TOLEDO ELECTRICAL BENEFIT PLANS

Toledo Electrical Welfare Fund

Local No. 8 I.B.E.W. Retirement Plan & Trust

Mailing Address: P.O. Box 60408 • Rossford, Ohio 43460

December 1, 2016

Dear Participant,

What you need to know about this mailing:

- The Summary of Benefits & Coverage (SBC) is a required disclosure
- The SBC is presented in a standardized format that explains the health plan benefits and coverage
- We will be mailing multiple required notices this month
- If you would like to receive these notices electronically, please fill out the enclosed Email Opt In form and return to the Fund Office

Under the Affordable Care Act, the Toledo Electrical Welfare Fund is required to send a notification in a specific format called a Summary of Benefits and Coverage (SBC) explaining the health plan benefits and coverage. Under the law, a group health plan is required to provide participants with a concise document detailing, in plain language, simple and consistent information about the health plan benefits and coverage. This document will help you better understand the coverage that you have and allow you to easily compare different coverage options. It summarizes key features of the plan including covered benefits, cost-sharing provisions, and coverage limitations and exceptions. This is a legally required notice; no action is required.

If you have questions regarding this required disclosure, call the Funds Office at (419) 666-4450 or visit us at www.electricalfunds.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call the Fund's Office to request a copy.

We have enclosed a copy of our Email Opt In Form for you to return to our office if you would like to start receiving the required disclosures electronically. Your participation in the program is completely voluntary and at any time, you can opt-out by selecting "unsubscribe" at the bottom of each email communication. Should you decide to opt-out, these notices and communications will be provided to you through the U.S. postal mail at no additional charge.

As always you can also contact the Funds Office if you have questions.

Regards,

Toledo Electrical Benefits Plan

Suite 200 • 727 Lime City Road • Rossford, Ohio 43460 • (419) 666-4450 • FAX (419) 666-5410
E-mail: benefits@electricalfunds.org • Web: www.electricalfunds.org

Toledo Electrical Welfare Fund: Plan A – Actives

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 1/1/2017 – 12/31/2017

Coverage for: Individual/Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.electricalfunds.org or by calling the Fund's Office at (419) 666-4450.

Important Questions	Answers	Why this Matters:
What is the overall annual deductible?	FrontPath and Non-Discounted: **$250** indiv./**$500** family; Discounted non-FrontPath: **$500** indiv./**$1,000** family. Co-pays don't count toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes, there is a $25 per person annual deductible for dental benefits.	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.
Is there an annual out–of–pocket limit on my expenses?	**Yes.** FrontPath and Non-Discounted: **$1,250** indiv./**$2,500** family; Discounted non-FrontPath: **$2,500** indiv./**$5,000** family; **$1,000** generic Rx drugs per family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, deductibles, balance-billed charges, health care this Plan doesn't cover, and penalties for failure to pre-cert services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the Plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.frontpath.com for a list of in-network **providers**. The Plan also uses AmWINs pharmacies, VSP vision providers, and Dentemax dental providers. Contact the Fund's Office for contact information.	If you use an in-network doctor or health care **provider**, the plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their **network.** See the chart on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No, but some **specialist** care is subject to written pre-certification to the plan.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services.

Questions: Call the Fund's Office at (419) 666-4450 or visit us at www.electricalfunds.org.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call the Fund's Office to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Discounted Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay/visit	$20 co-pay/visit	If you visit an out-of-network non-discounted provider, you could be subject to a balance bill.
	Specialist visit	$20 co-pay/visit	$20 co-pay/visit	
	Other practitioner office visit	$20 co-pay/visit	$20 co-pay/visit	
	Preventive care/screening/immunization	No charge	40% co-insurance after deductible	
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance after deductible	40% co-insurance after deductible	If you visit an out-of-network non-discounted provider, you could be subject to a balance bill. Mammography and colonoscopies are covered at no charge. Imaging requires precertification.
	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible	40% co-insurance after deductible	

