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 2018

RE: 2019 Medical & Prescription Changes/Cards & Legally Required Notices

Dear Member:

2019 brings changes to your benefits. This mailing is to inform of these changes, provide you with new medical and prescription ID cards, and to deliver the notices the IRS requires us to send annually. The notices are regarding your benefits with the Local No 8 IBEW Retirement Plan & Trust and the Toledo Electrical Welfare Fund.

The Board of Trustees elected to implement the following changes effective January 1, 2019:

- Increase the medical deductible to $400 individual/$800 family and the out-of-pocket maximums to $1500 individual/$3000
- The Emergency Room copay will increase to $200
- **Express Scripts** will be the new prescription drug vendor
- Prescription Drug – New 3 tier copay system; $10 generic, $30 preferred brand and $50 non-preferred brand
- Monthly self-payment rate increases to $1400
- There will be **no** change to office visit copays, dental and/or vision benefits

Included with this mailing:

- **2019 Medical & Prescription ID Cards**
- Summary of Material Modifications (SMM)
- Summary of Benefits Coverage (SBC)
- Summary Annual Report (SAR)
- Certificate of Creditable Coverage for Medicare Prescription Drug coverage
- Women's Heath and Cancer Rights

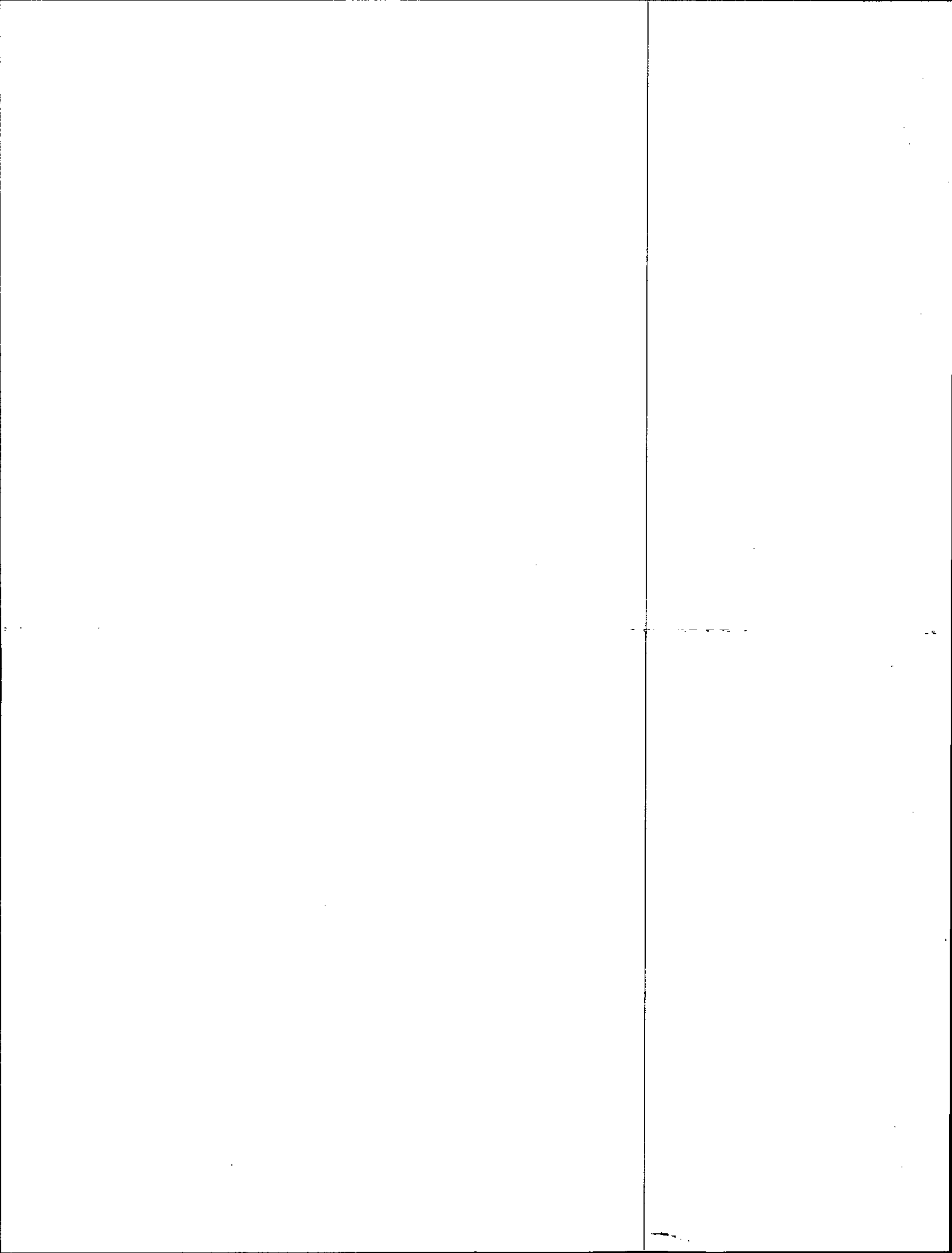
Please check your new ID cards for accuracy. To obtain prescription drugs as of January 1, 2019 you will need to use your new card.

