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?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable.	This plan does not have a deductible.
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?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.savrx.com or call 1-866-233-4239 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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Medicare Provider (You will pay the least)	Non-Medicare 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 Specialist visit Preventive care/screening/ immunization	No charge if allowed by Medicare	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of your Medicare Part B deductible and your coinsurance. Preventive Care: Some tests are covered 100%, others are 80% of Medicare-approved amount after Part B deductible; Plan pays up to $120 a year
If you have a test	Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)	No charge if allowed by Medicare	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of your Medicare Part B deductible and your coinsurance.
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	You must pay a $50/person deductible before this plan pays for prescription drugs. Supply: 30-day retail and 90-day mail order; refills after first retail refill must be filled through mail order. Specialty drug refills after first retail fill must be filled through mail order. Brand drugs require a letter of medical necessity. Omnipod DASH and Omnipod 5 covered, with preauthorization from Sav-Rx, at no charge after prescription drug deductible. Plan coordinates with Medicare and pays secondary.
	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	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	No charge if allowed by Medicare	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of your Medicare Part B deductible and your coinsurance.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Medicare Provider (You will pay the least)	Non-Medicare Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	No charge if allowed by Medicare	No charge if allowed by Medicare	The Plan pays 100% of your Medicare Part B deductible and your coinsurance.
	Emergency medical transportation	No charge if allowed by Medicare	Ground ambulance: You are responsible for the difference between the Medicare allowance and the billed amount Air ambulance: No charge if allowed by Medicare	
	Urgent care	No charge if allowed by Medicare	You are responsible for the difference between the Medicare allowance and the billed amount	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge if allowed by Medicare	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of your Medicare Part A deductible and your coinsurance; after Medicare's lifetime reserve days are used, Plan pays 100% for an additional 365 days per lifetime.
	Physician/surgeon fees	No charge if allowed by Medicare	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of your Medicare Part B deductible and your coinsurance; after Medicare's lifetime reserve days are used, Plan pays 100% for an additional 365 days per lifetime.
If you need mental health, behavioral health, or substance abuse services	Outpatient services Inpatient services	No charge if allowed by Medicare	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of your Medicare Part A deductible and coinsurance and your Medicare Part B deductible and coinsurance.
If you are pregnant	Office visits Childbirth/delivery professional services Childbirth/delivery facility services	No charge if allowed by Medicare	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of your Medicare Part A deductible and coinsurance and your Medicare Part B deductible and coinsurance.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Medicare Provider (You will pay the least)	Non-Medicare Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge if allowed by Medicare	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of your Medicare Part A deductible and coinsurance and your Medicare Part B deductible and coinsurance.
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care	No charge if allowed by Medicare	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of your Medicare Part A deductible and your coinsurance for 21st-100th day. Plan pays up to $100 per day for 101st-365th day. No coverage beyond 365 days.
	Durable medical equipment	No charge if allowed by Medicare	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of your Medicare Part B deductible and your coinsurance.
	Hospice services	No charge if allowed by Medicare	You are responsible for the difference between the Medicare allowance and the billed amount	The Plan pays 100% of your Medicare Part A deductible and coinsurance and your Medicare Part B deductible and coinsurance.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Covered only for retirees and their spouses who were eligible under the Inside Wireman Plan as active employees and their dependents. No calendar year maximum if under age 18. You may opt-out of coverage annually
	Children's glasses	No charge	No charge	Covered only for retirees and their spouses who were eligible under the Inside Wireman Plan as active employees and their dependents. 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
		Medicare Provider (You will pay the least)	Non-Medicare Provider (You will pay the most)	
	Children's dental check-up	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Covered only for retirees and their spouses who were eligible under the Inside Wireman Plan as active employees and their dependents. 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
- Bariatric surgery
- Cosmetic surgery (except for certain reconstructive surgeries)
- Infertility treatment
- Long-term care
- Routine foot care

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

- Chiropractic care
- Dental care (Adult) ($350 maximum per individual per calendar year; you may opt-out of coverage annually; covered only for certain retirees and their spouses)
- Hearing aids
- Non-emergency care when traveling outside the U.S. (participant must pay for services and file a claim for reimbursement)
- Private Duty Nursing (Medicare pays $0, Plan pays a maximum benefit amount of $30 per 8-hour shift. Maximum of 60 shifts per calendar year)
- 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 retirees and their spouses)
- Weight loss programs

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? No

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	N/A
■ Specialist copayment	N/A
■ Hospital (facility) coinsurance	N/A
■ Other coinsurance	N/A

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*	$10
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

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

■ The plan's overall deductible	N/A
■ Specialist copayment	N/A
■ Hospital (facility) coinsurance	N/A
■ Other coinsurance	N/A

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*	$50
Copayments	$0
Coinsurance	$760
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$830**

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

■ The plan's overall deductible	N/A
■ Specialist copayment	N/A
■ Hospital (facility) coinsurance	N/A
■ Other coinsurance	N/A

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*	$10
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$10**

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

Medicare and the plan (as a secondary payer) would be responsible for the other costs of these EXAMPLE covered services.