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Discounted Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available in the Fund's SPD.	Generic drugs	$10 co-pay before $1,000 limit. $0 after $1,000 limit	Participants may be required to pay for prescriptions at non-participating pharmacies and submit their receipts for reimbursement, less applicable co-pay and amounts that exceed reimbursement limits.	Kroger Pharmacies will reduce all co-pays by $1 and allow for up to a 90 day supply. 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 co-pay before $1,000 limit. $10 after $1,000 limit.		
	Specialty drugs	$30 co-pay before $1,000 limit. $10 after $1,000 limit.	Not Covered	No benefit without clinical pre-authorization. No coverage for specified specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	40% co-insurance after deductible	If you visit an out-of-network non-discounted provider, you could be subject to a balance bill.
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	
If you need immediate medical attention	Emergency room services	$100 co-pay, then 20% coinsurance after deductible	$100 co-pay, then 20% coinsurance after deductible	Co-pay waived if admitted to the hospital. If you visit an out-of-network non-discounted provider, you could be subject to a balance bill.
	Emergency medical transportation	20% co-insurance after deductible	40% co-insurance after deductible	
	Urgent care	$20 co-pay, then 20% coinsurance after deductible	$20 co-pay, then 40% co-insurance after deductible	

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Discounted Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible	40% co-insurance after deductible	If you visit an out-of-network non-discounted provider, you could be subject to a balance bill.
	Physician/surgeon fee	20% co-insurance after deductible	40% co-insurance after deductible	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	If you visit an out-of-network non-discounted provider, you could be subject to a balance bill. All inpatient and substance abuse services must be pre-certified.
	Mental/Behavioral health inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	
	Substance use disorder outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	
	Substance use disorder inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	
If you are pregnant	Prenatal and postnatal care	20% co-insurance after deductible	40% co-insurance after deductible	If you visit an out-of-network non-discounted provider, you could be subject to a balance bill. All inpatient services must be pre-certified
	Delivery and all inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Discounted Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% co-insurance after deductible	40% co-insurance after deductible	Home health, skilled nursing, and hospice services, and durable medical equipment in excess of $1,500 must be pre-certified. If you visit an out-of-network non-discounted provider, you could be subject to a balance bill.
	Rehabilitation services	20% co-insurance after deductible	40% co-insurance after deductible	
	Habilitation services	20% co-insurance after deductible	40% co-insurance after deductible	
	Skilled nursing care	20% co-insurance after deductible	40% co-insurance after deductible	
	Durable medical equipment	20% co-insurance after deductible	40% co-insurance after deductible	
	Hospice service	20% co-insurance after deductible	40% co-insurance after deductible	
If your child needs dental or eye care	Eye exam	**VSP Provider** $10 co-pay	**Non-VSP** $35 allowance	Non-VSP lens coverage is: $25 allowance – single, $40 allowance – bifocal, $55 allowance – trifocal, $80 allowance – lenticular Medically necessary contacts covered at 100% in-network/$210 allowance out-of-network
	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.	
	Dental check-up	**Dentemax Provider** Covers 100% of fee schedule amount for two cleanings/exams per year.	**Non-Dentemax Provider**	Exams are not subject to the annual deductible. Non-Dentemax providers may not accept the fee schedule amount as payment in full.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs.)

- Acupuncture
- Chiropractic Care
- Dental Care (adult)
- Hearing Aids
- Infertility Treatment (diagnostic only)
- Private-duty Nursing
- Routine Eye Care (adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 419-666-4450. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 419-666-4450 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at 419-666-4450. 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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,392
- **Patient pays** $2,148

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions (in hospital)	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Co-pays	$300[1]
Co-insurance	$1,348
Limits or exclusions	$0
Total	**$1,708**

[1] Assumes 10 generic Rxs and 10 office visits.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,560
- **Patient pays** $840

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$250
Co-pays	$360[1]
Co-insurance	$230[2]
Limits or exclusions	$0
Total	**$840**

[1] Assumes 12 generic Rxs and 12 office visits

[2] 20% of medical equip. and lab tests less deductible

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call the Fund's Office at (419) 666-4450 or visit us at www.electricalfunds.org.
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Toledo Electrical Welfare Fund: Plan B – Base Benefits

Coverage Period: 1/1/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.electricalfunds.org or by calling the Fund's Office at (419) 666-4450.

