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 (315) 474 5729. 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 call (315) 474 5729 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $500/Individual $1,000/Family Out-of-Network: $1,000/Individual $ 2,000/Family	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 two or more family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Inpatient hospital, skilled nursing facility, home health care, and prescription drugs 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?	Yes. In-Network: None; Out-of-Network: $1,500 per Individual	In-Network: This plan does not have an out-of-pocket limit on your in-network benefits. Out-of- Network: The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan does not cover, copayments, deductibles, penalties for failure to obtain pre-authorization for services and in-network benefits.	In-Network: This plan does not have an out-of-pocket limit on your in-network expenses. Out-of- Network: 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.umr.com or call 800-826-9781 for a list of network providers.	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 copay/visit	20% coinsurance + balance-billed charges	None
	Specialist visit	$20 copay/visitr	20% coinsurance + balance-billed charges	Acupuncture and chiropractic care not covered.
	Preventive care/screening/ immunization	Routine Adult Physical: No charge up to $250, deductible does not apply; Well Child Visit and other preventive care (*e.g.*, bone density testing, colonoscopy, mammography, cervical cancer screening and prostate cancer screening): $20 copay/visit	Routine Adult Physical: No charge up to $250, thereafter 20% coinsurance plus balance-billed charges after deductible; Well Child Visit: 20% coinsurance plus balance-billed charges after deductible; Other preventive care (bone density testing, colonoscopy, mammography, cervical cancer screening and prostate cancer screening): No charge except balance billed charges	Subject to age and frequency limitations.
If you have a test	Diagnostic test (x-ray, blood work)	Physician office and freestanding lab: No charge, Outpatient hospital facility: No charge.	Physician office, freestanding lab and outpatient skilled nursing facility: No charge except balance-billed charges; Outpatient hospital facility: 50% coinsurance + balance-billed charges.	Failure to precertify an MRA or MRI will result in a benefit reduction of the lesser of 50% or $250.
	Imaging (CT/PET scans, MRIs)	Physician office and freestanding lab: $20 copay/test; Outpatient hospital or skilled nursing facility: No charge	Physician office, freestanding lab: No charge except balance billed charges; Outpatient hospital facility: 50% coinsurance + balance billed charges	

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.savrx.com or 1-866-233-4239.	Generic drugs (Tier 1)	Retail: $5 copay/script; Mail Order: $10 copay/script Deductible does not apply	Not covered	Retail pharmacy will provide up to a 30-day supply per prescription. Mail Order pharmacy will provide up to a 90-day supply per prescription. Mandatory Generic Substitution Program: If you purchase a brand name drug and a generic substitution is available, you will pay the difference in price between the brand name drug and the generic substitute. Step Therapy Program applies to proton pump inhibitors. Prior authorization required for certain drugs. Specialty drugs that cost more than $5,000 are subject to clinical review. Not covered out-of-network; Opt-of-network out-of-pocket limit does not apply
	Preferred brand drugs (Tier2)	Retail: $20 copay/script Mail Order: $40 copay/script Deductible does not apply	Not covered	
	Non-preferred brand drugs (Tier 3)	Retail: $35 copay/script Mail Order: $70 copay/script Deductible does not apply	Not covered	
	Specialty drugs	Retail: $35 copay/script Mail Order: $70 copay/script Deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Freestanding facility: $20 copay/procedure; Outpatient hospital surgical center: No charge. Deductible does not apply	Freestanding facility: No charge except balance billed charges; Outpatient hospital surgical center: 50% coinsurance + balance billed charges; deductible does not apply.	None.
	Physician/surgeon fees	$20 copay/procedure	No charge except balance billed charges	Failure to precertify certain procedures will result in a benefit reduction of the lesser of 50% or $250.

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	Facility fee: No charge; Physician fee: $20 copay/visit; deductible does not apply	Facility fee: 50% coinsurance + balance billed charges; Physician fee: No charge except balance billed charges	Must be within 72 hours of accident or 12 hours of onset of sudden and serious symptoms. Treatment of non-emergency conditions not covered. Professional/physician charges may be billed separately.
	Emergency medical transportation	Land and Air: No charge	Land: 20% coinsurance + balance billed charges Air: No charge except balance billed charges	Land ambulance: transfer from an inpatient facility (or other facility) to another facility (or other location) must be ordered by a physician and not be merely for the convenience of the patient.
	Urgent care	No charge; deductible does not apply	No charge except balance billed charges; deductible does not apply	For urgent care visits not within 72 hours of accident or 12 hours of onset of sudden and serious symptoms: In-Network: No charge after deductible; Out-of-Network: 20% coinsurance + balance-billed charges.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge; deductible does not apply	No charge except balance billed charges; deductible does not apply	Precertification required. Failure to precertify services will result in a benefit reduction of $250. Limited to 120 days per approved inpatient stay. Semi-private room only unless a private room is medically necessary.
	Physician/surgeon fees	$20 copay/visit; deductible does not apply	No charge except balance billed charges; deductible does not apply	Precertification required. Failure to precertify certain procedures will result in a benefit reduction of the lesser of 50% or $250. Limited to one visit per day per approved inpatient hospital stay.

