
 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, visit www.tristatewelfarefund.com or call 1-844-395-4467. 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 1-844-395-4467 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$300 person/\$600 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<u>In-network</u> : \$5,000 person/ \$10,000 family; <u>Out-of-network</u> : No limits	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> does not cover, and <u>out-of-network</u> expenses.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. Call 1-800-810-2583 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		In-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% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com	Generic drugs	Therapeutic class: No charge (retail and mail order); Other drugs: \$7.50 <u>copay</u> /fill retail/\$15 <u>copay</u> /fill mail order	Full price of the prescription minus amount the <u>in-network</u> pharmacy would have paid	Retail: 34-day supply or 100 units Mail Order: 90-day supply
	Preferred brand drugs	Therapeutic class: \$10 <u>copay</u> /fill (retail)/\$20 <u>copay</u> /fill (mail order); Other drugs: 20% <u>coinsurance</u> up to \$50 (retail)/ 20% <u>coinsurance</u> up to \$100 (mail order)	Full price of the prescription minus amount the <u>in-network</u> pharmacy would have paid	Retail: 34-day supply or 100 units Mail Order: 90-day supply You must pay the difference the difference between the brand name and generic plus the brand name <u>copay</u> if you receive a brand name drug when a generic is available.
	Non-preferred brand drugs	Therapeutic class: \$20 <u>copay</u> /fill (retail)/\$40 <u>copay</u> /fill (mail order); Other drugs: 30% <u>coinsurance</u> up to \$75 (retail)/ 30% <u>coinsurance</u> up to \$150 (mail order)	Full price of the prescription minus amount the <u>in-network</u> pharmacy would have paid	Retail: 34-day supply or 100 units Mail Order: 90-day supply You must pay the difference the difference between the brand name and generic plus the brand name <u>copay</u> if you receive a brand name drug when a generic is available.
	<u>Specialty drugs</u>	Same <u>cost sharing</u> as generic, preferred brand, and non-preferred brand drug, depending on the type of <u>specialty drug</u>	Full price of the prescription minus amount the <u>in-network</u> pharmacy would have paid	Retail: 34-day supply or 100 units Mail Order: 90-day supply

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$50 <u>copay/visit</u>	\$50 <u>copay/visit</u>	<u>Copay</u> waved if admitted to the hospital.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Air ambulance charges limited to 300% of the Medicare reimbursement rate.
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> will result in \$200 penalty. Private rooms covered only if <u>medically necessary</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits, intensive outpatient services, and partial hospitalization: 20% <u>coinsurance</u>	Office visits, intensive outpatient services, and partial hospitalization: 40% <u>coinsurance</u>	None
	Inpatient services	Acute inpatient admission and residential treatment facilities: 20% <u>coinsurance</u>	Acute inpatient admission and residential treatment facilities: 40% <u>coinsurance</u>	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> will result in \$200 penalty. Private rooms covered only if <u>medically necessary</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Private rooms covered only if <u>medically necessary</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage is limited to 100 visits per year.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 120 days per year. <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> will result in \$200 penalty.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Must be diagnosed as terminally ill with a life expectancy of 6 months or less. Pre-approval is required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of this service, even <u>in-network</u> .
	Children's glasses	Not covered	Not covered	You must pay 100% of this service, even <u>in-network</u> .
	Children's dental check-up	Not covered	Not covered	You must pay 100% of this service, even <u>in-network</u> .

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.)

- Bariatric surgery
- Cosmetic surgery (Except for injury and reconstructive surgery following mastectomy)
- Dental Care (Adult and Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult and Child)
- 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.)

- Acupuncture
- Chiropractic care
- Hearing aids (up to \$2,500 per ear, once every 36 months [active and retired employees only])
- Infertility treatment
- Private-duty nursing

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 1-866-444-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: Group Administrators at 1-847-519-1880. You may also contact 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:

Para obtener asistencia en Español, llame al 1-844-395-4467.

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 \$300
- Specialist coinsurance 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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,380
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,750

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

- The plan's overall deductible \$300
- Specialist coinsurance 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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$90
<u>Coinsurance</u>	\$940
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Joe would pay is	\$1,400

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

- The plan's overall deductible \$300
- Specialist coinsurance 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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$60
<u>Coinsurance</u>	\$430
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$790