




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 <a href="#">deductible</a> ?	<b>\$1,000</b> Individual/ <b>\$3,000</b> Family Certain <a href="#">out-of-network claims</a> are treated as <a href="#">in-network claims</a> (see page 2).	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Prescription drugs</a> , Teladoc visits, GLP-1 drugs for obesity, and <a href="#">in-network</a> preventive services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	Yes. <b>\$50</b> non-accident emergency room <a href="#">deductible</a> after first 2 visits.	You must pay all of the costs for these specific services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>Medical <a href="#">Coinsurance Out-of-Pocket Maximum</a>:</b> <b>\$3,000</b> Individual/ <b>\$6,000</b> Family <b>Maximum PPO <a href="#">Out-of-Pocket Limit</a>:</b> <b>Medical:</b> <b>\$4,600</b> Individual/ <b>\$9,200</b> Family <b><a href="#">Prescription</a>:</b> <b>\$4,600</b> Individual/ <b>\$9,200</b> Family <b>Non-PPO <a href="#">Out-of-Pocket Limit</a>:</b> No limit Certain <a href="#">out-of-network claims</a> are treated as <a href="#">in-network claims</a> (see page 2).	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<b>Medical <a href="#">Coinsurance Out-of-Pocket Maximum</a>:</b> <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, <a href="#">deductibles</a> , office visit <a href="#">copayments</a> , <a href="#">prescription drugs</a> , non-accident emergency room <a href="#">deductible</a> , chiropractic services, <a href="#">coinsurance</a> for Non-Centers of Excellence organ transplant benefits, <a href="#">cost sharing</a> for hearing aids, and health care that this <a href="#">plan</a> doesn't cover. <b>PPO <a href="#">Out-of-Pocket Limit</a>:</b> <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, expenses for Non-PPO Providers, GLP-1 drugs for obesity, and health care that this <a href="#">plan</a> does not cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <a href="#">network provider</a> ?	Yes.* See <a href="https://www.whyuhc.com/uhss">https://www.whyuhc.com/uhss</a> or contact the Fund Office at 1-800-765-4239 for a list of PPO <a href="#">providers</a> . <i>*Out-of-network providers may be treated as <a href="#">network providers</a> for <a href="#">cost-sharing</a> purposes for out-of-<a href="#">network</a> emergency services, <a href="#">out-of-network providers</a> at in-<a href="#">network</a> facilities, and <a href="#">out-of-network</a> air ambulance costs for <a href="#">emergencies</a>.</i>	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>

 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
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copayment</a> /visit	\$20 <a href="#">copayment</a> /visit	Certain services are available through Teladoc. There is no <a href="#">copayment</a> , <a href="#">deductible</a> , or <a href="#">coinsurance</a> for a virtual visit through Teladoc.
	<a href="#">Specialist</a> visit	\$20 <a href="#">copayment</a> /visit. 50% <a href="#">coinsurance</a> for chiropractic care.	\$20 <a href="#">copayment</a> /visit. 50% <a href="#">coinsurance</a> for chiropractic care.	Chiropractic care limited to 48 visits per individual per calendar year. Certain services are available through Teladoc. There is no <a href="#">copayment</a> , <a href="#">deductible</a> , or <a href="#">coinsurance</a> for a virtual visit through Teladoc.
	<a href="#">Preventive care/screening</a> /immunization	No charge	40% <a href="#">coinsurance</a>	Certain services are available through Teladoc. There is no <a href="#">copayment</a> , <a href="#">deductible</a> , or <a href="#">coinsurance</a> for a virtual visit through Teladoc. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. See <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> for covered preventive services.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)			

