SUMMARY OF BENEFITS—Effective as of June 1, 2017

The following chart highlights the key features of the Plan in effect as of **June 1, 2017**. These benefits are described in detail in the Plan's Summary Plan Description/Plan Document benefit booklet. **Note:** Calendar Year refers to the period from January 1 through December 31 of each year. **All inpatient and certain outpatient services require pre-authorization.**

Remember to present your ID card to any provider of service to ensure that the Fund is only paying claims based on the negotiated rates for In-Network providers. If you do not provide this information to the network provider within 30 days of the date of service, your claim may be processed at the Out-of-Network level of benefits and therefore, in many instances, may not be covered. Any covered Out-of-Network charges are limited to Usual, Customary and Reasonable (UCR) amounts.

Plan Provisions (All medical benefits are subject to the applicable deductible and co-insurance, unless otherwise noted)	
Annual Deductible[1] (June 1 - May 31)	**You pay:**
Medical (In-Network)	$250 per person; $750 per family
Medical (Out-of-Network)	$500 per person; $1,500 per family
Annual Out-of-Pocket Maximum (January 1 – December 31)	**You pay:**
In-Network	$3,500 per person; $7,000 per family
Out-of-Network (Does not include excess of UCR)	$5,000 per person; $10,000 per family
Co-insurance for In-Network Coverage	**You pay:**
Emergency Room[2]	$50 per occurrence
Medicare & Non-Medicare Eligible Participants	Plan covers, unless otherwise specified:
In-Network Hospital / Facility	95%
In-Network Physician / Professional	90%
Emergency Ambulance Services—Ground / Air Transport[2]	**Plan covers:**
Hospital / Facility	95%
Physician / Professional	90%
Co-insurance for Out-of-Network Coverage	**Plan covers:**
Hospital / Facility	75% of UCR
Physician / Professional	70% of UCR
Benefits With In-Network Coverage Only. No coverage for Out-of-Network Providers. (Benefits are subject to the applicable deductible and co-insurance, unless otherwise noted)	
	Plan covers:
Routine Physical Examination, Pap Smear and Mammogram[3]	
Adult (Participant and Spouse)	
Health Dynamics Provider	100%; no deductible
Non-Health Dynamics Provider	90%; in-network only
Dependent Child	90%; in-network only
Immunizations: Adults and Children	100%
Mental Health and Substance Abuse Treatment	100%; no deductible; in-network only
Custom Foot Orthotics	$350 per person per calendar year; in-network only
Diabetic Shoes	$700 per person per calendar year; in-network only
Occupational Therapy and Physical Therapy	40 visits (combined) per person per calendar year; in-network only
Speech Therapy (pre-authorization required)[4]	In-network only
Temporomandibular Joint Disorder (Non-Surgical)	$2,000 per person per lifetime; in-network only
Infertility Benefits	$2,000 per person per lifetime; in-network only
Employee Assistance Program (EAP) Call Anthem at 1-800-865-1044	100% on up to five visits per issue such as mental health, substance abuse, stress and family matters
Transplant Benefits[5]	
Co-insurance	100%; no deductible; in-network only
Transportation, Lodging and Meal Maximums	$150 per day, up to $10,000 per procedure
Private Nursing Care Maximum	$10,000 per procedure; in-network only

Benefits With In-Network & Out-of-Network Coverage[6]		
	Plan covers:	
Treatment/Services in the Event of an Emergency	Applicable in-network or out-of-network co-insurance	
Radiologist, Pathologist and Anesthesiologist Services	Applicable in-network or out-of-network co-insurance	
Emergency Room Physician and Laboratory Technician Services	Applicable in-network or out-of-network co-insurance	
Chiropractic Therapy	Applicable in-network or out-of-network co-insurance; up to $1,200 per person per calendar year	
Acupuncture	90%, up to $1,200 per person per calendar year	
Hearing Care	Applicable in-network or out-of-network co-insurance	
Hearing Examination	One exam per person per calendar year	
Hearing Aids (Provider Services)	$6,000 per person in any 72-month period	
Hearing Aid Repair	$300 per person per calendar year	
Prescription Drug Benefits, Up to a 90-Day Supply		
	Plan covers:	
Generic Drugs	90%; no deductible	
Brand Name Drugs	80%; no deductible	
Specialty Drugs		
Co-insurance	80%; you pay 20%, up to $200 per prescription	
Out-of-Pocket Maximum	100%, after you reach a $3,000 specialty drug out-of-pocket maximum per calendar year	
Dental Benefits (Optional Under Retiree Coverage)		
Co-insurance	**Plan covers:**	
Diagnostic and Preventive Care	90% of UCR	
Routine Dental Care	80% of UCR	
Calendar Year Maximum for Routine Dental Care Only	$2,500 per person	
Orthodontics (Dependent Children Only)	80% of UCR; $5,000 per person lifetime maximum; no maximum for dependent children under age 19	
Vision Benefits (Optional Under Retiree Coverage)		
	Plan covers:	
Exam Maximum	100%; one exam per person per calendar year	
Lenses, Frames and Contacts	100%, up to $300 per person every two calendar years	
Loss of Time Benefits (Active Participants Only)[7]		
Weekly Benefit	$325	
Maximum Duration	26 weeks	
Death and Dismemberment Benefits (Participants Only)	**Active Employee**	**Retired Employee**
Death Benefit[8]	$20,000	$10,000
Accidental Death Benefit (Full Amount)[9]	$20,000	$5,000

1 *If only two members of your family are covered under the Plan, the family maximum is double the per person amount. Annual deductibles are waived for active employees if they work 2,600 or more hours for which contributions are made on their behalf to the Fund in the preceding Calendar Year. In addition, if an active participant works 2,900 or more hours for which contributions are made on their behalf to the Fund in the preceding Calendar Year, the annual deductibles are waived for the participant and spouse.*

2 *The co-insurance amount is in addition to any other amounts you are responsible to pay and does not apply toward meeting your annual out-of-pocket maximum. The co-insurance is waived if you are admitted to the hospital. In addition, the Fund covers emergency ambulance services received out-of-network in the event of an emergency.*

3 *Includes coverage for associated office visits and outpatient visits.*

4 *Benefits for speech therapy are paid based on medical necessity alone. You must obtain pre-authorization and follow the authorized treatment plan for expenses to be covered.*

5 *Transplant Benefit provisions do not apply for Medicare-primary participants and dependents. Transplant coverage for Medicare-primary participants and dependents is provided under the Plan's Comprehensive Medical Benefits. Transplant must be performed by in-network provider.*

6 *The Fund does not cover the costs of services you receive from out-of-network providers, except for those listed. Radiologist, pathologist, anesthesiologist and emergency room physician and laboratory technician services are covered out-of-network when performed at an in-network facility or doctor's office (regardless of whether or not the individual providing the service is an in-network provider).*

7 *If the non-job related disability is due to a mental health issue, eating disorder, or substance abuse, benefits are only payable while you are confined in the hospital.*

8 *You are eligible to receive an "accelerated benefit" of up to 50% of your basic life insurance amount if you become terminally ill due to an injury or illness. However, the benefit will not exceed $10,000 for active participants and $5,000 for retirees.*

9 *This benefit is in addition to the Death Benefit.*