If you have questions please contact the Funds Office.

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



Required Notice

TO: All Toledo Electrical Welfare Fund Participants and Covered Dependents

FROM: Plan Administrator, Toledo Electrical Welfare Fund

DATE: 12/2018

RE: Required notice of protection for breast cancer patients under the Women's Health and Cancer Rights Act

This notice is intended to remind you of the Women's Health and Cancer Rights Act of 1998, which allows you to receive additional benefits under your group health plan. This act states that group health plans that offer coverage for a mastectomy must also provide coverage for breast cancer patients who elect breast reconstruction in connection with a mastectomy. In the case of a participant or covered dependent who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. Reconstruction of the breast on which the mastectomy was performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

3. Prostheses; and

4. ~~Treatment of physical complications at all stages of the mastectomy, including lymphedemas.~~

The Women's Health and Cancer Rights Act specifically states that group health plans may impose deductible or co-insurance requirements for the reconstructive surgery such that they are consistent with those established for other benefits under the plan. The Toledo Electrical Welfare Fund in network plan design requires a 20% coinsurance payment by the participant, with a yearly $3,000 out-of-pocket maximum per family.
Please review plan information for out of network costs.

If you have any question regarding these benefits, please contact the Fund Office at 419-666-4450 or via email at benefits@electricalfunds.org.

If you and any covered dependents are NOT Medicare eligible in the next 12 months, you may disregard this notice.

Important Notice from Toledo Electrical Welfare Fund About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Toledo Electrical Welfare Fund (TEWF) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Toledo Electrical Welfare Fund has determined that the prescription drug coverage offered by Toledo Electrical Welfare Fund is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you do decide to join a Medicare drug plan and want to drop your TEWF prescription drug coverage, you will need to withdraw from all benefits under our Plan since the prescription drug coverage is not freestanding. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. You will find a full description of the prescription coverage under our Plan in the Summary Plan Description you were issued. Also be aware that you and your dependents may not be able to get this coverage back except as provided under the TEWF Health Plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with TEWF and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through TEWF. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage: Visit www.medicare.gov. Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Toledo Electrical Welfare Fund
October 1, 2018
Name of Sender – N.W.O. Electrical Administrators
727 Lime City Road
Rossford, Ohio 43460
(419) 666-4450

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

SUMMARY ANNUAL REPORT FOR THE LOCAL NO. 8 IBEW RETIREMENT PLAN AND TRUST

TO ALL PARTICIPANTS

This is a summary of the annual report for the Local No. 8 IBEW Retirement Plan and Trust, I.D. #34-6596899 for the Plan year beginning January 1, 2017 and ending December 31, 2017. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 [ERISA].

