Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Electrical Workers Local 369 Benefit Fund: Active Employees, Disabled Retirees, Surviving Spouses and Eligible Dependents

Coverage Period: 07/01/2023 – 06/30/2024
Coverage for: Individual + Family | Plan Type: PPO

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 1-800-427-2495 or 1-502-635-2611. 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 1-800-427-2495 or 1-502-635-2611 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300**/Individual or **$600**/Family (January 1 – December 31)	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?	In-Network preventive services, office visits, vision and dental 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?	Yes. **$50**/Individual for prescription drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$3,000**/Individual or **$6,000**/Family (January 1 – December 31)	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, deductible for prescription drugs, penalty for not obtaining preauthorization and health care this plan does not 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.anthem.com or call1-800-810-2583 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: In-Network Provider (You will pay the least)	What You Will Pay: Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment/visit; deductible does not apply	$20 copayment/visit then 20% coinsurance; deductible does not apply	None
	Specialist visit	$40 copayment/visit; deductible does not apply	$40 copayment/visit then 20% coinsurance; deductible does not apply	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply	20% coinsurance	Includes physical exams, immunizations and school physicals.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	None
	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.	Generic drugs	15% coinsurance after $5 minimum/$100 maximum copayment/fill retail and 10% coinsurance after $10 minimum/$125 maximum copayment/fill mail order.	Not covered	Supply: 30-day retail, 90-day mail order, and 90-day retail from Walgreens and CVS. $50 deductible for prescription drugs does not count toward the out-of-pocket limit. Omnipod DASH and Omnipod 5 covered, with preauthorization from Sav-Rx, at no charge after prescription drug deductible.
	Brand Name drugs	20% coinsurance after $5 minimum/$100 maximum copayment/fill retail and 15% coinsurance after $10 minimum/$125 maximum copayment/fill mail order, plus difference in cost between the generic and brand drug if generic is available.	Not covered	
	Specialty drugs	Your cost sharing depends on whether the drug is generic or brand. See above.	Not covered	Supply: 30-day retail and 90-day mail order; refills after first retail refill must be filled through mail order. $50 deductible for prescription drugs does not count toward the out-of-pocket limit.

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$40 copayment/visit	20% coinsurance	None
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	None
	Emergency medical transportation		20% coinsurance; except 10% coinsurance for air ambulance services	
	Urgent care		20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Preauthorization required for planned inpatient stay to avoid $200 penalty. Coverage based on cost of semi-private room.
	Physician/surgeon fees	No charge		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment/visit	$20 copayment/visit then 20% coinsurance for office visits; 20% coinsurance for other outpatient services	Deductible does not apply to office visits.
	Inpatient services	10% coinsurance	20% coinsurance	Preauthorization required for planned inpatient stay to avoid $200 penalty.
If you are pregnant	Office visits	$20 copayment/visit; deductible does not apply	$20 copayment/visit then 20% coinsurance; deductible does not apply	Expenses incurred for a dependent child's pregnancy are not covered, except for the pregnancy tests required by a Hospital or Physician in order to perform other non-pregnancy related procedures. Preauthorization required for planned inpatient hospitalization to avoid $200 penalty after 48 hours for vaginal delivery and 96 hours for Cesarean delivery confinements.
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	
	Childbirth/delivery facility services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	None
	Rehabilitation services	$20 copayment for first speech therapy visit then no charge; No charge for physical, and occupational therapy; 10% coinsurance for other services	20% coinsurance	Physical, occupational and speech therapy require letter of medical necessity or else not covered. Case management review required for speech therapy.
	Habilitation services	$20 copayment for first speech therapy visit then no charge; No charge for physical, and occupational therapy; 10% coinsurance for other services		
	Skilled nursing care	10% coinsurance	20% coinsurance	None
	Durable medical equipment	10% coinsurance		
	Hospice services	No charge for outpatient services; 10% coinsurance for inpatient facility	20% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Covered only for certain groups of actives and their dependents, and retirees who were eligible under the Inside Wireman Plan. No calendar year maximum if under age 18. You may opt-out of coverage annually.
	Children's glasses			Covered only for certain groups of actives and their dependents, and retirees who were eligible under the Inside Wireman Plan. No calendar year maximum if under age 18. Plan pays per calendar year for any one of the following: one set of frames and lenses, or one-year supply of contact lenses, or one set of frames and a one-year supply of contact lenses.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's dental check-up	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Covered only for certain groups of actives and their dependents, and retirees who were eligible under the Inside Wireman Plan. You may opt-out of coverage annually. $350 maximum per individual per calendar year. Coverage for one dental check-up 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
- Cosmetic surgery (except for certain reconstructive surgeries)
- Infertility treatment
- 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.)

- Bariatric surgery (subject to preapproval by MCM)
- Chiropractic care (limited to 24 visits/calendar year per person)
- Dental care (Adult) ($350 maximum per individual per calendar year; you may opt-out of coverage annually; covered only for certain groups of actives and their dependents)
- Hearing aids (one exam/device per ear every 5 years)
- Non-emergency care when traveling outside the U.S. (participant must pay for services and file a claim for reimbursement)
- Routine eye care (Adult) (for persons age 18 and older; you may opt-out of coverage annually; $150 maximum per calendar year per person; covered only for certain groups of actives and their dependents)
- Weight loss programs ($2,500 lifetime maximum per person)

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 Department of Labor's Employee Benefits Security Administration at 1-866-44-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 on how 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, Electrical Workers Local 369 Benefit Fund, 906 Minoma Avenue, Louisville, KY 40217, Telephone: 1-800-427-2495 or 1-502-635-2611. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-44-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal, contact the Kentucky Department of Insurance, Consumer Protection Division, P. O. Box 517, Frankfort, KY 40602-0517, 1-800-575-6053, http://insurance.KY.gov or consumerservices@ky.gov.

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.

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** **$300**
- **Specialist copayment** **$40**
- **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$310
Copayments	$0
Coinsurance	$1,230
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,600**

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

- **The plan's overall deductible** **$300**
- **Specialist copayment** **$40**
- **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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$350
Copayments	$240
Coinsurance	$820
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,430**

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

- **The plan's overall deductible** **$300**
- **Specialist copayment** **$40**
- **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$310
Copayments	$160
Coinsurance	$150
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$620**

***NOTE:** This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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