Important Questions	Answers	Why this Matters:
What is the overall annual deductible?	FrontPath and Non-Discounted: **$2,500** indiv./**$5,000** family; Discounted non-FrontPath: **$5,000** indiv./**$10,000** family. Co-pays don't count toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	**No.**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an annual out–of–pocket limit on my expenses?	**Yes.** FrontPath and Non-Discounted: **$1,500** indiv./**$3,000** family; Discounted non-FrontPath: **$2,500** indiv./**$5,000** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, deductibles, balance-billed charges, health care this Plan doesn't cover, and penalties for failure to pre-cert services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	**No.**	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.frontpath.com for a list of in-network **providers**. The Plan also uses AmWINs pharmacies, VSP vision **providers**, and Dentemax dental providers. Contact the Fund's Office for contact information.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	**No.**	You can see the **specialist** you choose without permission from this Plan.
Are there services this plan doesn't cover?	**Yes.**	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call the Fund's Office at (419) 666-4450 or visit us at www.electricalfunds.org.
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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay/visit	$20 co-pay/visit	If you visit an out-of-network non-discounted provider, you could be subject to a balance bill.
	Specialist visit	$20 co-pay/visit	$20 co-pay/visit	
	Other practitioner office visit	$20 co-pay/visit	$20 co-pay/visit	
	Preventive care/screening/immunization	No charge	40% co-insurance after deductible	
If you have a test	Diagnostic test (x-ray, blood work)	30% co-insurance after deductible	40% co-insurance after deductible	If you visit an out-of-network non-discounted provider, you could be subject to a balance bill. Mammography and colonoscopies are covered at 100%. Imaging requires precertification
	Imaging (CT/PET scans, MRIs)	30% co-insurance after deductible	40% co-insurance after deductible	

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available in the Fund's SPD.	Generic drugs	$10 co-pay	Participants may be required to pay for prescriptions at non-participating pharmacies and submit their receipts for reimbursement, less applicable co-pay and amounts that exceed reimbursement limits.	Kroger Pharmacies will reduce generic and brand name co-pays by $1 and allow for up to a 90 day supply. If a generic is available, Participant is responsible for the generic co-payment plus the cost difference between the generic and brand drug. Compounded drugs costing more than $100 must be pre-authorized; all compounds require brand drug co-pay. Specialty drugs require clinical pre-authorization. Some specialty drugs are not covered.
	Brand drugs	$30 co-pay		
	Specialty drugs	30% co-insurance		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-insurance after deductible	40% co-insurance after deductible	If you visit an out-of-network non-discounted provider, you could be subject to a balance bill.
	Physician/surgeon fees	30% co-insurance after deductible	40% co-insurance after deductible	
If you need immediate medical attention	Emergency room services	$100 co-pay, then 30% coinsurance after deductible	$100 co-pay, then 30% coinsurance after deductible	Co-pay waived if admitted to the hospital. If you visit an out-of-network non-discounted provider, you could be subject to a balance bill.
	Emergency medical transportation	30% co-insurance after deductible	40% co-insurance after deductible	
	Urgent care	$50 co-pay, then 30% co-insurance after deductible	$50 co-pay, then 40% co-insurance after deductible	

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance after deductible	40% co-insurance after deductible	If you visit an out-of-network non-discounted provider, you could be subject to a balance bill.
	Physician/surgeon fee	30% co-insurance after deductible	40% co-insurance after deductible	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% co-insurance after deductible	40% co-insurance after deductible	Inpatient and substance abuse services require pre-certification. If you visit an out-of-network non-discounted provider, you could be subject to a balance bill.
	Mental/Behavioral health inpatient services	30% co-insurance after deductible	40% co-insurance after deductible	
	Substance use disorder outpatient services	30% co-insurance after deductible	40% co-insurance after deductible	
	Substance use disorder inpatient services	30% co-insurance after deductible	40% co-insurance after deductible	
If you are pregnant	Prenatal and postnatal care	30% co-insurance after deductible	40% co-insurance after deductible	If you visit an out-of-network non-discounted provider, you could be subject to a balance bill. Inpatient services require pre-certification.
	Delivery and all inpatient services	30% co-insurance after deductible	40% co-insurance after deductible	