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 mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: No charge Other outpatient services: No charge; deductible does not apply	Office visit: 20% co-insurance + balance billed charges Other outpatient services: No charge except balance billed charges; deductible does not apply	None.
	Inpatient services	Facility and professional fees: No charge; deductible does not apply	Facility and professional fees: No charge except balance billed charges; deductible does not apply	Precertification required. Failure to percertify services will result in a benefit reduction of $250. Limited to 120 days per approved inpatient stay. Semi-private room only unless a private room is medically necessary.
If you are pregnant	Office visits	$20 copay/visit	No charge except balance-billed charges	Elective abortions and services and supplies related to surrogate maternity care are not covered. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound)
	Childbirth/delivery professional services	$20 copay/visit	No charge except balance-billed charges	
	Childbirth/delivery facility services	No charge; deductible does not akgpply	No charge except balance-billed charges; deductible does not apply	

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	First 40 visits: No charge; deductible does not apply All visits thereafter: No charge after deductible	First 40 visits: No charge; All visits thereafter: 20% coinsurance + balance billed charges	Failure to precertify services will result in a benefit reduction of $250. After the first 40 covered visits, there is a limit of an additional 325 visits per calendar year. Services must be in lieu of inpatient bed stay and provided by an agency licensed by New York State. Up to four hours of care is equal to one visit.
	Rehabilitation services	Physician office and freestanding facility: $20 copay/visit Outpatient hospital or skilled nursing facility and inpatient facilities: No charge; deductible does not apply	Physician office and freestanding facility: 20% coinsurance + balance billed charges Outpatient hospital: 50% coinsurance + balance billed charges; Outpatient skilled nursing facility and inpatient facilities: No charge except balance billed charges; deductible does not apply	Services must be ordered by a physician. Includes physical therapy, speech therapy and vision therapy. Deductible applies to outpatient hospital and skilled nursing facility based physical or occupational therapies not furnished within six months of a related surgery or hospital discharge.
	Habilitation services	Not covered	Not covered	You must pay 100% of these services, even in-network.
	Skilled nursing care	No charge; deductible does not apply	No charge except balance billed charges; deductible does not apply	Failure to precertify services will result in a benefit reduction of $250. Services must be in lieu of hospitalization and provided by a licensed facility. Limited to one visit per day for up to 120 days per approved inpatient Hospital or Skilled Nursing Facility stay.
	Durable medical equipment	$20 copay/DME	20% coinsurance + balance billed charges	Failure to precertify DME will result in a benefit reduction of the lesser of 50% or $250. Must be ordered by a physician.
	Hospice services	No charge	No charge except balance billed charges	Limited to 210 days per lifetime and up to 5 bereavement counseling visits for family members. Facility must be certified by NYSDOH or, if outside NY, certified under similar standards.

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 your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	50% coinsurance	50% coinsurance + balance-billed charges	Limited to two dental check-ups per individual 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
- Chiropractic care
- Cosmetic surgery (Except to restore tissue damaged by an illness or injury or for reconstructive surgery)
- Elective abortions
- Habilitation services
- Hearing aids
- Infertility treatment (Limited to diagnosis and treatment of underlying medical condition)
- Long-term care
- Routine eye care (Adult) (Child)
- Routine foot care (Except for patients with severe systemic disorders, such as diabetes)
- Weight loss programs

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

- Bariatric surgery (For treatment of Morbid Obesity)
- Dental care (Adult) (Limited to dental check-ups, bitewing x-rays and prophylaxis two times per calendar year)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Only when Medically Necessary)

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 Fund Office at IBEW Local No. 43 and Electrical Contractors Welfare Fund, 4568 Waterhouse Road, Clay, New York 13041 or via phone at (315) 474 5729. You may also contact the Department of Labor's Employee Benefits Security administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/health reform.

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 (315) 474 5729.

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	$500
Specialist copayment	$20
Hospital (facility) coinsurance	None
Other copayments	$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	$500
Copayments	$110
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$670**

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 copayment	$20
Hospital (facility) coinsurance	None
Other copayment	$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	$500
Copayments	$1,140
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Joe would pay is	**$1710**

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

The plan's overall deductible	$500
Specialist copayment	$20
Hospital (facility) coinsurance	None
Other copayment	$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	$500
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$540**

Your Health Reimbursement Account (HRA) may be available for reimbursement for out-of-pocket expenses.

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