**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, call 419-666-4450. 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 https://www.healthcare.gov/sbcglossary or call 419-666-4450 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$400** individual/**$800** 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 and services listed as "No charge." | 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?** | **$25**/individual for dental | 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. |
| **What is the out-of-pocket limit for this plan?** | **Yes. $1,500** individual/**$3,000** family; **$1,000** generic Rx drugs per family pre-Medicare/$500 per individual for Medicare enrollees. | 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, the overall family out-of-pocket limit must be met. |
| **What is not included in the out-of-pocket limit?** | Premiums, deductibles, balance-billed charges, health care this Plan doesn't cover, and failure to preauthorize penalties. | 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.** See www.frontpath.com for a list of in-network providers. The Plan also uses Express Scripts' pharmacies, EyeMed vision providers, and Delta Dental providers. Contact the Fund Office at 419-666-4450 for more information. | You pay the least if you use a provider in network. You pay more if you use a provider in out-of-network/discounted. You will pay the most if you use an out-of-network/non-discounted 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 per visit | $20 copayment per visit | If you visit an out-of-network provider, you could be subject to a balance bill.<br><br>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. |
| | Specialist visit | $20 copayment per visit | $20 copayment per visit | |
| | Preventive care/screening/ Immunization | No charge | 40% coinsurance after deductible | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance after deductible | 40% coinsurance after deductible | If you visit an out-of-network provider, you could be subject to a balance bill.<br><br>Mammography and colonoscopies are covered at no charge. Imaging requires precertification. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance after deductible | 40% coinsurance after deductible | |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.electricalfunds.org | Generic drugs | $10 copayment until $1,000 maximum, then $0 | Participants may be required to pay for prescriptions at nonparticipating pharmacies and submit receipts for reimbursement, less applicable copayment and amounts that exceed allowed limit. | 90-day supply available. Kroger Pharmacies will reduce all co-pays by $1.<br><br>If a generic is available, a brand drug costs the generic co-pay plus the cost difference between the generic/brand.<br><br>Compounded drugs costing more than $100 must be pre-authorized; all compounds require brand drug co-pay. |
| | Brand Drugs | $30 copayment until $1,000 maximum, then $10 | | |
| | Specialty drugs | $50 copayment until $1,000 maximum, then $25 | Not covered | Precertification req'd. Certain drugs are non-essential benefits and will not apply to max. Copay may be set and paid by manufacturer. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible | 40% coinsurance after deductible | If you visit an out-of-network provider, you could be subject to a balance bill. |
| | Physician/surgeon fees | 20% coinsurance after deductible | 40% coinsurance after deductible | |

[* For more information about limitations and exceptions, see the plan or policy document at www.electricalfunds.org.]

| 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 | $200 copayment, then 20% coinsurance after deductible | $200 copayment, then 20% coinsurance after deductible | Copayment waived if admitted to the hospital.<br><br>If you visit an out-of-network provider, you could be subject to a balance bill. |
| | Emergency medical transportation | 20% coinsurance after deductible | 40% coinsurance after deductible | |
| | Urgent care | $20 copayment, then 20% coinsurance after deductible | $20 copayment, then 40% coinsurance after deductible | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance after deductible | 40% coinsurance after deductible | If you visit an out-of-network provider, you could be subject to a balance bill. |
| | Physician/surgeon fees | 20% coinsurance after deductible | 40% coinsurance after deductible | If you visit an out-of-network provider, you could be subject to a balance bill. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance after deductible | 40% coinsurance after deductible | If you visit an out-of-network provider, you could be subject to a balance bill. |
| | Inpatient services | 20% coinsurance after deductible | 40% coinsurance after deductible | If you visit an out-of-network provider, you could be subject to a balance bill. |
| **If you are pregnant** | Office visits | $20 copayment per visit | $20 copayment per visit | If you visit an out-of-network provider, you could be subject to a balance bill.<br><br>No preauthorization required for 48 hours/vaginal birth or 96 hours/cesarean section. All other inpatient services must be pre-certified. |
| | Childbirth/delivery professional services | 20% coinsurance after deductible | 40% coinsurance after deductible | |
| | Childbirth/delivery facility services | 20% coinsurance after deductible | 40% coinsurance after deductible | |

[* For more information about limitations and exceptions, see the plan or policy document at www.electricalfunds.org.]

| 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 help recovering or have other special health needs** | Home health care | 20% coinsurance after deductible | 40% coinsurance after deductible | Home health, skilled nursing, and hospice services, and durable medical equipment in excess of $1,500 must be pre-certified.<br><br>If you visit an out-of-network provider, you could be subject to a balance bill. |
| | Rehabilitation services | | | |
| | Habilitation services | | | |
| | Skilled nursing care | | | |
| | Durable medical equipment | | | |
| | Hospice services | | | |
| **If your child needs dental or eye care** | Children's eye exam (EyeMed) | $10 copayment | $35 allowance | Non- EyeMed lens coverage is:<br>$25 allowance – single,<br>$40 allowance – bifocal,<br>$55 allowance – trifocal,<br>$80 allowance – lenticular<br><br>Medically necessary contacts covered at 100% in-network/$210 allowance out-of-network |
| | Children's glasses | $25 co-pay for any type lenses; $170 allowance for frames and up to $120 allowance for elective contacts. | Tiered allowance for lenses. $45 allowance for frames; up to $105 allowance for elective contacts. | |
| | Children's dental check-up | No charge of fee schedule | 100% of fee schedule amount for two cleanings/exams per year | Exams are not subject to the annual deductible. Non Delta Dental providers may not accept the fee schedule amount as payment in full. Benefits limited to $1,250 per year, per person. |

[* For more information about limitations and exceptions, see the plan or policy document at www.electricalfunds.org.]

## 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
- Long-term Care
- Non-emergency care when travelling outside the U.S unless service is normally covered
- Routine Foot Care (other than surgery)
- 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)
- Hearing Aids
- Infertility Treatment (diagnostic only)
- 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: 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 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: the Plan at 419-666-4450 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**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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.

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

[* For more information about limitations and exceptions, see the plan or policy document at www.electricalfunds.org.]

## 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** | **$400** |
| **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 | $400 |
| Copayments | $0 |
| Coinsurance | $1,250 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,700** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$400** |
| **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** | **$7,400** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $400 |
| Copayments | $900 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $30 |
| **The total Joe would pay is** | **$1,600** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$400** |
| **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** | **$1,900** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $400 |
| Copayments | $200 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$900** |

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