




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?	\$0 – This plan coordinates with Medicare and pays the part A & B deductibles.	See the Common Medical Events chart below for services this plan covers.
Are there services covered before you meet your deductible?	There is no deductible.	While this plan has no deductible amount, 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
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. Annual out-of-pocket limits are coordinated with Medicare and limited to the Medicare-approved amount, less any payments made by Medicare or the Plan. \$500 generic Rx drugs per Medicare enrollee, \$1,000 per family for non-Medicare family members.	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 <a href="http://www.frontpath.com">www.frontpath.com</a> for a list of in-network providers. The Plan uses Express Scripts pharmacies, EyeMed vision providers, and Delta Dental providers. Contact the Fund at 419-666-4450 for 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?	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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	Covered up to 100% of Medicare-approved amount.	Covered up to 100% of Medicare-approved amount.	If you receive services from a <u>provider</u> that does not accept assignment of benefits from Medicare, you could be subject to a <u>balance bill</u> .  You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	<u>Specialist</u> visit			
	<u>Preventive care/screening/Immunization</u>			
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Covered up to 100% of Medicare-approved amount.	Covered up to 100% of Medicare-approved amount.	If you receive services from a <u>provider</u> that does not accept assignment of benefits from Medicare, you could be subject to a <u>balance bill</u> .
	Imaging (CT/PET scans, MRIs)			
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.electricalfunds.org">www.electricalfunds.org</a>	Generic drugs	\$10 <u>copayment</u> until maximum, then \$0	Participants may be required to pay for prescriptions at nonparticipating pharmacies and submit receipts for reimbursement, less applicable <u>copayment</u> and amounts that exceed <u>allowed limit</u> .	90-day supply available. Kroger Pharmacies will reduce all co-pays by \$1.  If a generic is available, a brand drug costs the generic co-pay plus the cost difference between the generic/brand.  Compounded drugs costing more than \$100 must be pre-authorized; all compounds require brand drug co-pay.
	Brand Drugs	\$30 <u>copayment</u> until maximum, then \$10		
	<u>Specialty drugs</u>	\$50 <u>copayment</u> until maximum, then \$25		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Covered up to 100% of Medicare-approved amount.		If you receive services from a <u>provider</u> that does not accept assignment of benefits from

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)	
	Physician/surgeon fees			Medicare, you could be subject to a <u>balance bill</u> .
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	Covered up to 100% of Medicare-approved amount.	Covered up to 100% of Medicare-approved amount.	If you receive services from a <u>provider</u> that does not accept assignment of benefits from Medicare, you could be subject to a <u>balance bill</u> .
	<u>Emergency medical transportation</u>			
	<u>Urgent care</u>			
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Covered up to 100% of Medicare-approved amount.	Covered up to 100% of Medicare-approved amount.	If you receive services from a <u>provider</u> that does not accept assignment of benefits from Medicare, you could be subject to a <u>balance bill</u> .
	Physician/surgeon fees			
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Covered up to 100% of Medicare-approved amount.	Covered up to 100% of Medicare-approved amount.	If you receive services from a <u>provider</u> that does not accept assignment of benefits from Medicare, you could be subject to a <u>balance bill</u> .
	Inpatient services			
<b>If you are pregnant</b>	Office visits	Covered up to 100% of Medicare-approved amount.	Covered up to 100% of Medicare-approved amount.	If you receive services from a <u>provider</u> that does not accept assignment of benefits from Medicare, you could be subject to a <u>balance bill</u> .
	Childbirth/delivery professional services			

[\* For more information about limitations and exceptions, see the plan or policy document at [www.electricalfunds.org](http://www.electricalfunds.org).]

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services			
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	Covered up to 100% of Medicare-approved amount.	Covered up to 100% of Medicare-approved amount.	If you receive services from a <u>provider</u> that does not accept assignment of benefits from Medicare, you could be subject to a <u>balance bill</u> .
	<u>Rehabilitation services</u>			
	<u>Habilitation services</u>			
	<u>Skilled nursing care</u>			
	<u>Durable medical equipment</u>			
	<u>Hospice services</u>			
<b>If your child needs dental or eye care</b>	Children's eye exam (EyeMed)	\$10 <u>copayment</u>	\$35 allowance	Non- EyeMed lens coverage is: \$25 allowance – single, \$40 allowance – bifocal, \$55 allowance – trifocal, \$80 allowance – lenticular
	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 <u>deductible</u> . 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](http://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](http://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](http://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](http://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.* —————

## 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 <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> copayment	\$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$0</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> copayment	\$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

#### 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$0</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> copayment	\$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

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