BASIC FINANCIAL STATEMENT

Benefits under the Plan are provided by Trust Investments. Plan expenses were $22,872,037. These expenses included $1,949,857 in administrative expenses and $20,922,180 in benefits paid to participants and beneficiaries. A total of 2,832 persons were participants in or beneficiaries of the plan at the end of the plan year, although not all of these persons had yet earned the right to receive benefits.

The value of Plan assets, after subtracting liabilities of the Plan, was $455,117,197 as of December 31, 2017, compared to $377,884,051 as of December 31, 2016. During the Plan year, the Plan experienced an increase in its net assets of $77,233,146. This increase included unrealized appreciation in the value of Plan assets; that is, the difference between the value of the Plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. The Plan had total income of $84,359,364 including employer contributions of $18,462,331, participant contributions of $3,041,338 and income from investments of $62,855,695. There was a transfer of $15,745,819 of net assets from the IBEW Local No. 8 401(K) Plan due to a merger of the Plans, effective January 1, 2017.

YOUR RIGHTS TO ADDITIONAL INFORMATION

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report.

1. Independent Auditors' Report
2. Financial Statements
3. Supplemental Schedules

To obtain a copy of the full annual report, or any part thereof, write or call the office of Board of Trustees, Local No. 8 IBEW Retirement Plan and Trust, who is the Plan Administrator, at 727 Lime City Road, Rossford, OH 43460, (419) 666-4450.

There will be a reasonable charge to cover copying costs if a copy is requested.

You also have the right to receive from the Plan Administrator, on request and at no charge, a statement of the net assets available for plan benefits of the Plan, and accompanying notes, or a statement of changes in net assets available for plan benefits, or both. If you request a copy of the full annual report from the Plan Administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover the copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the Plan Administrator, 727 Lime City Road, Rossford, OH 43460, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to:

U.S. Department of Labor
Employee Benefit Security Administration
Public Disclosure Room
200 Constitution Ave., N.W., Suite N-1513
Washington, D.C. 20210

SUMMARY ANNUAL REPORT FOR TOLEDO ELECTRICAL WELFARE FUND

TO ALL PARTICIPANTS

This is a summary of the annual report for the Toledo Electrical Welfare Fund, I.D. #34-4441661 for the year beginning January 1, 2017 and ending December 31, 2017. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 [ERISA].

The Trustees have committed the Plan to pay benefits which include medical, prescription drug, disability, vision, death, accidental death and dismemberment, education reimbursement, employee retention, dental, hearing and supplemental fringe benefits under the terms of the Plan.

INSURANCE INFORMATION

The Plan also has contracts with (1) The Union Labor Life Insurance Company for stop loss insurance for catastrophic medical claims (2) United of Omaha Life Insurance Company, and; (3) Vision Service Plan. Total premiums paid for the Plan year December 31, 2017 were $1,148,622.

BASIC FINANCIAL STATEMENT

The value of the Plan assets, after subtracting liabilities of the Plan, was $50,062,913 as of December 31, 2017, compared to $39,562,917 as of December 31, 2016. At December 31, 2017, Plan assets were segregated by the following three groups: Welfare - $26,351,913; Supplemental Fringe Benefit Fund - $10,769,459; Employee Retention Program - $12,941,541. During the Plan year, the Plan experienced an increase in its net assets of $10,499,996. The Plan had a total income of $45,503,427, including employer contributions of $42,671,243, participants' contributions of $1,262,895, and income from investments of $1,569,289.

Plan expenses were $35,003,431. These expenses included $1,656,902 in administrative expenses, and $33,346,529 in benefits paid to or on behalf of Plan participants and beneficiaries.

YOUR RIGHTS TO ADDITIONAL INFORMATION

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report.

1. Independent Auditor's Report
2. Financial Statements
3. Supplemental Schedules

To obtain a copy of the full annual report, or any part thereof, write or call the office of Board of Trustees, Toledo Electrical Welfare Fund, who is the Plan Administrator, at 727 Lime City Road, Rossford, OH 43460, (419) 666-4450.