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% co-insurance after deductible	40% co-insurance after deductible	Home health, skilled nursing, and hospice services, and durable medical equipment in excess of $1,500 must be pre-certified. If you visit an out-of-network non-discounted provider, you could be subject to a balance bill.
	Rehabilitation services	20% co-insurance after deductible	40% co-insurance after deductible	
	Habilitation services	20% co-insurance after deductible	40% co-insurance after deductible	
	Skilled nursing care	20% co-insurance after deductible	40% co-insurance after deductible	
	Durable medical equipment	20% co-insurance after deductible	40% co-insurance after deductible	
	Hospice service	20% co-insurance after deductible	40% co-insurance after deductible	
If your child needs dental or eye care	Eye exam	**VSP Provider** $10 co-pay	**Non - VSP** $35 allowance	Non-VSP lens coverage is: $25 allowance – single, $40 allowance – bifocal, $55 allowance – trifocal, $80 allowance – lenticular Medically necessary contacts covered at 100% in-network/$210 allowance out-of-network
	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.	
	Dental check-up	**Dentemax Provider** No charge for the Dentemax fee schedule amount for two cleanings/exams per year.	**Non-Dentemax** Exams are not subject to the annual deductible. Non-Dentemax providers may not accept the fee schedule amount as payment in full.	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs.)

- Acupuncture
- Chiropractic Care
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment (diagnostic only)
- Private-duty Nursing
- Routine Eye Care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 419-666-4450. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 419-666/4450 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at 419-666-4450. 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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $1,568
- **Patient pays** $5,972

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions (in hospital)	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$5,000
Co-pays	$300[1]
Co-insurance	$672
Limits or exclusions	$0
Total	**$5,972**

[1] Assumes 10 generic Rxs and 10 office visits.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $1,778
- **Patient pays** $3,622

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,500
Co-pays	$360[1]
Co-insurance	$762
Limits or exclusions	$0
Total	**$3,622**

[1] Assumes 12 generic Rxs and 12 office visits.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call the Fund's Office at (419) 666-4450 or visit us at www.electricalfunds.org.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call the Fund's Office to request a copy.

Toledo Electrical Welfare Fund: Plan M – Medicare Supp.

Coverage Period: 1/1/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual/Family | Plan Type: Supplemental

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.electricalfunds.org or by calling the Fund's Office at (419) 666-4450.

Important Questions	Answers	Why this Matters:
What is the overall annual deductible?	**$0 –** This plan coordinates with Medicare and pays part A & B deductibles.	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an annual out–of–pocket limit on my expenses?	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; **$1,000** generic Rx drugs/family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, deductibles, balance-billed charges, health care this Plan doesn't cover, and penalties for failure to pre-cert services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.frontpath.com for a list of in-network **providers**. The Plan also uses AmWINs pharmacies, VSP vision providers, and Dentemax dental providers. Contact the Fund's Office for contact information.	If you use an in-network doctor or health care **provider**, the plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their **network.** See the chart on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No, but some **specialist** care is subject to written pre-certification to the plan.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services.

Questions: Call the Fund's Office at (419) 666-4450 or visit us at www.electricalfunds.org.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call the Fund's Office to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	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 provider that does not accept assignment of benefits from Medicare, you could be subject to a balance bill.
	Specialist visit			
	Other practitioner office visit			
	Preventive care/screening/immunization			
If you have a test	Diagnostic test (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 provider that does not accept assignment of benefits from Medicare, you could be subject to a balance bill.
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available in the Fund's SPD.	Generic drugs	$10 co-pay before $1,000 limit. $0 after $1,000 limit	Participants may be required to pay for prescriptions at non-participating pharmacies and submit their receipts for reimbursement, less applicable co-pay and amounts that exceed reimbursement limits.	Kroger Pharmacies will reduce all co-pays by $1 and allow for up to a 90 day supply. 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 co-pay before $1,000 limit. $10 after $1,000 limit.		
	Specialty drugs	$30 co-payment	Not Covered	No benefit without clinical pre-authorization. No coverage for specified specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Covered up to 100% of Medicare approved amount	Covered up to 100% of Medicare approved amount	If you receive services from a provider that does not accept assignment of benefits from Medicare, you could be subject to a balance bill.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	Covered up to 100% of Medicare approved amount	Covered up to 100% of Medicare approved amount	If you receive services from a provider that does not accept assignment of benefits from Medicare, you could be subject to a balance bill.
	Emergency medical transportation			
	Urgent care			

