**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, www.ewtf.org or 1-800-929-EWTF (3983). 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.dol.gov/ebsa/healthreform or https://www.healthcare.gov/sbc-glossary or call 1-800-929-EWTF (3983) to request a copy. "H" Plan employees may not be eligible for all benefits and may have other limitations.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$150**/Individual **or $300**/family<br>Doesn't apply to **hospitalization**. | 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 services covered before you meet your deductible?** | Yes<br>Doesn't apply to **hospitalization**. | You must pay all the costs up to the **deductible** amount before this **plan** begins to pay for covered services you use. |
| **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. |
| **What is the out-of-pocket limit for this plan?** | **$10,000** | 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?** | **Premiums**, **balance-billed** charges, the annual **deductible**, dental and vision, charges above the **Plan's allowance** and health care this **plan** doesn't 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-UnitedHealthcare Integrated Services (UHC). See http://directory.UHIS.com or call EWTF for a list of in-**network providers**. | 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 you need a referral to see a specialist?** | No | You can see the **specialist** you choose without a **referral**. |



* For more information about limitations and exceptions, see the plan or policy document at www.ewtf.org.

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 |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network 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 | **80% of allowed amount** | **80% of allowed amount** | None |
| | Specialist visit | **80% of allowed amount** | **80% of allowed amount** | Coverage is limited to 26 visits annually. Applies to chiropractic and acupuncture separately. |
| | Preventive care/screening/ immunization | **80% of allowed amount** | **80% of allowed amount** | Well Woman Visit covered at 80% of **allowed** amount. Initial routine examination for Newborn covered at 100% of **allowance**. Mammogram covered at 80%, one per year, women age 35 and over. Pap test covered at 80%, one routine exam per year. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | **80% of allowed amount** | **80% of allowed amount** | None |
| | Imaging (CT/PET scans, MRIs) | **80% of allowed amount** | **80% of allowed amount** | None |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.caremark.com | Generic drugs | $10 **co-pay** or $20 mail order (90-day supply) | $10 **co-pay** | **Covers up to a 34-day supply (CVS retail prescription); 31-90 day supply (mail order prescription). Out-of-Network is stated co-pay plus difference between allowance and retail price.** |
| | Preferred brand drugs | $25 **co-pay** or $50 mail order (90-day supply) | $25 **co-pay** | |
| | Non-preferred brand drugs | $35 **co-pay** or $70 mail order (90-day supply) | $35 **co-pay** | |
| | Specialty drugs | Same as other drug coverage (see above) | Same as other drug coverage (see above) | Some drugs require **prior authorization**. Failure to comply will result in non-payment of **claim**. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 100% of **allowance**. 80% **allowance** after $7,000 | 100% of **allowance**. 80% **allowance** after $7,000 | 100% coverage is for first $7,000 per spell of illness. |
| | Physician/surgeon fees | 80% of **allowed amount** | 80% of **allowed amount** | Assistant or Co-Surgeon covered at 25% of **allowed amount** for Surgeon, at 80%. Anesthesia covered at 80% of **allowed amount**. Second Surgical Opinion covered at 100%. |