There will be a reasonable charge to cover copying costs if a copy is requested.

You also have the right to receive from the Plan Administrator, on request and at no charge, a statement of net assets available for plan benefits, a statement of changes in net assets available for plan benefits, and accompanying notes. If you request a copy of the full annual report from the Plan Administrator, these statements and accompanying notes will be included as part of that report. The charge to cover the copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the Plan Administrator at 727 Lime City Road, Rossford, OH 43460, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to:

U.S. Department of Labor
Employee Benefit Security Administration
Public Disclosure Room
200 Constitution Ave., N.W., Suite N-1513
Washington, D.C. 20210

5/29/2018

SUMMARY OF MATERIAL MODIFICATIONS TO THE TOLEDO ELECTRICAL WELFARE FUND

Re: Changes to Out-of-Network Case Management Protocols

The Board of Trustees periodically reviews the way in which healthcare is delivered and how the state of the industry affects the Toledo Electrical Welfare Fund ("Fund") and the benefits offered by it. To best serve all participants and beneficiaries in the Fund, the Board must occasionally adjust the way in which certain benefits are administered. Therefore, the following is a summary of the adjustments the Board has determined to be in the best interests of the Fund. Unless otherwise indicated, all changes are effective June 1, 2018.

Referral to Case Managemet for Certain Out-of Network Claims

It is the Trustees' goal to provide participants with the best benefits possible. To that end, the Trustees are engaging the Fund's Case Management review agency to review certain out-of-network claims. This change allows the Fund to ensure that participants and beneficiaries are receiving the proper level of the most appropriate care at the correct facility. The Case Manager will review the diagnosis, treatment you are receiving, and the facility in which you are receiving it. This does not mean that there will necessarily be any change in your treatment plan; instead, this review simply guarantees that you are receiving the best possible care.

Inpatient Admissions

When you are admitted to a hospital or any other inpatient facility that is not in the FrontPath network, your admission will be referred to the Fund's Case Management review agency whenever that stay lasts longer than six days.

Claim Costs

Utilizing facilities and providers in the FrontPath network whenever possible provides the best quality care at the most advantageous cost for both you and the Fund. In-network providers are contractually obligated to provide care at a reasonable, negotiated price. Out-of-network providers are under no such obligation. Therefore, the Fund's Case Management review agency will review all out-of-network claims under the following circumstances:

- Whenever a claim exceeds 250% of the FrontPath reimbursement amount, it will not be a covered benefit until it goes through the claims review process through Case Management.
- Whenever any single claim or any course of treatment exceeds $10,000, that claim or course of treatment will be referred to Case Management.[1]

You may contact the Fund Office at 419-666-4450 if you have any questions about this Summary of Material Modifications, or any other questions about your benefits under the Fund.

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[1] This threshold does not apply to emergency admissions, except to the extent allowed by the Patient Protection and Affordable Care Act.

7/18/2018

SUMMARY OF MATERIAL MODIFICATIONS TO THE TOLEDO ELECTRICAL WELFARE FUND

Re: Changes to Allowed Well Baby Benefits

The Board of Trustees periodically reviews the way in which healthcare is delivered and how the state of the industry affects the Toledo Electrical Welfare Fund ("Fund") and the benefits offered by it. To best serve all participants and beneficiaries in the Fund, the Board must occasionally adjust the way in which certain benefits are administered. Therefore, the following is a summary of the adjustments the Board has determined to be in the best interests of the Fund. Unless otherwise indicated, all changes are retroactively effective January 1, 2017.

