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. 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 or call 800-397-9598 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$400** Individual, **$1,200** 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, Preventive Care, Emergency Room and Physician Office Visits are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$1,200** Individual, **$2,400** Family (deductible & coinsurance); Affordable Care Act (ACA) Cost Share Maximum: **$2,500** Individual, **$5,000** Family (all out-of-pocket combined)	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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	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 out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.egtrust.org or call 800-397-9598 for a list of network providers.	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.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay	No deductible
	Specialist visit	$30 copay	
	Preventive care/screening/ immunization	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.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	LabCard services no charge
	Imaging (CT/PET scans, MRIs)	10% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.express-scripts.com**	Generic drugs	Retail: 30-day $12 copay; 90-day $36 copay; Mail: 90-day only $30 copay;	Precertification 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 copay; 90-day $85 copay; Mail: 90-day only $55 copay;	
	Non-preferred brand drugs	Retail: 30-day $40 copay; 90-day $130 copay; Mail: 90-day only $100 copay;	
	Specialty drugs	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
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay then 10% coinsurance	Precertification is required. Failure to precertify will result in a $250 penalty.
	Physician/surgeon fees	10% coinsurance	None
If you need immediate medical attention	Emergency room care	$300 copay then 15% coinsurance	No deductible. Copay waived if admitted to hospital.
	Emergency medical transportation	20% coinsurance	None
	Urgent care	$40 copay then 10% coinsurance	Deductible 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
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay then 10% coinsurance	Precertification is required. Failure to precertify will result in a $250 penalty.
	Physician/surgeon fees	10% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay for PCP; $30 copay for Specialist	No deductible. Limited to 52 visits per calendar year.
	Inpatient services	$250 copay Facility; 10% coinsurance all other services	Precertification is required. Failure to precertify will result in a $250 penalty. Maximum 80 days lifetime benefit.
If you are pregnant	Office visits	$25 copay	No deductible for office visits.
	Childbirth / delivery professional services	10% coinsurance	
	Childbirth / delivery facility services	$250 copay then 10% coinsurance	Precertification 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.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Precertification is required. Failure to precertify will result in a $250 penalty.
	Rehabilitation services	10% coinsurance	Precertification is required. Failure to precertify will result in a $250 penalty.
	Habilitation services	10% coinsurance	
	Skilled nursing care	10% coinsurance	Precertification is required. Failure to precertify will result in a $250 penalty.
	Durable medical equipment	10% coinsurance	Precertification is required for equipment in excess of $1,500. Replacement is available only if equipment cannot be repaired.
	Hospice services	10% coinsurance	Precertification is required. Failure to precertify will result in a $250 penalty.
If your child needs dental or eye care	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.

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. 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 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, kwiijigo 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*)

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$345
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,605**

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)*

Total Example Cost	**$7,405**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$845
Coinsurance	$140
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,440**

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)*

Total Example Cost	**$1,950**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$330
Coinsurance	$155
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$885**

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