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 1-888-466-9094. 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 https://www.cms.gov/cciio/index.html or call 1-888-466-9094 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers, $550 individual /$1,650 family; for out-of-network providers, $1,100 individual/ $3,300 family. *Certain Out-of-Network claims are treated as In-Network claims as required by No Surprises Act.	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. Preventive care services and in-network outpatient diagnostic tests 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. 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: For network providers, $4,750 individual or family; for out-of-network providers, $9,500 individual or family. Prescription: For network providers, $1,650 individual/ $8,800 family; for out-of-network providers, unlimited. *Certain Out-of-Network claims are treated as In-Network claims as	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.

	required by the No Surprises Act.	
What is not included in the out-of-pocket limit?	Premiums, penalties for non-compliance, 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.
Will you pay less if you use a network provider?	Yes. See www.highmarkbcbs.com or call 1-800-810-blue for a list of network providers. **Out-of-Network providers may be treated as In-Network providers as required by 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
		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	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	No charge for network outpatient laboratory testing and deductible does not apply.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization may be required for some tests.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.savrx.com. 1-866-233-IBEW	Generic drugs	10% coinsurance /prescription (retail); $15 copay/prescription (mail order)	Not covered	Retail 34-day supply: $10 minimum, $100 maximum. Preferred retail 90-day supply: $30 minimum, $300 maximum. Preauthorization may be required.
	Preferred brand drugs	20% coinsurance /prescription (retail); 20% coinsurance/ prescription (mail order)	Not covered	Retail 34-day supply: $20 minimum, $100 maximum. Preferred retail 90-day supply: $60 minimum, $300 maximum. Mail order 90-day supply: $40 minimum, $200 maximum. Step therapy program may apply. You must try the generic equivalent first, otherwise you will pay the copay plus the difference in cost between generic and brand name. Preauthorization may be required. Infusion medications must be filled by a Sav-Rx pharmacy.
	Non-preferred brand drugs	30% coinsurance /prescription (retail); 30% coinsurance/ prescription (mail order)	Not covered	Retail 34-day supply: $40 minimum, $100 maximum. Preferred retail 90-day supply: $120 minimum, $300 maximum. Mail order 90-day supply: $80 minimum, $200 maximum. Step therapy program may apply. You must try the generic equivalent first, otherwise you will pay the copay plus the difference in cost between generic and brand name. Preauthorization may be required. Infusion medications must be filled by a Sav-Rx pharmacy.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Preauthorization may be required.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance unless otherwise required by No Surprises Act	None
	Emergency medical transportation	20% coinsurance	20% coinsurance 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	Preauthorization may be required.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	None
	Inpatient services	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Preauthorization may be required
If you are pregnant	Office visits	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Cost sharing does not apply to certain preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			

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 help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required.
	Rehabilitation services	20% coinsurance	40% coinsurance	
	Habilitation services	20% coinsurance	40% coinsurance	If dependent child is receiving treatment for delayed communication, speech therapy covered but limited to 20 visits per calendar year.
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to $50,000 for attendance of a registered graduate nurse in the home. Preauthorization may be required.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	For patients with a life expectancy of six months or less.
If your child needs dental or eye care	Children's eye exam	No charge	Amount charged above $30	Limited to 1 exam per calendar year
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	No charge	No charge	Limited to 2 exams 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.)

- Acupuncture
- Children's glasses
- Cosmetic surgery, unless necessary to correct a birth deformity or the result of an accidental injury
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs, except as required by law under the Affordable Care Act.

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

- Bariatric surgery to treat morbid obesity
- Chiropractic care, limited to $500 per calendar year
- Dental care (adult), subject to yearly benefit maximum
- Hearing aids for children younger than 18, limited to $1,500 lifetime; hearing aids for adults under certain circumstances
- Private Duty Nursing Care
- Routine eye care (adult examination)

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, 1-866-444-EBSA (3272), 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 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 1-888-466-9094 or visit www.4thdistrictheatlhfund.com 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: See Addendum

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

The plan's overall deductible	$550
Specialist coinsurance	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	$550
Copayments	$0
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,010**

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

The plan's overall deductible	$550
Specialist coinsurance	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	$550
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,570**

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

The plan's overall deductible	$550
Specialist coinsurance	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	$550
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$950**

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