Well-Baby Visit Benefit

It is the Trustees' goal to provide participants with the best benefits possible. To that end, the Trustees review recommendations from recognized experts on the proper protocols for the delivery of healthcare. The Trustees have enacted a change in the allowed number of well baby visits, to make the benefit more in line with the American Academy of Pediatrics' recommendations as follows:

Previous Well Baby Benefit:	Well Baby Benefit	Effective Date
6 visits, birth through 12 months	7 visits, birth through 12 months	1/1/2017
6 visits, 13 months through 23 months	3 visits, 13 months through 23 months	9/1/2018
6 visits, 24 months through 35 months	3 visits, 24 months through 35 months	9/1/2018
2 visits, 36 months through 47 months	2 visits, 36 months through 47 months	9/1/2018

Except as specified herein, all other benefits remain unchanged. You may contact the Fund Office at 419-666-4450 if you have any questions about this Summary of Material Modifications, or any other questions about your benefits under the Fund.

11/15/2018

SUMMARY OF MATERIAL MODIFICATIONS TO THE TOLEDO ELECTRICAL WELFARE FUND

Re: Changes in Plan Design

The Board of Trustees periodically reviews the way in which healthcare is delivered and how the state of the industry affects the Toledo Electrical Welfare Fund ("Fund") and the benefits offered by it. To best serve all participants and beneficiaries in the Fund, the Board must occasionally make adjustments to Fund benefits. Therefore, the following is a summary of the adjustments the Board has determined to be in the best interests of the Fund. Unless otherwise indicated, changes are effective January 1, 2019.

Medical and Prescription Cost-Sharing

It is the Trustees' goal to provide participants with the best benefits possible. To that end, the Trustees review recommendations from recognized experts on the Fund's benefit structure. Therefore, the Trustees have decided to implement the following changes:

	Previous Benefit Design:	New Design, eff. 1/1/19
Plan Deductible:	In-Network and Non-Discounted Out-of-Network: $250 individual /$500 family; Discounted Out-of-Network: $500 individual/$1,000 family	$400 individual/$800 family, with no in-/out-of-network distinction
Out-of-Pocket Limits:	In-Network and Non-Discounted Out-of-Network: $1,250 individual /$2,500 family; Discounted Out-of-Network: $2,500 individual/$5,000 family	$1,500 individual/$3,000 family, with no in-/out-of-network distinction
Emergency Room Copayment	$100	$200
Prescription Drug: Non-Preferred Brand and Specialty Drugs	$30 copayment until $1,000 drug maximum, then $10 copayment	$50 copayment until $1,000 drug maximum, then $25 copayment

Except as specified herein, all other benefits remain unchanged. You may contact the Fund Office at 419-666-4450 if you have any questions about this Summary of Material Modifications, or any other questions about your benefits under the Fund.

11/15/2018

SUMMARY OF MATERIAL MODIFICATIONS TO THE LOCAL NO. 8 IBEW RETIREMENT PLAN

We are providing you with this Summary of Material Modifications to inform you of changes made this year to the percentage of your wages you may contribute available under the Employee Elective Deferral feature of the Local No. 8 IBEW Retirement Plan (referred to below as the "Plan"). These changes will take effect at the dates indicated below.

Contribution Rates

	Previous Benefit Design:	New Design	Effective Date
Automatic Contribution Amount	3% of pay at dispatch	5% of pay at dispatch	Inside agreement: 6/25/2018 VDV agreement: 8/27/2018
Allowed Contribution	0% to 15% of pay, in whole percentages	0% to 20% of pay, in whole percentages	Inside agreement: 6/25/2018 VDV agreement: 8/27/2018

