




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

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Specialist visit</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>None.</u>
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	20% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	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.

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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)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com	Generic drugs	Retail: \$10 <u>copay</u> per prescription Mail Order: \$20 <u>copay</u> per prescription	Retail: \$10 <u>copay</u> 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 <u>preauthorization</u> or no benefits will be provided. <u>Out-of-network</u> cost is stated <u>copay</u> plus the difference between the <u>allowed amount</u> and the retail price.
	Preferred brand drugs	Retail: \$25 <u>copay</u> per prescription Mail Order: \$50 <u>copay</u> per prescription	Retail: \$25 <u>copay</u> per prescription Mail Order: Not covered	
	Non-preferred brand drugs	Retail: \$35 <u>copay</u> per prescription Mail Order: \$70 <u>copay</u> per prescription	Retail: \$35 <u>copay</u> per prescription Mail Order: Not covered	
	<u>Specialty drugs</u>	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% <u>coinsurance</u> ; <u>deductible</u> does not apply	No charge for the first \$7,000; after \$7,000, 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	None
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	75% <u>coinsurance</u> for assistant or co-surgeon. No charge for second surgical opinions; <u>deductible</u> does not apply.
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Out-of-network providers'</u> ability to <u>balance bill</u> participants may be limited under the No Surprises Act.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	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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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				\$7,000, <u>deductible</u> does not apply.
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge for the first \$7,000; after \$7,000, 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	No charge for the first \$7,000; after \$7,000, 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	None
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Inpatient services	No charge for the first \$7,000; after \$7,000, 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	No charge for the first \$7,000; after \$7,000, 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	None
If you are pregnant	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u>	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% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	No charge for the first \$7,000; after \$7,000, 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	No charge for the first \$7,000; after \$7,000, 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required or no benefits will be provided.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to maximum of 60 days per spell of illness. Based on semi-private accommodations rate charged by hospital.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to maximum of 60 days per spell of illness. Based on semi-private accommodations rate charged by hospital.

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	<u>None.</u>
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None.
	<u>Hospice services</u>	No charge; <u>deductible</u> does not apply	No charge; <u>deductible</u> 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; <u>deductible</u> does not apply	Patient pays difference between actual charge and allowance; <u>deductible</u> 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; <u>deductible</u> does not apply	Patient pays difference between actual charge and allowance; <u>deductible</u> 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; <u>deductible</u> does not apply	20% <u>coinsurance</u> ; <u>deductible</u> 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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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.

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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>	\$150
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$150
<u>Copayments</u>	\$60
<u>Coinsurance</u>	\$1,080
<i>What isn't covered</i>	
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 <u>plan's</u> overall <u>deductible</u>	\$150
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$150
<u>Copayments</u>	\$910
<u>Coinsurance</u>	\$230
<i>What isn't covered</i>	
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 <u>plan's</u> overall <u>deductible</u>	\$150
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$150
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$530
<i>What isn't covered</i>	
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.