
 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/ccio/index.html> or call 1-888-466-9094 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	For <a href="#">network providers</a> , \$750 individual /\$2,250 family; for <a href="#">out-of-network providers</a> , \$1,100 individual/ \$3,300 family. <i>*Certain Out-of-Network claims are treated as In-Network claims as required by No Surprises Act</i>	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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> services and in- <a href="#">network</a> outpatient <a href="#">diagnostic tests</a> 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. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<u>Medical</u> For <a href="#">network providers</a> , \$6,500 individual or family; for <a href="#">out-of-network providers</a> , \$9,500 individual or family. <u>Prescription</u> For <a href="#">network providers</a> , \$1,650 individual/ \$8,800 family; for <a href="#">out-of-network providers</a> , unlimited. <i>*Certain Out-of-Network claims are treated as In-Network claims as required by the No Surprises Act</i>	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.

<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><a href="#">Premiums</a>, penalties for non-compliance, <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes. See <a href="http://www.highmarkbcbs.com">www.highmarkbcbs.com</a> or call 1-800-810-blue for a list of <a href="#">network providers</a>. <i>*Out-of-Network providers may be treated as In-Network providers as required by No Surprises Act</i></p>	<p>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.</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>No.</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</p>

 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 <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	No charge for <a href="#">network</a> outpatient laboratory testing and <a href="#">deductible</a> does not apply.
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required for some tests.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.savrx.com</a> . 1-866-233-IBEW	Generic drugs	10% <a href="#">coinsurance</a> /prescription (retail); \$15 <a href="#">copay</a> /prescription (mail order)	Not covered	Retail 34-day supply: \$10 minimum, \$100 maximum. Preferred retail 90-day supply: \$30 minimum, \$300 maximum. <a href="#">Preauthorization</a> may be required.
	Preferred brand drugs	20% <a href="#">coinsurance</a> /prescription (retail); 20% <a href="#">coinsurance</a> /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 <a href="#">copay</a> plus the difference in cost between generic and brand name. <a href="#">Preauthorization</a> may be required. Infusion medications must be filled by a Sav-Rx pharmacy.
	Non-preferred brand drugs	30% <a href="#">coinsurance</a> /prescription (retail); 30% <a href="#">coinsurance</a> / 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 <a href="#">copay</a> plus the difference in cost between generic and brand name. <a href="#">Preauthorization</a> 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)	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance unless otherwise required by No Surprises Act</a>	<a href="#">Preauthorization</a> may be required.
	Physician/surgeon fees			
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance unless otherwise required by No Surprises Act</a>	None
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance unless otherwise required by No Surprises Act</a>	None
	<a href="#">Urgent care</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance unless otherwise required by No Surprises Act</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance unless otherwise required by No Surprises Act</a>	<a href="#">Preauthorization</a> may be required.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance unless otherwise required by No Surprises Act</a>	None
	Inpatient services	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance unless otherwise required by No Surprises Act</a>	<a href="#">Preauthorization</a> may be required.
If you are pregnant	Office visits	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance unless otherwise required by No Surprises Act</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> or <a href="#">deductible</a> 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	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is be required.
	<a href="#">Rehabilitation services</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	If dependent child is receiving treatment for delayed communication, speech therapy covered but limited to 20 visits per calendar year.
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Limited to \$50,000 for attendance of a registered graduate nurse in the home. <a href="#">Preauthorization</a> may be required.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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](http://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](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 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.4thdistricthealthfund.com](http://www.4thdistricthealthfund.com) or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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**

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

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$750
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$3,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,310</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$750
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,870</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$750
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,350</b>