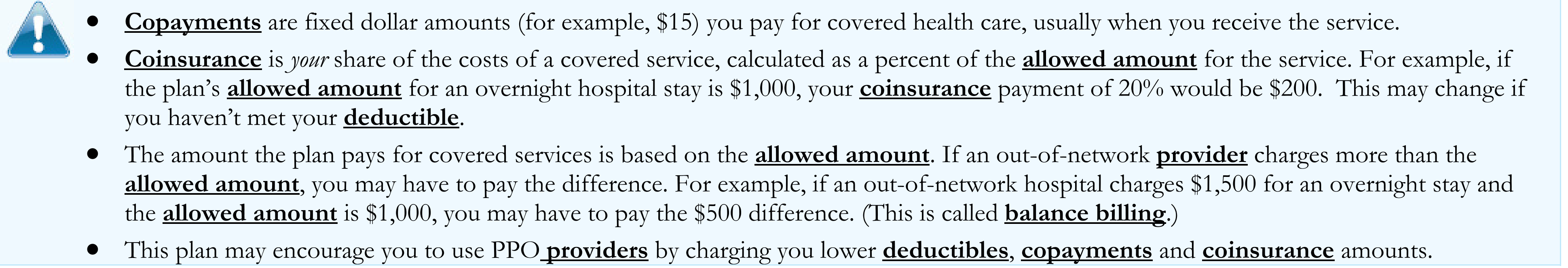
This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.ibew347benefits.com or by calling 1-844-347-4239.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$200** Individual **/ $600** Family; Doesn't apply to most services where only a copayment is applicable. Copayments, prescriptions, dental, vision, and payments for non-covered charges do not count towards the deductible. The Plan also offers HRA Benefits that may be used to offset all or a portion of your deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For PPO Providers **$600** / Individual. Copayments will continue even after the annual out-of-pocket limit has been met. The Plan offers HRA Benefits that may be used to offset all or a portion of your out-of-pocket expenses.	The **out–of–pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Deductibles, non-PPO provider charges, copayments, dental, vision, prescriptions, premiums, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of network providers, see **http://welcometouhc.com/uhss** or contact the Fund Office at **1-844-347-4239.**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.



- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment	40% coinsurance	PPO Provider visit is not subject to the deductible.
	Specialist visit	$20 copayment	40% coinsurance	PPO Provider visit is not subject to the deductible.
	Other practitioner office visit	Retail Nurse Practitioner clinic: $10 copayment Chiropractor: $20 copayment	Retail Nurse Practitioner clinic: 40% coinsurance Chiropractor: 20% coinsurance	PPO Provider chiropractic care is not subject to the deductible.
	Preventative care/ screening/immunization	Mammogram & Colonoscopy: Routine: No Charge Non-routine: 20% coinsurance Routine Physical Exams: $20 copayment Well Child Care: No Charge	Mammogram & Colonoscopy: Routine: No Charge Non-routine: 40% coinsurance Routine Physical Exams & Well Child Care: 40% coinsurance	Routine Mammogram limited to one per year. Routine Colonoscopy limited to one per five years. Well Child Care limited to seven visits from ages birth to 1, two visits for age 1, one visit per year for ages 2, 3, 4, 5, and 6 and no visits after the child's 7th birthday. Deductible waived on all routine Mammogram & Colonoscopy exams and Well Child Care. Deductible waived only on Routine Physical Exams provided by a PPO Provider.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	Outpatient Hospital or Facility: 20% coinsurance; Physician's Office: No Charge	Outpatient Hospital or Facility: 40% coinsurance Physician's Office: 40% coinsurance	PPO Provider services in a Physician's office not subject to deductible.
	Imaging (CT/PET scans, MRIs)	Outpatient Hospital or Facility: 20% coinsurance; Physician's Office: No Charge	Outpatient Hospital or Facility: 40% coinsurance Physician's Office: 40% coinsurance	PPO Provider services in a Physician's office not subject to deductible.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.LDIRx.com** or by calling **1-866-516-3121.**	Generic drugs	Retail: > of 20% or $7 copayment; Mail Order: $10 copayment	Retail: > of 20% or $7 copayment; Mail Order: $10 copayment	Retail limited to 34-day supply. Mail order limited to 90-day supply. Non-PPO Provider: 100% up front; submit claim form to LDI for reimbursement.
	Preferred brand drugs	Retail: The greater of: 20% or $15 copayment; Mail Order: $10 copayment	Retail: The greater of: 20% or $15 copayment; Mail Order: $10 copayment	Retail limited to 34-day supply. Mail order limited to 90-day supply. If you purchase a brand drug when a generic equivalent is available, you will be required to pay the applicable copayment plus the price difference between the generic drug and the preferred or non-preferred brand name drug unless your Physician has indicated "Dispense as Written" on your prescription. Non-PPO Provider: 100% up front; submit claim form to LDI for reimbursement.
	Non-preferred brand drugs	Retail: The greater of: 25% or $30 copayment; Mail Order: $70 copayment	Retail: The greater of: 25% or $30 copayment; Mail Order: $70 copayment	
	Specialty drugs	Retail: $50 copayment; Mail Order: $50 copayment	100% coinsurance	Specialty drugs are limited to a 30-day supply and must be purchased directly through LDI Specialty Pharmacy, 1-866-516-3121.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	-------------------------none-------------------------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Surgical care performed during PPO Provider physician office visit is paid 100% after $20 copay.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$50 copayment	$50 copayment and 20% coinsurance	Hospital Emergency Room copayment waived if admitted. When a Covered Person receives treatment for a Medical Emergency at a non-PPO Hospital either because of circumstances beyond his control or because the time necessary to obtain treatment from a PPO Provider could endanger his life, the Plan will pay benefits at the PPO Provider benefit level.
	Emergency medical transportation	20% coinsurance	20% coinsurance	-------------------------none-------------------------
	Urgent care	$20 copayment	40% coinsurance	PPO Provider services not subject to deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	-------------------------none-------------------------
	Physician/surgeon fee	20% coinsurance	40% coinsurance	No charge for second surgical opinion.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Outpatient Hospital or Facility: 20% coinsurance; Physician's Office: $20 copayment	40% coinsurance	PPO Provider services in a Physician's office not subject to deductible.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	-------------------------none-------------------------
	Substance use disorder outpatient services	Outpatient Hospital or Facility: 20% coinsurance; Physician's Office: $20 copayment	40% coinsurance	PPO Provider services in a Physician's office not subject to deductible.
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	-------------------------none-------------------------
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	Not available to Retirees with Plan B Coverage and their Dependents.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Not available to Retirees with Plan B Coverage and their Dependents.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Limit 40 home health care visits per Calendar Year. A home health care visit is a visit that lasts up to four hours. A visit that lasts more than four hours is considered two visits.
	Rehabilitation services	20% coinsurance	40% coinsurance	-------------------------none-------------------------
	Habilitation services	20% coinsurance	40% coinsurance	-------------------------none-------------------------
	Skilled nursing care	20% coinsurance	20% coinsurance	Limited to 120 days per Sickness or Injury.
	Durable medical equipment	20% coinsurance	20% coinsurance	-------------------------none-------------------------
	Hospice service	20% coinsurance	20% coinsurance	-------------------------none-------------------------
If your child needs dental or eye care	Eye exam	$10 copayment	$10 copayment	Limited to once per Calendar Year. Non-PPO Provider limit of $50 for individuals 19 and over.
	Glasses	Frames: $20 copayment Lenses: $20 copayment	Frames: $20 copayment Lenses: $20 copayment	Limited to once every other Calendar Year. PPO Provider frame maximum of $120 plus 20% off any out-of-pocket expense. Non-PPO Provider frame maximum of $70. Non-PPO Provider lenses maximum of $50 single, $75 bifocal, $100 trifocal, $125 lenticular.
	Dental check-up	$10 copayment	$10 copayment	Limited to one every 6 months. Limit of $2,500 per calendar year but does not apply to individuals under age 19. Not available to Retirees with Plan B coverage or their Dependents.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery (unless related to Sickness or Injury and completed within 12 months)
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs (except in connection with bariatric surgery)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (restrictions apply)
- Chiropractic care
- Dental care
- Infertility treatment (restrictions apply and $4,000 Lifetime Maximum)
- Long-term care, (restrictions apply)
- Routine eye care
- Routine foot care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-844-347-4239. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the Fund Office at 1-844-347-4239or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,100
- **Patient pays** $1,440

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$400
Copays	$40
Coinsurance	$800
Limits or exclusions	$200
Total	**$1,440**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,220
- **Patient pays** $1,180

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$200
Copays	$200
Coinsurance	$700
Limits or exclusions	$80
Total	**$1,180**

The Plan also offers Health Reimbursement Arrangement ("HRA") Benefits. The HRA Benefits can be used to reimburse Participants or Dependents for certain out-of-pocket medical care expenses.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.