

 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, [www.egtrust.org](http://www.egtrust.org). 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.cciio.cms.gov](http://www.cciio.cms.gov) or call 800-397-9598 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<b>\$400</b> Individual, <b>\$1,200</b> Family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes, Preventive Care, Emergency Room and Physician Office Visits are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<b>\$1,200</b> Individual, <b>\$2,400</b> Family (deductible & coinsurance); Affordable Care Act (ACA) Cost Share Maximum: <b>\$6,600</b> Individual, <b>\$13,200</b> Family (all out-of-pocket combined)	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Premiums, penalties, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.egtrust.org">www.egtrust.org</a> or call 800-397-9598 for a list of <a href="#">network providers</a> .	The plan does not use a provider network for hospitals and other facilities. The plan uses a provider network only for physician services and certain ancillary services. The plan benefit levels (copays, coinsurance and out-of-pocket limits) are the same whether you use network or out-of-network providers, but your costs may be different depending on what the providers charge. You may also be balance billed for out-of-network services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No. You don't need a referral to see a <a href="#">specialist</a> .	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a>	No deductible.
	<a href="#">Specialist</a> visit	\$30 <a href="#">copay</a>	
	<a href="#">Preventive care/screening/immunization</a>	No Charge	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	<a href="#">LabCard</a> services no charge
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	Retail: 30-day \$12 <a href="#">copay</a> ; 90-day \$36 <a href="#">copay</a> ; Mail: 90-day only \$30 <a href="#">copay</a> ;	<a href="#">Precertification</a> is required for infusion therapy in excess of \$1,500. Failure to precertify will result in a \$250 penalty.
	Preferred brand drugs	Retail: 30-day \$25 <a href="#">copay</a> ; 90-day \$85 <a href="#">copay</a> ; Mail: 90-day only \$55 <a href="#">copay</a> ;	
	Non-preferred brand drugs	Retail: 30-day \$40 <a href="#">copay</a> ; 90-day \$130 <a href="#">copay</a> ; Mail: 90-day only \$100 <a href="#">copay</a> ;	
	<a href="#">Specialty drugs</a>	Copay + 3% cost of drug up to a maximum of \$150/month	All specialty drugs (oral & injectable) will have a maximum member cost of \$150 per month
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$250 <a href="#">copay</a> then 10% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required. Failure to precertify will result in a \$250 penalty.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$300 <a href="#">copay</a> then 15% <a href="#">coinsurance</a>	No <a href="#">deductible</a> . <a href="#">Copay</a> waived if admitted to hospital.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$40 <a href="#">copay</a> then 10% <a href="#">coinsurance</a>	<a href="#">Deductible</a> does not apply except to physician related charges.

 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
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250 <a href="#">copay</a> then 10% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required. Failure to precertify will result in a \$250 penalty.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 <a href="#">copay</a> for PCP; \$30 <a href="#">copay</a> for Specialist	No deductible. Limited to 52 visits per calendar year.
	Inpatient services	\$250 <a href="#">copay</a> Facility; 10% <a href="#">coinsurance</a> all other services	<a href="#">Precertification</a> is required. Failure to precertify will result in a \$250 penalty. Maximum 80 days lifetime benefit.
<b>If you are pregnant</b>	Office visits	\$25 <a href="#">copay</a>	No deductible for office visits.
	Childbirth / delivery professional services	10% <a href="#">coinsurance</a>	
	Childbirth / delivery facility services	\$250 <a href="#">copay</a> then 10% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required for inpatient Hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). Failure to precertify will result in a \$250 penalty.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required. Failure to precertify will result in a \$250 penalty.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required. Failure to precertify will result in a \$250 penalty.
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required. Failure to precertify will result in a \$250 penalty.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required for equipment in excess of \$1,500. Replacement is available only if equipment cannot be repaired.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required. Failure to precertify will result in a \$250 penalty.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	The plan covers only the vision screening services required by federal law. Other services are not covered.
	Children's glasses	Not Covered	None
	Children's dental check-up	Not Covered	The plan covers only the dental screening services required by federal law. Other services are not covered.

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

## Excluded Services & Other Covered Services:

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

- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Private Duty Nursing
- 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
- Bariatric Surgery (for treatment of morbid obesity only)
- Chiropractic Care (Chiropractic Care maximum calendar year benefits of \$750)
- Infertility Treatment (assisted Reproduction Techniques maximum lifetime benefit \$20,000)

**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 Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: The Plan at 800-397-9598.

### 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](#).

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800-397-9598.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-397-9598

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码800-397-9598.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 800-397-9598.

————— *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 pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$400
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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

<b>Total Example Cost</b>	<b>\$12,840</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$345
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,605</b>

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

- The [plan's](#) overall [deductible](#) \$400
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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

<b>Total Example Cost</b>	<b>\$7,405</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$845
Coinsurance	\$140
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,440</b>

**Mia's Simple Fracture**  
(emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$400
- [Specialist copayment](#) \$30
- Hospital ER (facility) [coinsurance](#) 15%
- Other [coinsurance](#) 10%

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

<b>Total Example Cost</b>	<b>\$1,950</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$330
Coinsurance	\$178
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$908</b>