		
	Specialty drugs through prescription drug program	10% coinsurance (retail and mail order) up to $125 maximum/fill. Medical deductible does not apply.		

Common Medical Event	Services You May Need	What You Will Pay: PPO Provider (You will pay the least)	What You Will Pay: Non-PPO Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Provider charges for co-surgeons are limited to 50% of allowed amount. Provider charges for assistant surgeons are limited to 20% of allowed amount. No coverage for organ transplants without precertification.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	20% coinsurance; $50 non-accident emergency room deductible applies after first 2 visits per individual per calendar year.	40% coinsurance unless otherwise required by No Surprises Act. $50 non-accident emergency room deductible applies after first 2 visits per individual per calendar year.	None
	Emergency medical transportation	20% coinsurance	20% coinsurance for ground ambulance; 40% coinsurance for all other transportation unless otherwise required by No Surprises Act	None
	Urgent care	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Charges based on semi-private room rates.
	Physician/surgeon fees			Provider charges for co-surgeons are limited to 50% of allowed amount. Provider charges for assistant surgeons are limited to 20% of allowed amount. No coverage for organ transplants without precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment/office visit; 20% coinsurance for all other services	$20 copayment/office visit; 40% coinsurance for all other services unless otherwise required by No Surprises Act	Certain services are available through Teladoc. There is no copayment, deductible, or coinsurance for a virtual visit through Teladoc. Dependents must be 12 years old to use this service and dependents under age 18 require a parent/guardian present.
	Inpatient services	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Charges based on semi-private room rates.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Plan does not cover the pregnancy of a dependent child, except as otherwise required by law.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			

Common Medical Event	Services You May Need	What You Will Pay: PPO Provider (You will pay the least)	What You Will Pay: Non-PPO Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	60-day maximum per occurrence
	Rehabilitation services			Limited to 12 weeks per individual per calendar year for cardiac rehab. Limited to 48 visits per individual per calendar year combined for physical/massage therapy/acupuncture. Limited to 48 visits per individual per calendar year for speech therapy. Limited to 48 visits per individual per calendar year for occupational therapy. Physical/massage/speech/occupational therapy limits apply to individuals age six and older. There are no limits for dependents under age six if the dependent is making ongoing therapeutic progress. Sword Health Virtual Physical Therapy - no copayment, deductible or coinsurance.
	Habilitation services	20% coinsurance	40% coinsurance	Coverage is limited to ABA therapy.
	Skilled nursing care			None
	Durable medical equipment			Equipment cannot exceed 130% of its wholesale cost.
	Hospice services			None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of this service, even if you use a PPO provider.
	Children's glasses			
	Children's dental check-up			

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 (except for injury, sickness, disease, or reconstructive surgery following mastectomy) • Dental care (Adult and Child)	• Habilitation services (except for ABA therapy) • Long-term care • Non-emergency care when traveling outside the U.S.	• Private duty nursing (except for Hospice care) • Routine eye care (Adult and Child) • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (up to 48 visits per individual per calendar year combined with physical therapy and massage therapy) • Bariatric surgery	• Chiropractic care (up to 48 visits per individual per calendar year) • Hearing aids (up to $1,250 per ear every 5 years; no limit for individuals under age 18)	• Infertility treatment (artificial means of treatment are excluded) • 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 https://www.dol.gov/agencies/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 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 Administrator, NECA-IBEW Welfare Trust Fund, 2120 Hubbard Avenue, Decatur, IL 62526-2871, Telephone 1-800-765-4239. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa.

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:

Para obtener asistencia en Español, llame al 1-800-765-4239.

Fer Hilf griege in Deitsch, ruf1-800-765-4239 uff.

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 (deductible, 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 PPO pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$20**
- **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$10
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,370**

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$20**
- **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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$700
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$20**
- **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$70
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,370**

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