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	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 provider that does not accept assignment of benefits from Medicare, you could be subject to a balance bill.
	Physician/surgeon fee			
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Covered up to 100% of Medicare approved amount	Covered up to 100% of Medicare approved amount	If you receive services from a provider that does not accept assignment of benefits from Medicare, you could be subject to a balance bill.
	Mental/Behavioral health inpatient services			
	Substance use disorder outpatient services			
	Substance use disorder inpatient services			
If you are pregnant	Prenatal and postnatal care	Covered up to 100% of Medicare approved amount	Covered up to 100% of Medicare approved amount	If you receive services from a provider that does not accept assignment of benefits from Medicare, you could be subject to a balance bill.
	Delivery and all inpatient services			

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Covered up to 100% of Medicare approved amount	Covered up to 100% of Medicare approved amount	If you receive services from a provider that does not accept assignment of benefits from Medicare, you could be subject to a balance bill.
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice service			
If your child needs dental or eye care	Eye exam	**VSP Provider**	**Non-VSP Provider**	Non-VSP lens coverage is: $25 allowance – single, $40 allowance – bifocal, $55 allowance – trifocal, $80 allowance – lenticular Medically necessary contacts covered at 100% in-network/$210 allowance out-of-network
		$10 co-pay	$35 allowance	
	Glasses	$25 co-pay for any type lenses; $170 allowance for frames and up to $120 allowance for elective contacts.	$45 allowance for frames; up to $105 allowance for elective contacts	
	Dental check-up	**Dentemax Provider**	**Non-Dentemax Provider**	Exams are not subject to the annual deductible. Non-Dentemax providers may not accept the fee schedule amount as payment in full.
		Covers 100% of fee schedule amount for two cleanings/exams per year		

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs.)

- Acupuncture
- Chiropractic Care
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment (diagnostic only)
- Private-duty Nursing
- Routine Eye Care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at (419) 666-4450. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Fund's Office at (419) 666-4450. You may also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

Questions: Call the Fund's Office at (419) 666-4450 or visit us at **www.electricalfunds.org**.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call the Fund's Office to request a copy.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,540
- **Patient pays** $0

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions (in hospital)	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$0
Total	**$0**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,400
- **Patient pays** $0

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$0
Total	**$0**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call the Fund's Office at (419) 666-4450 or visit us at www.electricalfunds.org.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call the Fund's Office to request a copy.

Toledo Electrical Welfare Fund: Plan R – Early Retirees

Coverage Period: 1/1/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms of the policy or plan document at www.electricalfunds.org or by calling the Fund's Office at (419) 666-4450.

Important Questions	Answers	Why this Matters:
What is the overall annual deductible?	FrontPath and Non-Discounted: **$250** indiv./**$500** family; Discounted non-FrontPath: **$500** indiv./**$1,000** family. Co-pays don't count toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes, there is a $25 per person annual deductible for dental benefits.	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.
Is there an annual out–of–pocket limit on my expenses?	**Yes.** FrontPath and Non-Discounted: **$1,250** indiv./**$2,500** family; Discounted non-FrontPath: **$2,500** indiv./**$5,000** family; **$1,000** generic Rx drugs/family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, deductibles, balance-billed charges, health care this Plan doesn't cover, and penalties for failure to pre-cert services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.frontpath.com for a list of in-network **providers**. The Plan also uses AmWINs pharmacies, VSP vision providers, and Dentemax dental providers. Contact the Fund's Office for information.	If you use an in-network doctor or health care **provider**, the plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their **network.** See the chart on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No, but some **specialist** care is subject to written pre-certification to the plan.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services.

Questions: Call the Fund's Office at (419) 666-4450 or visit us at www.electricalfunds.org.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call the Fund's Office to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Discounted Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay/visit	$20 co-pay/visit	If you visit an out-of-network non-discounted provider, you could be subject to a balance bill.
	Specialist visit	$20 co-pay/visit	$20 co-pay/visit	
	Other practitioner office visit	$20 co-pay/visit	$20 co-pay/visit	
	Preventive care/screening/immunization	No charge	40% co-insurance after deductible	
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance after deductible	40% co-insurance after deductible	If you visit an out-of-network non-discounted provider, you could be subject to a balance bill. Mammography and colonoscopies are covered at no charge. Imaging requires precertification.
	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible	40% co-insurance after deductible	