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)	
<p><b>If you need <a href="#">drugs</a> to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.medimpact.com">www.medimpact.com</a></p>	Generic <a href="#">drugs</a>	\$25 <a href="#">copayment</a> /fill (retail) and \$50 <a href="#">copayment</a> /fill (mail order). <a href="#">Medical deductible</a> does not apply.		<p>34-day supply (retail); 90-day supply (mail order)  Maintenance <a href="#">medications</a> limited to 3 fills at a retail pharmacy, then fills must be through mail order.  90-day supply for maintenance <a href="#">drugs</a> available through CVS Mandatory Choice90 (retail and mail order).  Your <a href="#">cost sharing</a> applies toward the <a href="#">prescription out-of-pocket limit</a>.  Individuals age 19 and younger subject to opioid utilization program, which includes limiting members new to therapy to a 3-day supply.  Drugs considered <a href="#">preventive</a> services under the ACA are covered at 100% and not subject to <a href="#">prescription drug copayments</a>.  <a href="#">Specialty drugs</a> 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 <a href="#">precertification</a> for medical necessity and participation in the Select Drugs and Products Program. Gene and Cellular Therapy Products are not covered by this <a href="#">plan</a>. Humira, Skyrizi, and Rinvoq are not covered by this <a href="#">plan</a>.  All covered persons receiving <a href="#">specialty drugs</a> included on the Select Drugs and Products List must enroll in the Select Drugs and Products Program. <a href="#">Specialty drugs</a> are subject to <a href="#">prior authorization</a>, step-therapy, and administrative review that may require specific drug distribution channels be used. Failure to obtain <a href="#">prior authorization</a> 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 <a href="#">prior authorization</a>, and 4) not subject to the Plan's annual Rx <a href="#">out-of-pocket limit</a> or <a href="#">deductible</a>.</p>
	Preferred brand <a href="#">drugs</a>	\$40 <a href="#">copayment</a> /fill (retail) and \$80 <a href="#">copayment</a> /fill (mail order) plus the difference between generic and brand when generic is available. <a href="#">Medical deductible</a> does not apply.	50% <a href="#">coinsurance</a> (retail). <a href="#">Medical deductible</a> does not apply.	
	Non-Preferred brand <a href="#">drugs</a>	\$50 <a href="#">copayment</a> /fill (retail) and \$100 <a href="#">copayment</a> /fill (mail order) plus the difference between generic and brand when generic is available. <a href="#">Medical deductible</a> does not apply.		
	<a href="#">Specialty drugs</a> through <a href="#">prescription drug</a> program	10% <a href="#">coinsurance</a> (retail and mail order) up to \$125 maximum/fill. <a href="#">Medical deductible</a> does not apply.	50% <a href="#">coinsurance</a> (retail). <a href="#">Medical deductible</a> does not apply	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)			None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> unless otherwise required by No Surprises Act	<a href="#">Provider</a> charges for co-surgeons are limited to 50% of <a href="#">allowed amount</a> . <a href="#">Provider</a> charges for assistant surgeons are limited to 20% of <a href="#">allowed amount</a> . No coverage for organ transplants without <a href="#">precertification</a> .
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a> ; \$50 non-accident emergency room <a href="#">deductible</a> applies after first 2 visits per individual per calendar year.	40% <a href="#">coinsurance</a> unless otherwise required by No Surprises Act; \$50 non-accident emergency room <a href="#">deductible</a> applies after first 2 visits per individual per calendar year.	None
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> for ground ambulance transportation; 40% <a href="#">coinsurance</a> for all other transportation unless otherwise required by No Surprises Act	None
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> unless otherwise required by No Surprises Act	None
If you have a hospital stay	Facility fee (e.g., hospital room)			Charges based on semi-private room rates.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> unless otherwise required by No Surprises Act	<a href="#">Provider</a> charges for co-surgeons are limited to 50% of <a href="#">allowed amount</a> . <a href="#">Provider</a> charges for assistant surgeons are limited to 20% of <a href="#">allowed amount</a> . No coverage for organ transplants without <a href="#">precertification</a> .

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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 <a href="#">copayment</a> /office visit; 20% <a href="#">coinsurance</a> for all other services	\$20 <a href="#">copayment</a> /office visit; 40% <a href="#">coinsurance</a> for all other services unless otherwise required by No Surprises Act	Certain services are available through Teladoc. There is no <a href="#">copayment</a> , <a href="#">deductible</a> , or <a href="#">coinsurance</a> 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% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> unless otherwise required by No Surprises Act	Charges based on semi-private room rates.
<b>If you are pregnant</b>	Office visits	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> unless otherwise required by No Surprises Act	<a href="#">Plan</a> does not cover the pregnancy of a dependent child, except as otherwise required by law.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	60-day maximum per occurrence
	<a href="#">Rehabilitation services</a>			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 <a href="#">copayment</a> , <a href="#">deductible</a> or <a href="#">coinsurance</a> .
	<a href="#">Habilitation services</a>			Coverage is limited to ABA therapy.
	<a href="#">Skilled nursing care</a>			None
	<a href="#">Durable medical equipment</a>			Equipment cannot exceed 130% of its wholesale cost.
	<a href="#">Hospice services</a>			None

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 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 <a href="#">provider</a> .
	Children's glasses			
	Children's dental check-up			

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Cosmetic surgery (except for injury, sickness, disease, or <a href="#">reconstructive surgery</a> following mastectomy)</li> <li>Dental care (Adult and Child)</li> </ul>	<ul style="list-style-type: none"> <li><a href="#">Habilitation services</a> (except for ABA therapy)</li> <li>Long-term care</li> <li>Non-<a href="#">emergency</a> care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private duty nursing (except for <a href="#">Hospice</a> care)</li> <li>Routine eye care (Adult and Child)</li> <li>Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Acupuncture (48 visits per individual per calendar year combined with physical therapy and massage therapy)</li> <li>Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic care (up to 48 visits per individual per calendar year)</li> <li>Hearing aids (up to \$1,250 per ear every 5 years no limit for individuals under age 18)</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment (artificial means of treatment are excluded)</li> <li>Routine foot care</li> </ul>

**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](http://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.

Für Hilfe griechisch in Deutsch, ruf 1-800-765-4239 an.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,370</b>

### Managing Joe's Type 2 Diabetes

(a year of routine PPO care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,820</b>

### Mia's Simple Fracture

(PPO emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$70
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,370</b>