This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by emailing ieew@rehnonline.com or by calling 1-800-872-8979.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$300** person / **$900** family Does not apply to prescription drugs from network pharmacies, routine dental and vision services, preventive care, pre-admission testing, or surgical second opinions.	You must pay all the costs up to the **deductible**amount before thisplan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible**starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there otherdeductiblesfor specific services?	**Yes.** $25 person/$75 family for routine dental services. 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.
Is there an out–of–pocket limiton my expenses?	Yes **$2,500 per person.**	The **out-of-pocket limit**is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Deductibles, copays, balance-billed charges, prescription drugs, routine dental and vision services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limiton what the plan pays?	**No.**	The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a networkof providers?	Yes. For a list of participating providers, seewww.aetna.com or call (800) 872-8979.	If you use an in-network doctor or other health care **provider**, thisplan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participatingfor **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist**you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services thisplan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-872-8979 or email ieew@rehnonline.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa or call 1-800-872-8979 to request a copy.

- **Copayments**are fixed dollar amounts (for example, $20) you pay for covered health care, usually when you receive the service.
- **Coinsurance**is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount**for the service. For example, if theplan's **allowed amount**for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network**provider**charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount**is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **PPO networkproviders**by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use anIn-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after the deductible	20% coinsurance after the deductible	None.
	Specialist visit	20% coinsurance after the deductible	20% coinsurance after the deductible	None.
	Other practitioner office visit	20% coinsurance after the deductible	20% coinsurance after the deductible	Acupuncture and massage therapy are not covered.
	Preventive care/screening/immunization	No charge	No charge	Employees and dependents: One routine physical exam per year, including lab, x-ray and recommended cancer screenings. Well baby exams: seven exams up to age 12 months. Immunizations: as recommended by the Center for Disease Control and Prevention.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after the deductible	20% coinsurance after the deductible	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after the deductible	20% coinsurance after the deductible	None.

Common Medical Event	Services You May Need	Your Cost If You Use anIn-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage**is available at www.savrx.com.	Generic drugs	Retail: $5 copay/prescription Mail Order: $10 copay/prescription	20% coinsurance	Covers up to a 30-day supply; 90 day supply for mail order drugs.
	Preferred brand drugs	Retail: $25 copay/prescription Mail Order: $50 copay/prescription	20% coinsurance	
	Non-Preferred brand drugs	Retail: $25 copay/prescription Mail Order: $50 copay/prescription	20% coinsurance	Covers up to a 30-day supply; 90 day supply for mail order drugs.
	Specialty Drugs	Retail: $25 copay/prescription Mail Order: $50 copay/prescription	20% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after the deductible	20% coinsurance after the deductible	Should be pre-certified.
	Physician/surgeon fees	20% coinsurance after the deductible	20% coinsurance after the deductible	
If you need immediate medical attention	Emergency room services	20% coinsurance after the deductible	20% coinsurance after the deductible	None.
	Emergency medical transportation	20% coinsurance after the deductible	20% coinsurance after the deductible	None.
	Urgent care	20% coinsurance after the deductible	20% coinsurance after the deductible	None.

If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after the deductible	20% coinsurance after the deductible	Services should be pre-certified. Certain surgeries are required to be performed on an outpatient basis. Unless inpatient care is determined to be medically necessary, surgery related charges for these surgeries will be paid at 50% if performed on an inpatient basis.
	Physician/surgeon fee	20% coinsurance after the deductible	20% coinsurance after the deductible	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance after the deductible	20% coinsurance after the deductible	None.
	Mental/Behavioral health inpatient services	20% coinsurance after the deductible	20% coinsurance after the deductible	None.
	Substance use disorder outpatient services	20% coinsurance after the deductible	20% coinsurance after the deductible	Services must be furnished by a state-approved treatment program.
	Substance use disorder inpatient services	20% coinsurance after the deductible	20% coinsurance after the deductible	Services must be furnished by a state-approved treatment program.
If you are pregnant	Prenatal and postnatal care	20% coinsurance after the deductible	20% coinsurance after the deductible	None.
	Delivery and all inpatient services	20% coinsurance after the deductible	20% coinsurance after the deductible	None.

If you need help recovering or have other special health needs	Home health care	20% coinsurance after the deductible	20% coinsurance after the deductible	Up to 130 visits per person per calendar year. Services should be pre-certified.
	Rehabilitation services	20% coinsurance after the deductible	20% coinsurance after the deductible	Services should be pre-certified.
	Habilitation services	Not covered	Not covered	Not covered.
	Skilled nursing care	20% coinsurance after the deductible	20% coinsurance after the deductible	Services should be pre-certified.
	Durable medical equipment	20% coinsurance after the deductible	20% coinsurance after the deductible	Services should be pre-certified.
	Hospice service	20% coinsurance after the deductible	20% coinsurance after the deductible	Services should be pre-certified.
If your child needs dental or eye care	Eye exam	20% coinsurance plus any charges over $185	20% coinsurance plus any charges over $185	One exam per person per year.
	Glasses	For lenses, 20% coinsurance plus any charges over $135 per pair. For frames, any charges over $100 per frame.	For lenses, 20% coinsurance plus any charges over $135 per pair. For frames, any charges over $100 per frame.	One pair of lenses per calendar year. One set of frames every 2 calendar years.
	Dental check-up	$25 deductible then 30% of usual and customary charges in first year, 20% in second year, 10% in third year, 0% in fourth year or later provided you visit a dentist at least once each calendar year.	$25 deductible then 30% of usual and customary charges in first year, 20% in second year, 10% in third year, 0% in fourth year or later provided you visit a dentist at least once each calendar year.	No more than two exams in a calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Dental care (Adult)
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-331-6158. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to**appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Inland Empire Electrical Workers Health and Welfare Trust, PO Box 5433, Spokane WA 99205, 1-800-872-8979. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy doesprovide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Actestablishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coveragedoesmeet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtenerasistencia en Español, llame al 1-800-872-8979

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations.Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under thisplan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,690
- **Patient pays** $1,850

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Copays	$10
Coinsurance	$1,390
Limits or exclusions	$150
Total	**$1,850**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:**$5,400
- **Plan pays** $4,380
- **Patient pays** $1,020

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$200
Coinsurance	$440
Limits or exclusions	$80
Total	**$1,020**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or healthplan.
- The patient'scondition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.**Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.**Coverage Examplesare **not** cost estimators. You can't use the examples to estimate costs for an actual condition. Theyare for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers**charge, and the reimbursement your healthplan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "PatientPays" boxin each example. The smaller that number, the more coverage the planprovides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium**you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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