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 employer cost (called contributions) for this plan can be found within the Collective Bargaining Agreement. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibew697benefits.com or call 1-219-845-4433. 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 1-219-845-4433 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$200** per person, **$400** per family. This deductible does not apply to prescription drug, vision, and dental coverage or to services provided by Teladoc.	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. Preventive care and Class A hospital expenses 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. For example, this plan covers certain in-network preventive services before you meet your deductible.
Are there other deductibles for specific services?	No.	
What is the out-of-pocket limit for this plan?	**$2,500** per person, **$5,000** per family for **in-**network providers; **$5,000** per person, **$10,000** per family for out-of-network providers.	The Plan maintains two levels of out-of-pocket limits for individuals. If a participant utilizes in-network providers, and once the $2,500 or $5,000 limit is met, the Plan will pay one hundred percent (100%) of the covered service(s) rendered by a participating provider for the remainder of the calendar year. If the participant is utilizing an out-of-network provider, and after the second set of limits shown directly to the left are met, the Plan will pay one hundred percent (100%) of the Fund's allowable expense for a covered service rendered by a non-participating provider. 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.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)

(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	**1. Balance-billing charges** **2. Chiropractic care** **3. COBRA payments** **4. Deductibles,** **5. Dental expenses** **6. Drugs (Prescriptive)** **7. Expenses incurred for treatments or services not covered by the Plan.** **8. Self-payments** **9. Vision Benefits**	Even though you pay these expenses, they do not count toward the annual out-of-pocket limits
Will you pay less if you use a network provider?	Yes. See www.phcs.com or call 1-800-922-4362 for a list of participating physicians and durable medical equipment providers. See www.ibew697benefits.org for a listing of participating hospital facilities.	Physician and durable medical equipment services - This Plan uses the PHCS provider network for physician and durable medical equipment (DME) services. If the treatment you seek is a covered benefit of the Plan, you will pay less when utilizing the services of one of the PHCS physicians or DME providers than you would if you utilized the services of a non-participating / out of network physician. Hospitals - The Plan contracts directly with those hospital entities that are listed within the Funds website (www.ibew697benefits.org), SPD, and accompanying notice. You will pay less if you use a one of those contracted Hospital entities. You will pay more if you use a hospital facility that is not contained in the aforementioned document or website. Should you utilize a non-participating provider or out of network provider or a non-contracted hospital facility you may receive a bill from the provider for the difference between the provider's charge and what your plan pays (balance billing). **Warning**: Your network provider might use an out-of-network provider for some services (such as, but not limited to, radiologists, anesthesiologists, pathologists, emergency room physicians or laboratories for your blood work). When this occurs, the Plan will pay each professional in accordance with their network affiliation or lack thereof. Be advised that the Plan has no control over the business practices of these medical practitioners. Therefore, check with your provider about their business partners network affiliations before you receive 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.

[* For more information about limitations and exceptions, see the plan or policy document at www.ibew697benefits.org.]

Common Medical Event	Services You May Need	What You Pay When Utilizing In-Network Providers	What You Pay When Utilizing Out-of-Network Providers	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	10% coinsurance	30% coinsurance, deductible plus charges over the Plan's allowed amount**	$0 copay if you use Teladoc for non-emergency illnesses like colds and flu (www.teladoc.com or 1-800-Teladoc).
	Specialist visit	10% coinsurance	30% coinsurance, deductible plus charges over the Plan's allowed amount**	None.
	Preventive care/screening/ (See list of preventative services in far-right column)	10% coinsurance, deductible does not apply	30% coinsurance, deductible, plus charges over the Plan's allowed amount**	Preventative Services are limited to: • Bone density tests • Cardiac risk assessments • Cervical exams • Colorectal cancer screening • Diabetes assessments • Immunizations that have been approved by the Center for Disease Control Prevention and the U.S. Department of Health and Human Services • Mammograms • Pap tests • PSA test and Prostate exams • Routine Physicals & Well baby visits
If you have a test	Diagnostic test (x-ray, blood work)	Level A facility 0% coinsurance & no deductible. Level B - 10%	30% coinsurance, deductible plus charges over the Plan's allowed amount**	None.

[* For more information about limitations and exceptions, see the plan or policy document at www.ibew697benefits.org.]