* For more information about limitations and exceptions, see the plan or policy document at www.ewtf.org.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | 80% of **allowed amount** | 80% of **allowed amount** | Plan allowance considered "**allowed amount**" for **out-of-network provider** where foreknowledge of the affiliation of **provider** rendering service is beyond control of and unknown to patient. |
| | Emergency medical transportation | 80% of **allowed amount** | 80% of **allowed amount** | If transport results in an inpatient admission, coverage is 100% of first $7,000 and included in inpatient hospital benefit. |
| | Urgent care | 80% of **allowed amount** | 80% of **allowed amount** | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 100% of **allowance**. 80% of **allowance** after $7,000 | 100% of **allowance**. 80% of **allowance** after $7,000 | 100% coverage is for first $7,000 per spell of illness. |
| | Physician/surgeon fees | 80% of **allowed amount** | 80% of **allowed amount** | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 80% of **allowed amount** | 80% of **allowed amount** | None |
| | Inpatient services | 100% of **allowance**. 80% of **allowance** after $7,000 | 100% of **allowance**. 80% of **allowance** after $7,000 | 100% coverage is for first $7,000 per spell of illness. |
| **If you are pregnant** | Office visits | 80% of **allowed amount** | 80% of **allowed amount** | Excludes dependents. |
| | Childbirth/delivery professional services | 80% of **allowed amount** | 80% of **allowed amount** | None |
| | Childbirth/delivery facility services | 100% of **allowance**. 80% **allowance** after $7,000 | 100% of **allowance**. 80% **allowance** after $7,000 | 100% coverage is for first $7,000 per spell of illness. |
| **If you need help recovering or have other special health needs** | Home health care | 80% of **allowed amount** | 80% of **allowed amount** | **Prior authorization** required. Failure to comply will result in non-payment of **claims.** |
| | Rehabilitation services | 50% of actual charges | 50% of actual charges | Based on semi-private accommodations rate charged by hospital. 60 days maximum per spell of illness. Maximum benefit when combined with covered charges made by discharging hospital is $7,000. Charges that |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | | exceed maximum covered at 80%. |
| | Habilitation services | 50% of actual charges | 50% of actual charges | Based on semi-private accommodations rate charged by hospital. 60 days maximum per spell of illness. Maximum benefit when combined with covered charges made by discharging hospital is $7,000. Charges that exceed maximum covered at 80%. |
| | Skilled nursing care | 80% of **allowed amount** after annual **deductible** | 80% of **allowed amount** after annual **deductible** | **Prior authorization** required. Failure to comply will result in non-payment of **claims**. |
| | Durable medical equipment | 80% of **allowed amount** after annual **deductible** | 80% of **allowed amount** after annual **deductible** | None |
| | Hospice services | 100% of actual charges | 100% of actual charges | Approved facility only. |
| **If your child needs dental or eye care** | Children's eye exam | 100% of **allowance** | Patient pays difference between actual charge and **allowance**. | **Allowance** once per every two calendar years, unless prescription changes and meets certain specified criteria. |
| | Children's glasses | 100% of **allowance** | Patient pays difference between actual charge and **allowance**. | **Allowance** once per every two calendar years, unless prescription changes and meets certain specified criteria. |
| | Children's dental check-up | 80% of **allowance** | 80% of **allowance** | Benefit for age 18 and older is limited to $2,000 per calendar year. |

## 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
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

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

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric Surgery
- Chiropractic Care
- Dental Care (Adult)
- Hearing aids
- Private-duty nursing
- Routine eye care (Adult)

* For more information about limitations and exceptions, see the plan or policy document at www.ewtf.org.

**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:

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. 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 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: Electrical Welfare Trust Fund 301-731-1050 1-800-929-EWTF Email info@ewtf.org.

**Does this plan provide Minimum Essential Coverage?** **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 301-731-1050 1-800-929-3983.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 301-731-1050 1-800-929-3983.]
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码301-731-1050 1-800-929-3983.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 301-731-1050 1-800-929-3983.]

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

* For more information about limitations and exceptions, see the plan or policy document at www.ewtf.org.

## 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 in-**network** pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $150 |
| Specialist *Copayment* | $0 |
| Hospital (facility) *[cost sharing]* | 0% |
| Other *[cost sharing]* | 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** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| **Deductibles** | $150 |
| **Copayments** | $0 |
| **Coinsurance** | $550 |
| *What isn't covered* | |
| Limits or **exclusions** | $0 |
| **The total Peg would pay is** | **$700** |

### Managing Joe's type 2 Diabetes
(a year of routine in-**network** care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $150 |
| Specialist *[cost sharing]* | $0 |
| Hospital (facility) *[cost sharing]* | 0% |
| Other *[cost sharing]* | 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** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| **Deductibles** | $150 |
| **Copayments** | $0 |
| **Coinsurance** | $1,530 |
| *What isn't covered* | |
| Limits or **exclusions** | $0 |
| **The total Joe would pay is** | **$1,680** |

### Mia's Simple Fracture
(in-**network** emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $150 |
| Specialist *[cost sharing]* | $0 |
| Hospital (facility) *[cost sharing]* | 0% |
| Other *[cost sharing]* | 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** | **$1,900** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| **Deductibles** | $150 |
| **Copayments** | $0 |
| **Coinsurance** | $380 |
| *What isn't covered* | |
| Limits or **exclusions** | $0 |
| **The total Mia would pay is** | **$530** |

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