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, contact the Plan Administrator at (763) 493-8830 or 1-800-368-9045, or visit www.ibew292benefits.org. 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.healthcare.gov/glossary/ or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers: **$100** Eligible Individual/**$300** Family per calendar year*. For out-of-network providers: **$400** Eligible Individual/**$1,200** Family per calendar year. **Certain out-of-network claims are treated as in-network claims (see page 2) and count toward the in-network deductible.*	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. Network provider injections, online care, retail clinic care, wig benefit, mental health and chemical dependency medication management, COVID-19 diagnostic tests, and prescription drug benefits 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.
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?	For network providers: **$1,500** Eligible Individual/**$4,500** Family per calendar year. For out-of-network providers: **$3,500** Eligible Individual/**$10,500** Family per calendar year. **Certain out-of-network claims are treated as in-network claims (see page 2) and count toward the in-network out-of-pocket limit.*	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?	Premiums; balance-billing charges; copayments; coinsurance for prescriptions, dental and orthodontia services, vision care, and routine exams; 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.* Please visit http://welcometouhc.com/uhss for a list of participating providers. **Out-of-network providers* may be treated as network providers for cost-sharing purposes for out-of-network emergency services, out-of-network providers at in-network facilities, and out-of-network air ambulance costs for emergencies.*	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	$20.00 copay/office visit and 15% coinsurance._ In-Network Telehealth services through the Plan's dedicated telehealth provider, Teladoc, (and, through the last day of the month during the COVID-19 public health emergency, in-network telehealth visits generally) are covered 100% and are not subject to a copayment, deductible or coinsurance. Teladoc services can be accessed 24/7 at https://member.teladoc.com/signin.	25% coinsurance, and balance-billed charges.	Chiropractic care and acupuncture care is limited to $500 per calendar year combined. One health maintenance visit and one health maintenance mammogram per Eligible Individual over age 40 per calendar year is 100% covered. Coverage for some immunizations is 100%. Coverage for infertility treatment is limited to $1,500 per pregnancy. Participant may receive $100 credit towards the annual deductible if the participant completes the Health Dynamics Preventative Care Program Exam (or $300 credit if both Participant and a spouse complete the exam). Exam is offered at no cost. Credit will be applied towards annual deductible following the year in which the exam is completed. You may have
	Specialist visit			
	Preventive care/screening/ immunization			

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)	
				to pay for services that are 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)	15% coinsurance.	25% coinsurance, and balance-billed charges.	Tests must be ordered by a Physician to be covered. Certain out-of-network costs may be treated as in-network costs (see page 2). COVID-19 tests are covered 100% during the COVID-19 public health emergency, but over-the-counter COVID-19 tests are limited to 8 per month; out-of-network over-the-counter COVID-19 tests are covered up to $12.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.SavRx.com, or by phone at (866) 233-4239.	Generic drugs	**Retail**: the greater of $5 or 20% coinsurance, up to a maximum of $25 per prescription. **Mail Order**: the greater of $10 or 10% coinsurance, up to a maximum of $50 per prescription.	100%	No deductible on Prescription Benefits. Copayments for prescription drugs do not count towards reaching the deductible or annual maximum out-of-pocket limit for major medical benefits. Retail costs are for up to a 90 day supply; mail order is for a 90 day supply. 90-day supplies are discounted at the cost of two 30-day supplies. No coverage for Cosmetic, Experimental, Investigative, compound, off-label, or infertility drugs. Contact Sav-Rx at 1-866-233-4239 for pharmacy locations and mail order information. Certain specialty drugs are subject to preauthorization, split fills, and quantity level limits. Call 1-866-233-4239 for the current list of
	Brand drugs	**Retail**: the greater of $9 or 20% coinsurance, up to a maximum of $50 per prescription. **Mail Order**: the greater of $18 or 10% coinsurance, up to a maximum of $100 per prescription.		

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)	
				specialty drugs. Certain specialty drugs may have a lower cost under a copayment assistance program. Call the Plan Administrator at 800-368-9045 for more information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance.	25% coinsurance, and balance-billed charges.	Some surgeries are subject to limitation, exclusion, or pre-approval (e.g., gastric bypass, transplants, elective surgery). Certain surgeries are covered only when performed on an outpatient basis. Certain out-of-network costs are treated as in-network costs as described on page 2.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	$60.00 copay/visit plus 25% coinsurance.	$60.00 copay/visit plus 25% coinsurance.	The copayment is $60 plus 25% coinsurance if you are not admitted to the hospital in connection with the emergency room visit.
	Emergency medical transportation	15% coinsurance.	25% coinsurance and balance-billed charges.	Only transportation to the nearest hospital is covered unless medically necessary treatment is not available at the nearest hospital . Out-of-network air ambulance costs may be treated as in-network costs as described on page 2.
	Urgent care	$30.00 copay/visit plus 15% coinsurance. In-Network Telehealth services through the Plan's dedicated telehealth provider, Teladoc, are covered 100% and are not subject to a copayment, deductible or coinsurance. Teladoc services can	25% coinsurance, and balance-billed charges.	The network provider copayment is $10 if services are provided by a Minute Clinic (in-network only).