		coinsurance, deductible applies.		
	Imaging (CT/PET scans, MRIs)	Level A facility 0% coinsurance & no deductible. Level B - 10% coinsurance, deductible applies.	30% coinsurance, deductible plus charges over the Plan's allowed amount**	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medimpact.com on or after April 1, 2024 and www.savrx.com prior to that date.	Generic drugs	20% coinsurance (minimum $10 copayment)	20% coinsurance based on network negotiated price and network minimum copayment	Coverage is limited to 30-day supply retail or 31-90-day supply with mail-order. Annual deductible does not apply. Step therapy and preauthorization programs may apply. Mandatory generic.
	Preferred brand drugs	20% coinsurance (minimum $20 copayment)		
	Non-preferred brand drugs	20% coinsurance (minimum $35 copayment)		
	Specialty drugs	20% coinsurance (minimum copayments shown above apply)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Level A - 0% coinsurance, no deductible Level B - 10% coinsurance, deductible applies.	30% coinsurance, deductible plus charges over the Plan's allowed amount**	Preauthorization required for any surgery Effective 01/01/2022, you may only be responsible for the Level B coinsurance amount of 10% for charges for certain covered services or treatments performed by an out-of-network provider when received at a network facility or during an emergency medical condition. For more information, contact the Benefit Office.
	Physician/surgeon fees	10% coinsurance, deductible applies	30% coinsurance, deductible plus charges over the Plan's allowed amount**	
If you need immediate medical attention	Emergency room care	Level A - 0% coinsurance, no deductible Level B - 10% coinsurance, deductible	30% coinsurance, deductible plus charges over the Plan's allowed amount**	WARNING: The in-network or contracted hospital's emergency room may be staffed with out-of-network provider or utilize the services of out of network providers, such as, but not limited to, radiologists, anesthesiologists, pathologists, emergency

		applies.		room physicians or laboratories for your blood work. When this occurs, the Plan will pay each professional in accordance with their network affiliation or lack thereof. Be advised that the Plan has no control over the business practices of these medical practitioners. Effective 01/01/2022, you may only be responsible for the Level B coinsurance amount of 10% for charges for certain covered services or treatments performed by an out-of-network provider when received at a network facility or during an emergency medical condition. For more information, contact the Benefit Office.
	Emergency medical transportation	10% coinsurance, deductible applies	30% coinsurance, deductible plus charges over the Plan's allowed amount**	
	Urgent care	Level A – 0% coinsurance, no deductible Level B - 10% coinsurance, deductible applies.	30% coinsurance, deductible plus charges over the Plan's allowed amount.**	
If you have a hospital stay	Facility fee (e.g., hospital room)	Level A - 0% coinsurance, no deductible 10% coinsurance, deductible applies at Level B facilities	30% coinsurance, deductible plus charges over the Plan's allowed amount**	Preauthorization is required Effective 01/01/2022, you may only be responsible for the Level B coinsurance amount of 10% for charges for certain covered services or treatments performed by an out-of-network provider when received at a network facility or during an emergency medical condition. For more information, contact the Benefit Office.
	Physician/surgeon fees	10% coinsurance, deductible applies	30% coinsurance, deductible plus charges over the Plan's allowed amount**	Preauthorization for surgeries is required Effective 01/01/2022, you may only be responsible for the Level B coinsurance amount of 10% for charges for certain covered services or treatments performed by an out-of-network provider when received at a network facility or during an emergency medical condition. For more information, contact the Benefit Office.

If you need mental health, behavioral health, or substance abuse services	Outpatient services	Level A – 0% coinsurance, no deductible. Level B -10% coinsurance, deductible applies	30% coinsurance, deductible plus charges over the Plan's allowed amount**	Concurrent review authorization required after 17th visits or coverage will be denied starting with the 18th visit.
	Inpatient services	Level A - 0% coinsurance, no deductible Level B - 10% coinsurance, deductible applies.	30% coinsurance, deductible plus charges over the Plan's allowed amount**	Preauthorization is required.
If you are pregnant	Office visits	10% coinsurance, deductible applies	30% coinsurance, deductible plus charges over the Plan's allowed amount**	Dependent children are not covered under this benefit
	Childbirth/delivery professional services	10% coinsurance, deductible applies	30% coinsurance, deductible plus charges over the Plan's allowed amount**	0% coinsurance, no deductible for Level A hospital charges.
	Childbirth/delivery facility services	Level A - 0% coinsurance, no deductible Level B - 10% coinsurance, deductible applies.	30% coinsurance, deductible plus charges over the Plan's allowed amount**	

[* For more information about limitations and exceptions, see the plan or policy document at www.ibew697benefits.org.]

If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance plus charges over the Plan's allowed amount**	None.
	Physical Therapy services	10% coinsurance	30% coinsurance plus charges over the Plan's allowed amount**	Concurrent review authorization required after 17 visits or coverage will be denied starting with the 18th visit.
	Habilitation services	10% coinsurance	30% coinsurance plus charges over the Plan's allowed amount**	Coverage limited to children ages 18 months to 12 years (through age 11) for autism and certain other disorders up to a maximum of 50 visits per calendar year.
	Skilled nursing care	10% coinsurance	30% coinsurance plus charges over the Plan's allowed amount**	Preauthorization is required.
	Durable medical equipment	10% coinsurance	30% coinsurance plus charges over the Plan's allowed amount**	Coverage for a wheelchair or scooter is limited to $500.
	Hospice services	10% coinsurance	30% coinsurance plus charges over the Plan's allowed amount**	Preauthorization is required.
Dental or eye care	Eye exam	$5 copayment	$35	None.
	Glasses	$10 copayment	$45 for frame $25 for Single Vision Lenses $40 for Lined Bifocal Lenses $55 for Line Trifocal Lenses	None.
	Dental check-up	20% coinsurance	20% coinsurance	$3,000 maximum benefit per family per year.

