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, contact the Fund Office at (440) 260-0615. 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.healthcare.gov/sbc-glossary/ or call 1-440-260-0615 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In-Network Services: $280/Individual or $560/family For Out-of-Network Services: $1,000/Individual or $2,000/family	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.	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 preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $1,400 individual / $2,800 family; for out-of-network providers $5,000 individual / $10,000 family	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?	Copayments for certain services, prescription drugs, balance-billing charges, and health care this plan doesn't 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. Call 1-833-227-9002 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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network 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	$20 copayment /visit	40% coinsurance	None
	Specialist visit	$20 copayment /visit	40% coinsurance	None
	Preventive care/screening/ immunization	No charge for the first $300, then 20% coinsurance	40% coinsurance	None
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-440-260-0615.	Generic drugs	$10 copayment retail; $20 copayment mail order		The deductible does not apply. The Plan covers over the counter Prilosec, Claritin, and Claritin-D at a $0 co-pay. The Plan utilizes a Mandatory Generic Program. You are responsible for the cost difference of the generic versus the brand drug in addition to the applicable co-pay if you choose a brand drug over the generic equivalent. Certain Specialty drugs require participation in the Plan's Specialty Healthcare Advocacy Program, which requires completion of an application process and meeting medical necessity and step-therapy criteria required to receive coverage. If you do not participate in this program, there will be no coverage for Specialty drugs for which this applies.
	Preferred brand drugs (per formulary)	$30 copayment retail; $60 copayment mail order		
	Non-preferred brand drugs (per formulary)	$60 copayment retail; $120 copayment mail order		
	Specialty drugs (brand and generic)	In addition to the co-pays listed above, injectable drugs are covered with a 20% co-pay and must be preauthorized. There is an annual out-of-pocket maximum on injectable prescription drugs of $5,000.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copayment; 20% coinsurance for other services	$100 copayment; 20% coinsurance for other services; plus charges in excess of allowed amount.	$100 copayment is waived if admitted
	Emergency medical transportation	20% coinsurance	40% coinsurance	
	Urgent care	$35 copayment	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	No coverage above the semi-private room rate.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Limited to 1 visit/day.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Maternity benefits are for you and your legal spouse only; no other Dependents are eligible for maternity benefits. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	None
	Rehabilitation services	20% coinsurance	40% coinsurance	24 visits per year combined for Physical Therapy and Occupational Therapy.
	Habilitation services	20% coinsurance	40% coinsurance	24 visits per year for Speech Therapy.
	Skilled nursing care	20% coinsurance	40% coinsurance	100 days per year.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge for children age 18 and under		Permitted once per calendar year. $75 maximum for those age 19 and over.
	Children's glasses	Charges over the following amounts for every 2 year period: $275 for Single Vision RX Lenses and Frames; $325 for Bi-Focal RX Lenses and Frames; $345 for Tri-Focal RX Lenses and Frames; $365 for Lenticular Lenses and Frames; $240 for Contact Lenses.		One LASIK eye surgery covered per lifetime for adults age 19 and over with maximum benefit of $750
	Children's dental check-up	No charge.	Balance due after Plan pays 80% of fixed schedule	Maximum benefit of $1,000 per insured (no annual maximum for children age 18 and under); Limited to two examinations and cleanings per participant 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
- Infertility Treatment
- Long-term Care
- Routine Foot Care
- Weight Loss Programs

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

- Chiropractic care (12 visits per year)
- Dental care (Adult)
- Hearing Aids ($2,000/year, every 3 years)
- Non-emergency care when traveling outside U.S.
- Private-duty nursing
- Routine eye care (Adult)

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: 1-440-260-0615 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-440-260-0615.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-440-260-0615

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-440-260-0615.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-440-260-0615.

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	$280
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$280
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,440**

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

The plan's overall deductible	$280
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$280
Copayments	$500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$900**

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

The plan's overall deductible	$280
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$280
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$880**

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