Except as specified herein, all other benefits remain unchanged. You may contact the Fund Office at 419-666-4450 if you have any questions about this Summary of Material Modifications, or any other questions about your benefits under the Fund.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 419-666-4450. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbcglossary or call 419-666-4450 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$400** individual/**$800** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	**Yes.** Preventive care and services listed as "No charge."	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**$25**/individual for dental	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**Yes. $1,500** individual/**$3,000** family; **$1,000** generic Rx drugs per family pre-Medicare/$500 per individual for Medicare enrollees.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, deductibles, balance-billed charges, health care this Plan doesn't cover, and failure to preauthorize penalties.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	**Yes.** See www.frontpath.com for a list of in-network providers. The Plan also uses Express Scripts pharmacies, VSP vision providers, and Delta Dental providers. Contact the Fund Office at 419-666-4450 for more information.	You pay the least if you use a provider in network. You pay more if you use a provider in out-of-network/discounted. You will pay the most if you use an out-of-network/non-discounted provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment per visit	$20 copayment per visit	If you visit an out-of-network provider, you could be subject to a balance bill.
	Specialist visit	$20 copayment per visit	$20 copayment per visit	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.
	Preventive care/screening/ Immunization	No charge	40% coinsurance after deductible	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	If you visit an out-of-network provider, you could be subject to a balance bill.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	Mammography and colonoscopies are covered at no charge. Imaging requires precertification.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.electricalfunds.org	Generic drugs	$10 copayment until $1,000 maximum, then $0	Participants may be required to pay for prescriptions at nonparticipating pharmacies and submit receipts for reimbursement, less applicable copayment and amounts that exceed allowed limit.	90-day supply available. Kroger Pharmacies will reduce all co-pays by $1. 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 copayment until $1,000 maximum, then $10		
	Specialty drugs	$50 copayment until $1,000 maximum, then $25	Not covered	No benefit without precertification. No coverage for specified specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	If you visit an out-of-network provider, you could be subject to a balance bill.

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

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	$200 copayment, then 20% coinsurance after deductible	$200 copayment, then 20% coinsurance after deductible	Copayment waived if admitted to the hospital. If you visit an out-of-network provider, you could be subject to a balance bill.
	Emergency medical transportation	20% coinsurance after deductible	40% coinsurance after deductible	
	Urgent care	$20 copayment, then 20% coinsurance after deductible	$20 copayment, then 40% coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	If you visit an out-of-network provider, you could be subject to a balance bill.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	If you visit an out-of-network provider, you could be subject to a balance bill.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	If you visit an out-of-network provider, you could be subject to a balance bill.
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	If you visit an out-of-network provider, you could be subject to a balance bill.
If you are pregnant	Office visits	$20 copayment per visit	$20 copayment per visit	If you visit an out-of-network provider, you could be subject to a balance bill. No preauthorization required for 48 hours/vaginal birth or 96 hours/cesarean section. All other inpatient services must be pre-certified.
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	

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

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Home health, skilled nursing, and hospice services, and durable medical equipment in excess of $1,500 must be pre-certified. If you visit an out-of-network provider, you could be subject to a balance bill.
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice services			
If your child needs dental or eye care	Children's eye exam (VSP)	$10 copayment	$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
	Children's glasses	$25 co-pay for any type lenses; $170 allowance for frames and up to $120 allowance for elective contacts.	Tiered allowance for lenses. $45 allowance for frames; up to $105 allowance for elective contacts.	
	Children's dental check-up	No charge of fee schedule	100% of fee schedule amount for two cleanings/exams per year	Exams are not subject to the annual deductible. Non Delta Dental providers may not accept the fee schedule amount as payment in full. Benefits limited to $1,250 per year, per person.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery
- Long-term Care
- Non-emergency care when travelling outside the U.S unless service is normally covered
- Routine Foot Care (other than surgery)
- Weight Loss Programs

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

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Plan at 419-666-4450 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$400**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

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

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

- **The plan's overall deductible** **$400**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

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

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

- **The plan's overall deductible** **$400**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