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)	
		be accessed 24/7 at https://member.teladoc.com/signin.		
If you have a hospital stay	Facility fee (e.g., hospital room)	$60.00 copay/admission and 15% coinsurance.	25% coinsurance, and balance-billed charges. Semi-private room only.	Long-term inpatient care requires preauthorization. Some surgeries are subject to limitation, exclusion, or preauthorization (e.g., gastric bypass, transplants, elective surgery). Certain surgeries are covered only when performed on an outpatient basis. Certain out-of-network costs are treated as in-network costs as described on page 2.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance. In-Network Telehealth visits through the Plan's dedicated telehealth provider, Teladoc, (and, through the last day of the month during the COVID-19 public health emergency, in-network telehealth visits generally) are covered 100% and are not subject to a copayment, deductible or coinsurance. Teladoc services can be accessed 24/7 at https://member.teladoc.com/signin.	25% coinsurance, and balance-billed charges.	Long-term inpatient care requires preauthorization. Short-term counseling and referral services are available through TEAM, Inc., via telephone or in person. Call 651-642-0182 for more information. There is no cost for the services provided by TEAM, Inc. Certain out-of-network costs are treated as in-network costs as described on page 2.
	Inpatient services			
If you are pregnant	Office visits	15% coinsurance.	25% coinsurance, and balance-billed charges.	If you obtain network provider pregnancy-related services and participate in pre-natal support program, the in-network coinsurance is 15%. The Plan will cover at least 48 hours for the mother and newborn child following a vaginal delivery or at least 96 hours for the mother and
	Childbirth/delivery professional 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)	
	Childbirth/delivery facility services			newborn child following a cesarean section delivery. Certain out-of-network costs are treated as in-network costs as described on page 2.
If you need help recovering or have other special health needs	Home health care	15% coinsurance.	25% coinsurance and balance-billed charges.	Only available to home-bound Eligible Individuals.
	Rehabilitation services	15% coinsurance.	25% coinsurance, and balance-billed charges.	Treating Physician must submit a Plan of Treatment to the Fund Office for approval prior to beginning therapy.
	Habilitation services	15% coinsurance.	25% coinsurance, and balance-billed charges.	
	Skilled nursing care	15% coinsurance.	25% coinsurance, and balance-billed charges.	Pre-approval required; 30 day maximum per calendar year.
	Durable medical equipment	15% coinsurance.	25% coinsurance and balance-billed charges.	Must be certified as medically necessary by the prescribing physician.
	Hospice services	15% coinsurance.	25% coinsurance and balance-billed charges.	Requires physician certification of Terminal Illness. No coverage for certain costs (e.g., bereavement counseling). Only available to home-bound Eligible Individuals.
If your child needs dental or eye care	Children's eye exam	No charge.	$35.00	None.
	Children's glasses	$20 copay/frames and lenses, after which the Plan covers lenses 100% and the first $180 retail for frames.	$20 copay/frames and lenses, after which the Plan covers $50-$125 depending on lenses and the first $70 for frames.	The Plan covers glasses up to $180 retail for frames with the Vision Service Plan network provider. For an out-of-network provider, the Plan covers glasses up to $70.
	Children's dental check-up	No charge for Diagnostic/Preventative Care with Delta Dental	No charge up to allowed amount	None.

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 (unless as a result of a traumatic injury or correction of congenital defects)
- Experimental or investigational drugs
- Long-term care
- Private-duty nursing
- Routine foot care

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

- Acupuncture ($500/calendar year limit combined with chiropractic care)
- Bariatric surgery (Subject to preauthorization)
- Chiropractic care ($500/calendar year limit combined with acupuncture)
- Dental care
- Hearing aids ($1,500/ear five-calendar year limit after deductible, including multi-ear devices)
- Infertility treatment ($1,500/pregnancy limit; prescription drugs not covered)
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Weight loss programs ($1,500 2-consecutive calendar year limit within 10-consecutive calendar year period)

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 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 Plan Administrator at 1-800-368-9045 or contact 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

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 1-800-368-9045.

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	$100
Primary Care / Specialist copayment	$20
Hospital (facility) copayment	$60
Prescription copayment	$5/generic
Primary Care / Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$100
Coinsurance	$1,876
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,136**

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

The plan's overall deductible	$100
Specialist copayment	$20
Prescription [*cost sharing*]	$5/generic or 20% $9/brand or 20%
Specialist coinsurance	15%
Other coinsurance	15%

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$290
Coinsurance	$1,231
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,500**

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

The plan's overall deductible	$100
Specialist copayment	$20
Emergency Room Care copayment	$60
Specialist coinsurance	15%
Other coinsurance	15%

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$100
Coinsurance	$273
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$473**

Note: Calculations are based on a hypothetical example of a service generated by the U.S. Centers for Medicare and Medicaid Services which can be found at https://www.cms.gov/cciio/resources/forms-reports-and-other-resources/index.html. "Peg is Having a Baby" assumes Peg is a healthy woman who participates in the pre-natal support program. Peg was released on the second hospital day, and was prescribed generic prescriptions. "Managing Joe's type 2 Diabetes" example assumes Joe has four visits to a primary doctor and four specialist visits. Joe is prescribed both, generic and brand prescriptions.

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