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 (844) 347-4239. 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.healthcare.gov/sbc-glossary/ or call (844) 347-4239 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200 / individual or $600 / 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 services where only a copayment is applicable are covered before you meet your deductible. The plan also offers HRA Benefits that may be used to offset all or a portion of your deductible.	This plan covers some items and services even if you haven't 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Medical:** PPO Provider: $4,550 / individual or $9,100 / family Where applicable, coinsurance applies only on the first $3,000 of allowed charges per year. **Prescription:** $4,550 / individual or $9,100 / family The plan also 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 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?	Non-PPO Provider charges, dental, vision, 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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a PPO provider?	Yes*. See http://welcometouhc.com/uhss or contact the fund office at (877) 347-4239 for a list of PPO providers. **Non-PPO Providers* may be treated as *PPO Providers* as required by the No Surprises Act.*	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		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 provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment per visit	40% coinsurance	Dr. On Demand Online Doctor Visit Benefit – no copayment, deductible or coinsurance. PPO Provider copayment is not subject to the deductible.
	Specialist visit	$20 copayment per visit	40% coinsurance	
	Preventive care/screening/ immunization	No charge	Mammogram & Colonoscopy: Routine: No charge Non-routine: 40% coinsurance Routine Physical Exams & Well Child Care: No charge	No copayment, deductible or coinsurance for PPO provider preventive services classified as A or B Recommendations by the United States Preventive Task Force.
If you have a test	Diagnostic test (x-ray, blood work)	Outpatient Hospital or Facility: 20% coinsurance Physician's Office: No charge - deductible does not apply.	40% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	Outpatient Hospital or Facility: 20% coinsurance Physician's Office: No charge - deductible does not apply.	40% coinsurance	----------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 you need drugs to treat your illness or condition For more information about **prescription drug coverage** go to www.SavRx.com or call (866) 233-4239.	Generic drugs	Retail – greater of 20% or $7 copayment per prescription Mail Order – $10 copayment per prescription	Retail – greater of 20% or $7 copayment per prescription	Retail is limited to 34-day supply. Mail Order is 90-day supply. Mail Order not available through Non-PPO Provider If 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: Pay 100% up front; submit claim form to Sav-Rx for reimbursement. 90-day supplies are available for certain specialty drugs. Other specialty drugs limited to 30-day supply and must be purchased directly through Sav-Rx Specialty Pharmacy, 1-866-233-4239. For generic specialty drugs, the copay is the greater of $7 or 20% of the cost of the drug, not to exceed $50, or $10 if purchased through Sav-Rx Specialty Pharmacy, 1-866-233-4239.
	Preferred brand drugs	Retail – greater of 20% or $15 copayment per prescription Mail Order – $10 copayment per prescription	Retail – greater of 20% or $15 copayment per prescription	
	Non-preferred brand drugs	Retail – greater of 25% or $30 copayment per prescription Mail Order – $70 copayment	Retail – greater of 25% or $30 copayment per prescription	
	Specialty drugs	Retail or Mail Order – $50 copayment per prescription.	Retail – $50 copayment per prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	----------none----------
	Physician/surgeon fees	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Surgical care performed during PPO Provider physician office visit is paid at 100% after $20 copayment.

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 immediate medical attention	Emergency room care	$250 copayment per visit	$250 copayment per visit unless otherwise required by No Surprises Act	Copayment waived if admitted. PPO Provider rates apply if services provided in connection with a Medical Emergency.
	Emergency medical transportation	20% coinsurance	20% coinsurance Unless otherwise required by No Surprises Act	----------none----------
	Urgent care	$20 copayment per visit	40% coinsurance unless otherwise required by No Surprises Act	Dr. On Demand Online Doctor Visit Benefit – no copayment, deductible or coinsurance. PPO Provider copayment is not subject to the deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Private room, when medically necessary. Otherwise, benefit will be the price of a semi-private room.
	Physician/surgeon fees	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	No charge for second surgical opinion.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient Hospital or Facility: 20% coinsurance Physician's Office: $20 copayment per visit	40% coinsurance unless otherwise required by No Surprises Act	----------none----------
	Inpatient services	20% coinsurance	Not covered unless otherwise required by No Surprises Act	----------none----------

If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in this document (i.e. ultrasound). Inpatient stay of at least 48 hours for the mother and newborn child following a vaginal delivery or at least 96 hours for the mother and newborn child following a cesarean section delivery. Not available to Retirees with Plan B coverage and their Dependents. Cost-sharing does not apply to preventive services.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limit 40 home health care visits per Calendar Year. 1 visit = up to 4 hours. A visit that lasts more than 4 hours is considered 2 visits.
	Rehabilitation services	20% coinsurance	Not covered	----------none----------
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	Not covered	Limited to 120 days per Sickness or Injury.
	Durable medical equipment	20% coinsurance	40% coinsurance	----------none----------
	Hospice services	20% coinsurance	40% coinsurance	
If your child needs dental or eye care	Children's eye exam	$10 copayment per visit		Limited to once per Calendar Year. Non-PPO Provider limit of $50 for individuals age 19 and over.
	Children's glasses	Frames: $20 copayment per frames Lenses: $20 copayment per lenses		Frames limited to once every other Calendar Year. Lenses limited to once per 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.
	Children's dental check-up	$10 copayment per visit		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 for their Dependents.

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.)

- 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (restrictions apply)
- Chiropractic care
- Dental care (adult)
- Infertility treatment (restrictions apply and $4,000 Lifetime Maximum)
- Long-term care (restrictions apply)
- Routine eye care (adult)
- 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 Office at 1-844-347-4239 or the 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

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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-347-4239.

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 PPO-Provider pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$200**
- **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	$200
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$860**

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

- **The plan's overall deductible** **$200**
- **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	$200
Copayments	$200
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

- **The plan's overall deductible** **$200**
- **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	$200
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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