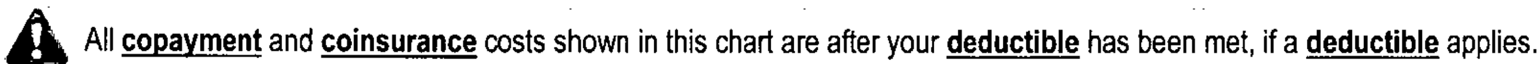
Cost Sharing	
Deductibles	$400
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 419-666-4450. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbcglossary or call 419-666-4450 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** – This plan coordinates with Medicare and pays the part A & B deductibles.	See the Common Medical Events chart below for services this plan covers.
Are there services covered before you meet your deductible?	There is no deductible.	While this plan has no deductible amount, a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**$25**/individual for dental	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**Yes.** Annual out-of-pocket limits are coordinated with Medicare and limited to the Medicare-approved amount, less any payments made by Medicare or the Plan. **$500** generic Rx drugs per Medicare enrollee, **$1,000** per family for non-Medicare family members.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, deductibles, balance-billed charges, health care this Plan doesn't cover, and failure to preauthorize penalties.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	**Yes.** See www.frontpath.com for a list of in-network providers. The Plan also uses Express Scripts pharmacies, VSP vision providers, and Delta Dental providers. Contact the Fund at 419-666-4450 for information.	You pay the least if you use a provider in network. You pay more if you use a provider in out-of-network/discounted. You will pay the most if you use an out-of-network/non-discounted provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral	No.	You can see the specialist you choose without a referral.

to see a specialist?		



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 Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
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			
	Preventive care/screening/ Immunization			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)	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)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.electricalfunds.org	Generic drugs	$10 copayment until maximum, then $0	Participants may be required to pay for prescriptions at nonparticipating pharmacies and submit receipts for reimbursement, less applicable copayment and amounts that exceed allowed limit.	90-day supply available. Kroger Pharmacies will reduce all co-pays by $1. 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 copayment until maximum, then $10		
	Specialty drugs	$50 copayment until maximum, then $25	Not covered	No benefit without precertification. 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	Covered up to 100% of Medicare-approved amount.	If you receive services from a provider that does not accept assignment of benefits from

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

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	amount.		Medicare, you could be subject to a balance bill.
If you need immediate medical attention	Emergency room 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.
	Emergency medical transportation			
	Urgent care			
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 fees			
If you need mental health, behavioral health, or substance abuse services	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.
	Inpatient services			
If you are pregnant	Office visits	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.
	Childbirth/delivery professional services			

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care			
	Rehabilitation services			
	Habilitation 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.
	Skilled nursing care			
	Durable medical equipment			
	Hospice services			
If your child needs dental or eye care	Children's eye exam (VSP)	$10 copayment	$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
	Children's glasses	$25 co-pay for any type lenses; $170 allowance for frames and up to $120 allowance for elective contacts.	Tiered allowance for lenses. $45 allowance for frames; up to $105 allowance for elective contacts.	
	Children's dental check-up	No charge of fee schedule	100% of fee schedule amount for two cleanings/exams per year	Exams are not subject to the annual deductible. Non Delta Dental providers may not accept the fee schedule amount as payment in full. Benefits limited to $1,250 per year, per person.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery
- Long-term Care
- Non-emergency care when travelling outside the U.S unless service is normally covered
- Routine Foot Care (other than surgery)
- Weight Loss Programs

