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, see www.ewtf.org or call 1-800-929-EWTF (3983). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-929-EWTF (3983) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$150**/individual or **$300**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay for covered services. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care, outpatient surgery facility services, second surgical opinions, inpatient hospital services, skilled nursing care, hospice services, dental care, and eye care are covered before you meet your deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$8,000** annually/family	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	The overall deductible, dental care, eye care, premiums, balance-billing charges, penalties for failure to obtain preauthorization, health care the plan doesn't cover, and charges in excess of the plan's allowed amounts	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.ewtf.org or call 1-800-929-EWTF (3983) for a list of network providers	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
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% coinsurance	20% coinsurance	None
	Specialist visit	20% coinsurance	20% coinsurance	None.
	Preventive care/screening/ immunization	No charge; deductible does not apply	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	None

* Once the Plan has paid $1,000,000 in a member's lifetime, 20% coinsurance is increased to 50% coinsurance and "non-essential health benefits" are no longer covered. To the extent required under the federal No Surprises Act, out-of-network provider services will be covered at the copay and coinsurance rates applicable to in-network provider services, and balance billing will not apply. "H" Plan employees may not be eligible for all benefits and may have other limitations.

** For more information about limitations and exceptions, see the plan document at www.ewtf.org. Note: "H" Plan employees may not be eligible for all benefits and may have other limitations.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	Retail: $10 copay per prescription Mail Order: $20 copay per prescription	Retail: $10 copay per prescription Mail Order: Not covered	Retail covered up to a 34-day supply Mail Order covered up to a 90-day supply. Certain drugs require preauthorization or no benefits will be provided. Out-of-network cost is stated copay plus the difference between the allowed amount and the retail price.
	Preferred brand drugs	Retail: $25 copay per prescription Mail Order: $50 copay per prescription	Retail: $25 copay per prescription Mail Order: Not covered	
	Non-preferred brand drugs	Retail: $35 copay per prescription Mail Order: $70 copay per prescription	Retail: $35 copay per prescription Mail Order: Not covered	
	Specialty drugs	Paid as Generic, Preferred brand, or Non-preferred brand, as described above	Paid as Generic, Preferred brand, or Non-preferred brand, as described above	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge for the first $7,000; after $7,000, 20% coinsurance; deductible does not apply	No charge for the first $7,000; after $7,000, 20% coinsurance; deductible does not apply	None
	Physician/surgeon fees	20% coinsurance	20% coinsurance	75% coinsurance for assistant or co-surgeon. No charge for second surgical opinions; deductible does not apply.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network providers' ability to balance bill participants may be limited under the No Surprises Act.
	Emergency medical transportation	20% coinsurance	20% coinsurance	If transport results in an inpatient admission, coverage is included in inpatient hospital benefit and there is no charge for the first

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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)	
				$7,000, deductible does not apply.
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge for the first $7,000; after $7,000, 20% coinsurance; deductible does not apply	No charge for the first $7,000; after $7,000, 20% coinsurance; deductible does not apply	None
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	None
	Inpatient services	No charge for the first $7,000; after $7,000, 20% coinsurance; deductible does not apply	No charge for the first $7,000; after $7,000, 20% coinsurance; deductible does not apply	None
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	Not covered for dependent children. Maternity care may include tests and services described somewhere else in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	No charge for the first $7,000; after $7,000, 20% coinsurance; deductible does not apply	No charge for the first $7,000; after $7,000, 20% coinsurance; deductible does not apply	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Preauthorization required or no benefits will be provided.
	Rehabilitation services	20% coinsurance	20% coinsurance	Limited to maximum of 60 days per spell of illness. Based on semi-private accommodations rate charged by hospital.
	Habilitation services	20% coinsurance	20% coinsurance	Limited to maximum of 60 days per spell of illness. Based on semi-private accommodations rate charged by hospital.

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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)	
	Skilled nursing care	20% coinsurance; deductible does not apply	20% coinsurance; deductible does not apply	None.
	Durable medical equipment	20% coinsurance	20% coinsurance	None.
	Hospice services	No charge; deductible does not apply	No charge; deductible does not apply	Services must be provided at an approved facility.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	Patient pays difference between actual charge and allowance; deductible does not apply	Limited to one exam every two calendar years, unless prescription changes and other conditions are met. Vision benefits are administered by VSP.
	Children's glasses	No charge; deductible does not apply	Patient pays difference between actual charge and allowance; deductible does not apply	Limited to frames and lenses every two calendar years, unless prescription changes and other conditions are met. Vision benefits are administered by VSP.
	Children's dental check-up	No charge; deductible does not apply	20% coinsurance; deductible does not apply	Limited to one check-up every six months. Dental benefits for individuals age 18 and older are limited to $3,000 per person per calendar year. Dental benefits are administered plan by United Concordia Dental.

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** For more information about limitations and exceptions, see the plan document at www.ewtf.org. Note: "H" Plan employees may not be eligible for all benefits and may have other limitations.

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.)

- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Plan at 1-800-929-EWTF (3983). 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. Maryland Office of the Attorney General, Health Education and Advocacy Unit, 200 St. Paul Place, Baltimore, MD 21202, (410) 528-8662, https://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/default.aspx (website), heau@oag.state.md.us (email)

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 301-731-1050 o 1-800-929-3983.

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

* Once the Plan has paid $1,000,000 in a member's lifetime, 20% coinsurance is increased to 50% coinsurance and "non-essential health benefits" are no longer covered. To the extent required under the federal No Surprises Act, out-of-network provider services will be covered at the copay and coinsurance rates applicable to in-network provider services, and balance billing will not apply. "H" Plan employees may not be eligible for all benefits and may have other limitations.

** For more information about limitations and exceptions, see the plan document at www.ewtf.org. Note: "H" Plan employees may not be eligible for all benefits and may have other limitations.

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	**$150**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**0%**
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	$150
Copayments	$60
Coinsurance	$1,080
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,310**

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

The plan's overall deductible	**$150**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$150
Copayments	$910
Coinsurance	$230
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,310**

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

The plan's overall deductible	**$150**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$150
Copayments	$10
Coinsurance	$530
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$690**

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