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Discounted Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available in the Fund's SPD	Generic drugs	$10 co-pay before $1,000 limit. $0 after $1,000 limit	Participants may be required to pay for prescriptions at non-participating pharmacies and submit their receipts for reimbursement, less applicable co-pay and amounts that exceed reimbursement limits.	Kroger Pharmacies will reduce all co-pays by $1 and allow for up to a 90 day supply. 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 co-pay before $1,000 limit. $10 after $1,000 limit.		
	Specialty drugs	$30 co-pay before $1,000 limit. $10 after $1,000 limit	Not Covered	No benefit without clinical pre-authorization. No coverage for specified specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	40% co-insurance after deductible	If you visit an out-of-network non-discounted provider, you could be subject to a balance bill.
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	
If you need immediate medical attention	Emergency room services	$100 co-pay, then 20% coinsurance after deductible	$100 co-pay, then 20% coinsurance after deductible	If you visit an out-of-network non-discounted provider, you could be subject to a balance bill. If you visit an out-of-network non-discounted provider, you may be subject to a balance bill.
	Emergency medical transportation	20% co-insurance after deductible	40% co-insurance after deductible	
	Urgent care	$20 co-pay, then 20% co-insurance after deductible	$20 co-pay, then 40% co-insurance after deductible	

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Discounted Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible	40% co-insurance after deductible	If you visit an out-of-network non-discounted provider, you could be subject to a balance bill. All inpatient services must be pre-certified.
	Physician/surgeon fee	20% co-insurance after deductible	40% co-insurance after deductible	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	If you visit an out-of-network non-discounted provider, you could be subject to a balance bill. All inpatient and substance abuse services must be pre-certified.
	Mental/Behavioral health inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	
	Substance use disorder outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	
	Substance use disorder inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	
If you are pregnant	Prenatal and postnatal care	20% co-insurance after deductible	40% co-insurance after deductible	If you visit an out-of-network non-discounted provider, you could be subject to a balance bill. All inpatient services must be pre-certified.
	Delivery and all inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Discounted Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% co-insurance after deductible	40% co-insurance after deductible	Home health, skilled nursing, and hospice services, and durable medical equipment in excess of $1,500 must be pre-certified. If you visit an out-of-network non-discounted provider, you could be subject to a balance bill.
	Rehabilitation services	20% co-insurance after deductible	40% co-insurance after deductible	
	Habilitation services	20% co-insurance after deductible	40% co-insurance after deductible	
	Skilled nursing care	20% co-insurance after deductible	40% co-insurance after deductible	
	Durable medical equipment	20% co-insurance after deductible	40% co-insurance after deductible	
	Hospice service	20% co-insurance after deductible	40% co-insurance after deductible	
If your child needs dental or eye care	Eye exam	**VSP Provider** $10 co-pay	**Non-VSP** $35 allowance	Non-VSP lens coverage is: $25 allowance – single, $40 allowance – bifocal, $55 allowance – trifocal, $80 allowance – lenticular Medically necessary contacts covered at 100% in-network/$210 allowance out-of-network
	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	
	Dental check-up	**Dentemax Provider** Covers 100% of fee schedule amount for two cleanings/exams per year.	**Non-Dentemax Provider**	Exams are not subject to the annual deductible. Non-Dentemax providers may not accept the fee schedule amount as payment in full.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs.)

- Acupuncture
- Chiropractic Care
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment (diagnostic only)
- Private-duty Nursing
- Routine Eye Care (adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 419-666-4450. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 419-666-4450 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at 419-666-4450. 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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,392
- **Patient pays** $2,148

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions (in hospital)	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Co-pays	$300[1]
Co-insurance	$1,348
Limits or exclusions	$0
Total	**$2,148**

[1] Assumes 10 generic Rxs and 10 office visits.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,560
- **Patient pays** $840

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$250
Co-pays	$360[1]
Co-insurance	$230[2]
Limits or exclusions	$0
Total	**$840**

[1] Assumes 12 generic Rxs and 12 office visits

[2] 20% of medical equip. and lab tests less deductible

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call the Fund's Office at (419) 666-4450 or visit us at www.electricalfunds.org.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call the Fund's Office to request a copy.