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

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

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

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

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

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

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$0**

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

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

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

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

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 419-666-4450. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbcglossary or call 419-666-4450 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	FrontPath and Non-Discounted: **$2,500** individual/**$5,000** family; Discounted non-FrontPath: **$5,000** individual/**$10,000** family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	**Yes.** Preventive care and services listed as "No charge."	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**$25**/individual for dental	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**Yes. $1,500** individual/**$3,000** family; **$1,000** generic Rx drugs per family pre-Medicare/$500 per individual for Medicare enrollees.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, deductibles, balance-billed charges, health care this Plan doesn't cover, and failure to preauthorize penalties.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	**Yes.** See www.frontpath.com for a list of in-network providers. The Plan also uses Express Scripts pharmacies, VSP vision providers, and Delta Dental providers. Contact the Fund Office at 419-666-4450 for more information.	You pay the least if you use a provider in network. You pay more if you use a provider in out-of-network/discounted. You will pay the most if you use an out-of-network/non-discounted provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment per visit	$20 copayment per visit	If you visit an out-of-network provider, you could be subject to a balance bill. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Specialist visit	$20 copayment per visit	$20 copayment per visit	
	Preventive care/screening/ Immunization	No charge	40% coinsurance after deductible	
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance after deductible	40% coinsurance after deductible	If you visit an out-of-network 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)	30% coinsurance after deductible	40% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.electricalfunds.org	Generic drugs	$10 copayment until $1,000 maximum, then $0	Participants may be required to pay for prescriptions at nonparticipating pharmacies and submit receipts for reimbursement, less applicable copayment and amounts that exceed allowed limit.	90-day supply available. Kroger Pharmacies will reduce all co-pays by $1. 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 copayment until $1,000 maximum, then $10		
	Specialty drugs	$50 copayment until $1,000 maximum, then $25	Not covered	No benefit without precertification. No coverage for specified specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	40% coinsurance after deductible	If you visit an out-of-network provider, you could be subject to a balance bill.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	30% coinsurance after deductible	40% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	$100 copayment, then 30% coinsurance after deductible	$100 copayment, then 30% coinsurance after deductible	Copayment waived if admitted to the hospital. If you visit an out-of-network provider, you could be subject to a balance bill.
	Emergency medical transportation	30% coinsurance after deductible	40% coinsurance after deductible	
	Urgent care	$50 copayment, then 30% coinsurance after deductible	$50 copayment, then 40% coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	40% coinsurance after deductible	If you visit an out-of-network provider, you could be subject to a balance bill.
	Physician/surgeon fees	30% coinsurance after deductible	40% coinsurance after deductible	If you visit an out-of-network provider, you could be subject to a balance bill.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance after deductible	40% coinsurance after deductible	If you visit an out-of-network provider, you could be subject to a balance bill.
	Inpatient services	30% coinsurance after deductible	40% coinsurance after deductible	If you visit an out-of-network provider, you could be subject to a balance bill.
If you are pregnant	Office visits	$20 copayment per visit	$20 copayment per visit	If you visit an out-of-network provider, you could be subject to a balance bill. No preauthorization required for 48 hours/vaginal birth or 96 hours/cesarean section. All other inpatient services must be pre-certified.
	Childbirth/delivery professional services	30% coinsurance after deductible	40% coinsurance after deductible	

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

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Childbirth/delivery facility services	30% coinsurance after deductible	40% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care			
	Rehabilitation services			
	Habilitation services	30% coinsurance after deductible	40% coinsurance after deductible	Home health, skilled nursing, and hospice services, and durable medical equipment in excess of $1,500 must be pre-certified. If you visit an out-of-network provider, you could be subject to a balance bill.
	Skilled nursing care			
	Durable medical equipment			
	Hospice services			
If your child needs dental or eye care	Children's eye exam (VSP)	$10 copayment	$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
	Children's glasses	$25 co-pay for any type lenses; $170 allowance for frames and up to $120 allowance for elective contacts.	Tiered allowance for lenses. $45 allowance for frames; up to $105 allowance for elective contacts.	
	Children's dental check-up	No charge of fee schedule	100% of fee schedule amount for two cleanings/exams per year	Exams are not subject to the annual deductible. Non Delta Dental providers may not accept the fee schedule amount as payment in full. Benefits limited to $1,250 per year, per person.

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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.)		
• Bariatric Surgery • Cosmetic Surgery	• Long-term Care • Non-emergency care when travelling outside the U.S unless service is normally covered	• Routine Foot Care (other than surgery) • Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Chiropractic Care	• Dental Care (adult) • Hearing Aids • Infertility Treatment (diagnostic only)	• Private-duty Nursing • Routine Eye Care (adult)

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

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

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About these Coverage Examples:

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Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	$2,500
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

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

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$600
Coinsurance	$400
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	**$3,550**

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

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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