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, [insert contact information]. 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 1-855 - 641 - 4966 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	EPO Network (preferred in-network hospital services): **$500**/individual; **$1,000**/family Parkview Signature Care Network (preferred in-network physician services): **$1,500**/individual; **$3,000**/family Out-of-Network: **$3,500**/individual; **$7,000**/family	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**. In-network amounts apply toward out-of-network deductible. Out-of-network amounts also apply toward in-network deductible.
Are there services covered before you meet your deductible?	**Yes**	Pre-admission testing, Colon/Rectal scanning, mammograms, annual physicals, immunizations and inoculations, well baby and child care, gynecological exam, prostate exams.
Are there other deductibles for specific services?	**No**	You must pay all of the costs up to the **deductible** amount before this plan begins to pay for covered services you use. See the chart starting on page 2 for how much you must pay for covered services after you meet the **deductible**.
What is the out-of-pocket limit for this plan?	EPO Network: **$3,000**/individual; **$6,000**/family Parkview Signature Care Network: **$5,000**/individual; **$10,000**/family Out-of-Network: No limit on Out-of-Network expenses	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, 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	Utilizing the EPO Network will cost less than the Parkview Network.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

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	10% coinsurance after deductible	40% coinsurance after deductible	————————none————————
	Specialist visit	10% coinsurance after deductible	40% coinsurance after deductible	If a network **provider** refers you to an out-of-network specialist who is the exclusive **provider** of the only medically necessary and appropriate treatment available, that service rendered by the out-of-network specialist will be charged at the network provider cost (i.e., 10% coinsurance after deductible).
	Preventive care/screening/ immunization	No charge, except see limitations and exceptions	40% coinsurance after deductible (50% coinsurance for colon/rectal screening)	Out-of-pocket maximum does not apply. In network: No coinsurance for immunizations recommended by the Advisory Committee on Immunization Practices. No charge for well-baby and child care. Out-of-network: Annual physical not covered. You may have to pay for services that are not preventative. Ask your provider if the services you need are preventative. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	40% coinsurance after deductible	————————none————————
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	40% coinsurance after deductible	————————none————————

[* For more information about limitations and exceptions, see the plan or policy document at https://www.ourbenefitoffice.com/UALocal166/Benefits/.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	Retail: $20.00 Mail: $50.00	Not covered	Retail: Up to a 34-day supply Mail: 35-90 day supply. If prescription not written "dispense as written" (DAW), it will be filled generic.
	Preferred brand drugs	Retail: $40.00 Mail: $100.00	Not covered	Retail: Up to a 34-day supply Mail: 35-90 day supply. If request brand drug and it's not DAW, must pay copay + difference between cost of generic and brand name drug. Step Therapy Program required for some brand name drugs. Contact Fund Office for list of drugs subject to Step Therapy. Once use of the brand name drug is approved under STP, only subject to copay.
	Non-preferred brand drugs	Retail: $80.00 Mail: $200.00	Not covered	Retail: Up to a 34-day supply Mail Order: 35-90 day supply. If request brand drug and it's not DAW, must pay copay + difference between cost of generic and brand name drug.
	Specialty drugs	Retail: 25% copayment, not to exceed $200.00 Mail: Only filled at retail	Not covered	Retail: Up to a 34-day supply Mail Order: 35-90 day supply. If request brand drug not DAW, pay copay + difference cost of generic and brand name drug. Step Therapy required for some Specialty name drugs. Contact Fund Office for list of drugs subject to Step Therapy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Physician/surgeon fees	10% coinsurance after deductible	40% coinsurance after deductible	——————none——————
If you need immediate medical attention	Emergency room care	10% coinsurance after a $200 copayment	10% coinsurance after a $200 copayment	If admitted to the hospital for life-threatening illness: 10% coinsurance, no copayment
	Emergency medical transportation	10% coinsurance after deductible	10% coinsurance after deductible	Trip must be to closest facility that can provide appropriate services. Air ambulance service covered when Medically Necessary.
	Urgent care	10% coinsurance after deductible	40% coinsurance after deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	40% coinsurance after deductible	Semi-private room

[* For more information about limitations and exceptions, see the plan or policy document at https://www.ourbenefitoffice.com/UALocal166/Benefits/.

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)	
	Physician/surgeon fees	10% coinsurance after deductible	40% coinsurance after deductible	In-Network: Surgical expense may differ for multiple surgical procedures. No charge for second surgical opinion
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Inpatient services	10% coinsurance after deductible	40% coinsurance after deductible	——————none——————
If you are pregnant	Office visits	10% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Childbirth/delivery professional services	10% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Childbirth/delivery facility services	10% coinsurance after deductible	40% coinsurance after deductible	——————none——————
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	40% coinsurance after deductible	Maximum 100 visits per calendar year. Each 4 hours shall be considered 1 visit.
	Rehabilitation services	10% coinsurance after deductible	40% coinsurance after deductible	Must be non-maintenance to be covered. Includes cardiac, pulmonary, chemotherapy, outpatient dialysis, radiation, respiratory, speech, physical and occupational therapy
	Habilitation services	Not covered	Not covered	Not applicable
	Skilled nursing care	10% coinsurance after deductible	40% coinsurance after deductible	Must begin within 2 days after confinement in hospital (with hospital stay lasting at least 3 consecutive days) and must be seen by doctor at least once every 30 days
	Durable medical equipment	10% coinsurance after deductible	40% coinsurance after deductible	Expenses not included in out-of-pocket maximum. Wheelchair or motorized scooter subject to $2,000 lifetime maximum.
	Hospice services	10% coinsurance	10% coinsurance	Treatment plan must be approved by Plan. Benefits may exceed 6 months should patient live beyond prognosis for life expectancy.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not applicable
	Children's glasses	Not Covered	Not Covered	Not applicable
	Children's dental check-up	Not Covered	Not Covered	Not applicable

[* For more information about limitations and exceptions, see the plan or policy document at https://www.ourbenefitoffice.com/UALocal166/Benefits/.

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
- Dental care (Adult)
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care

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

- Enteral/Parental Nutrition Therapy
- Private duty Nursing Services (Contact Fund Office for more information re: requirements)
- Transplants

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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 https://www.ourbenefitoffice.com/UALocal166/Benefits/.

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	$500
Specialist coinsurance	10%
Hospital (facility) *coinsurance*	10%
Other coinsurance	10%

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	$12,731

In this example, Peg would pay:

Cost Sharing	
Deductibles	$520
Copayments	$0
Coinsurance	$1,260
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,840

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

The plan's overall deductible	$500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$7,389

In this example, Joe would pay:

Cost Sharing	
Deductibles	$520
Copayments	$0
Coinsurance	$293
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$868

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

The plan's overall deductible	$500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$1,926

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$193
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$693

Questions: Call the Fund Office at 1-248-641-4966, toll free 1-855-641-4966. For in-network providers you may also call Parkview (1-800-666-4449) in Indiana or PHCS Multiplan (1-800-546-3887) outside Indiana. Call Caremark for Rx questions at 1-866-885-4944. If you aren't clear about any of the terms used in this form, call the Fund Office or see the Glossary at http://www.dol.gov/ebsa/healthreform.