**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 deductible?** | **$300** person/**$600** 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 policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care, some vision care expenses, and dental preventive care services 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. |
| **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?** | In-network: **$5,000** person/ **$10,000** family; Out-of-Network: No limits | 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?** | Premiums, balance-billing charges, out-of-network expenses, and health care this plan does not 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 1-800-810-2583 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 |
|---|---|---|---|---|
| | | 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% coinsurance | 40% coinsurance | None |
| | Specialist visit | 20% coinsurance | 40% coinsurance | None |
| | Preventive care/screening/ immunization | No charge. Deductible does not apply. | No charge. Deductible does not apply. | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% 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 www.express-scripts.com | Generic drugs | Therapeutic class: No charge (retail and mail order); Other drugs: $7.50 copay/fill (retail)/$15 copay/fill (mail order) | Full price of the prescription minus amount the in-network pharmacy would have paid | Retail: 34-day supply or 100 units<br>Mail Order:90-day supply |
| | Preferred brand drugs | Therapeutic class: $10 copay/fill (retail)/$20 copay/fill (mail order); Other drugs: 20% coinsurance up to $50 (retail)/20% coinsurance up to $100 (mail order) | Full price of the prescription minus amount the in-network pharmacy would have paid | Retail: 34-day supply or 100 units<br>Mail Order: 90-day supply<br>You must pay the difference between the brand name and generic plus the brand name copay if you receive a brand name drug when a generic is available. |
| | Non-preferred brand drugs | Therapeutic class: $20 copay/fill (retail)/$40 copay/fill (mail order); Other drugs: 30% coinsurance up to $75 (retail)/30% coinsurance up to $150 (mail order) | Full price of the prescription minus amount the in-network pharmacy would have paid | Retail: 34-day supply or 100 units<br>Mail Order: 90-day supply<br>You must pay the difference between the brand name and generic plus the brand name copay if you receive a brand name drug when a generic is available. |
| | Specialty drugs | Same cost sharing as generic, preferred brand, and non-preferred brand drugs, depending on the type of specialty drug | Full price of the prescription minus amount the network pharmacy would have paid | Retail: 34-day supply or 100 units<br>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% coinsurance | 40% coinsurance | None |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $50 copay/visit | $50 copay/visit | Copay waved if admitted. |
| | Emergency medical transportation | 20% coinsurance | 40% coinsurance | Air ambulance charges limited to 300% of the Medicare reimbursement rate. |
| | Urgent care | 20% coinsurance | 40% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Failure to obtain pre-approval results in $200 penalty. Private rooms covered only if medically necessary. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office visits, intensive outpatient services, and partial hospitalization: 20% coinsurance | Office visits, intensive outpatient services, and partial hospitalization: 40% coinsurance | None |
| | Inpatient services | Acute inpatient admission and residential treatment facilities: 20% coinsurance | Acute inpatient admission and residential treatment facilities: 40% coinsurance | Failure to obtain pre-approval results in $200 penalty. Private rooms covered only if medically necessary. |
| **If you are pregnant** | Office visits | 20% coinsurance | 40% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Private rooms covered only if medically necessary. |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |

| 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 need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | Coverage is limited to 100 visits per calendar year. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | None |
| | Habilitation services | 20% coinsurance | 40% coinsurance | None |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Limited to 120 days per calendar year. Failure to obtain pre-approval results in $200 penalty. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | None |
| | Hospice services | 20% coinsurance | 40% coinsurance | 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 | No charge and deductible does not apply up to $200, then not covered | No charge and deductible does not apply up to $200 total out-of-network vision care allowance, then not covered | Vision benefits are administered separately by VSP. No charge and deductible does not apply for in-network contact lens exam. $200 maximum per person per calendar year for in-network comprehensive eye exam. $200 combined allowance per person per calendar year for out-of-network vision care expenses. Not covered for Local 498 Retirees. |
| | Children's glasses | Lenses: No charge and deductible does not apply; Frames: No charge and deductible does not apply up to $200, then not covered | No charge and deductible does not apply up to $200 total out-of-network vision care allowance, then not covered | $200 maximum per person per calendar year for in-network frames. $200 combined allowance per person per calendar year for out-of-network vision care expenses. Not covered for Local 498 Retirees. |
| | Children's dental check-up | No charge. Deductible does not apply. | No charge. Deductible does not apply. | Coverage is limited to two (2) exams per person 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.)**

- Bariatric surgery
- Cosmetic surgery (except for injury and reconstructive surgery following mastectomy)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- Dental care (Adult) (up to $1,000 per person per calendar year, but limit does not apply to dental exams for individuals under age 19; $1,000 lifetime maximum for orthodontic services)
- Hearing aids (Maximum of $2,500 per ear and $5,000 for a pair every 36 months)
- Infertility treatment
- Private-duty nursing
- Routine eye care (Adult) (up to $200 per person per calendar year for eye exam and frames) (Not covered for Local 498 Retirees)

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $10 |
| Coinsurance | $2,380 |
| *What isn't covered* | |
| 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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $90 |
| Coinsurance | $940 |
| *What isn't covered* | |
| 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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $60 |
| Coinsurance | $430 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$790** |

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