NOTE: Subject to Plan and IRS rules, your deductibles and coinsurance, charges in excess of Plan limitations, and certain services not covered by the Plan may be reimbursable under the Plan's Health Reimbursement Arrangement benefit. For a list of allowable reimbursable expenses, as well as a list of ineligible or non-qualified expenses, please reference the Plan's Summary Plan Description Book or website at www.ibew697benefits.org.

This Plan's Heath Reimbursement Arrangement (HRA) benefit is not available to apprentices nor Indiana plan participants. It is only available to journeypersons and those individuals identified within an employer's participation agreement who meet and exceed the quarterly hourly requirement to earn said benefit. To find out more about how this benefit is earned, credited, and benefit maximums, please reference the Plan's Summary Plan Description Book or website at www.ibew697benefits.org.

Should a participant's eligibility be terminated, their debit cards will be immediately deactivated, and the participant will have sixty (60) days to manually submit unpaid medical expenses that were incurred during the time of coverage under this Plan for reimbursement.

[* For more information about limitations and exceptions, see the plan or policy document at www.ibew697benefits.org.]

Courtesy HRA Reminder:

1. **You need to keep your original receipts and documentation for prescriptions and health related expenses for all transactions (including debit card transactions), so you'll have them if needed to verify a claim. The IRS requires that all transactions are validated, including the debit card transactions.**

2. **Always wait until your medical claim is adjudicated first, before utilizing your debit card to make payment for any out-of-pocket expense. In other words, debit cards are not to be used for the prepayment of any out-of-pocket expense associated with any medical service, medical treatment or durable medical good or goods.**

3. **The use of a HRA debit card is not a right under the Plan. Misuse or failure to timely submit documentation needed to support a debit card purchase within the sixty (60) day period will result in the permanent deactivation of the debit card.**

4. **Both the allowable expenses and maximum allowances can change, and that the Trustees reserve the right to eliminate or modify this benefit at any time and at their sole discretion**

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	
• Infertility treatment	• Long-term care	• Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery if preauthorized	• Chiropractic care - coverage is limited to $40 per visit and $1,500 annual maximum	
• Hearing aids - coverage is limited to $1,500 once every three years, and does not cover fitting, repair, or replacement batteries	• Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult)
• Smoking cessation programs subject to coverage criteria covered at 100% up to 2 per lifetime	• Transplant donor benefits (limited to $10,000 maximum benefit when participant is donor for a non-covered patient if there is no other plan or entity covering donor)	

[* For more information about limitations and exceptions, see the plan or policy document at www.ibew697benefits.org.]

*** The maximum allowable amount for out-of-network facility charges is 130% of RBRVS (the Medicare allowable).*

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 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: 1-219-845-4433.

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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-219-845-4433.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-219-845-4433.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-219-845-4433.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-219-845-4433.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

Subject to Plan and IRS rules, your deductibles and coinsurance, charges in excess of Plan limitations, and certain services not covered by the Plan may be reimbursable under the Plan's Health Reimbursement Arrangement benefit.

[* For more information about limitations and exceptions, see the plan or policy document at www.ibew697benefits.org.]

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)

Cost sharing

The plan's overall deductible	**$200**
In-network specialist	**10%**
Level B Hospital	**10%**
Other in-network providers	**10%**

This EXAMPLE the patient has met the deductible and the event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services ($2,500)
Childbirth/Delivery Facility Services ($7,800)
Diagnostic tests *(ultrasounds and blood work = $900)*
Specialist visit *(anesthesia =$1,500)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$1,450
What isn't covered	
Limits or exclusions	$60*
The total Peg would pay is	**$1,510.00**

**Genetic tests are excluded.*

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

Cost sharing

The plan's overall deductible	**$200**
In-network specialist	**10%**
Level B Hospital facility ($0.00)	**10%**
Other in-network providers ($0.00)	**10%**

This EXAMPLE the patient has not met their annual deductible and event includes services like:
Primary care physician office visits *(including disease education)($500)*
Diagnostic tests *($1,088)*
Prescription drugs ($3,512)
Durable medical equipment *($500)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Physician & Diagnostic Coinsurance	$288.80
Drug Coinsurance	$702.40
What isn't covered	
Limits or exclusions:	$0.00
The total Joe would pay is	**$1191.20.**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

Cost Sharing

The plan's overall deductible	**$200**
In-network ER physician	**10%**
Level A Hospital facility	**0%**
In-network physician for follow-up	**10%**

In this EXAMPLE the patient has not met their annual deductible and includes a:
Level A - emergency room *(including medical supplies, diagnostic testing and crutches = $2,000.00)*
In-network physical therapy = *($800.00)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Total Physician Expense	$260
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$460.00**

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