



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.egtrust.org](http://www.egtrust.org) or by calling the Care Coordinators at 855-452-9997.

Important Questions	Answers	Why this Matters:
What is the overall <b>deductible</b> ?	Tier 1 <b>providers</b> : \$600 person/ \$1,800 family; Tier 2 <b>providers</b> : \$900 person / \$2,700 family; Tier 3 <b>providers</b> \$900 person / \$2,700 family; Tier 4 <b>providers</b> : \$900 person / \$2,700 family	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. Tier 1 <b>providers</b> \$1,300 person / \$3,900 family; Tier 2 <b>providers</b> \$1,900 person / \$5,700 family; Tier 3 <b>providers</b> \$3,500 person / \$10,500 family; Tier 4 <b>providers</b> : Unlimited.	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	*See the General Overview of the Plan section of your Plan Document for a list of expenses that do not count towards your out-of-pocket limit.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <b>network</b> of <b>providers</b> ?	Yes. See <a href="http://www.egtrust.org">www.egtrust.org</a> or call 855-452-9997 for a list of participating <b>providers</b> .	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <b>specialist</b> ?	No (but you will pay a higher copay when not obtaining a referral).	You can see the <b>specialist</b> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <b>excluded services</b> .

**Questions:** Call your employer or The Care Coordinators at 855-452-9997 or visit us at [www.egtrust.org](http://www.egtrust.org). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf](http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf) or call the Care Coordinators at 855-452-9997 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-participating **provider** hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use a Tier 3 – Non-Participating Providers	Your Cost if You Use Tier 4 – Non-Participating Providers in Metro St. Louis	Limitations & Exceptions
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or an illness	\$25 copay/visit	\$25 copay/visit	35% coinsurance	45% coinsurance	Copay applies to office visit only, all other services subject to deductible & coinsurance.
	Specialist visit	\$30 copay/visit (with referral) / \$40 copay/visit (without referral)	\$30 copay/visit (with referral) / \$40 copay/visit (without referral)	35% coinsurance	45% coinsurance	
	Other practitioner office visit	50% coinsurance for chiropractor	50% coinsurance for chiropractor	50% coinsurance for chiropractor	50% coinsurance for chiropractor	Maximum calendar year benefit of \$750. Coinsurance does not apply towards the out-of-pocket limit.
	Preventive care/ screening/immunization	No Charge	No Charge	35% coinsurance	Not Covered	Deductible does not apply for Tier 1 or 2.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	15% coinsurance	20% coinsurance	35% coinsurance	45% coinsurance	There is no charge for lab work received from a LabCard provider and the deductible does not apply.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	20% coinsurance	35% coinsurance	45% coinsurance	Precertification required. Failure to precertify will result in a 50% reduction of covered expenses (up to a max of \$250).
<b>If you need drugs to treat your illness or condition.</b>	Generic drugs	\$12 copay (30-day retail) / \$36 copay (90-day retail) / \$30 copay (mail order)		\$12 copay (30-day retail) / \$36 copay (90-day retail)		Deductible does not apply. Maintenance drugs must be filled through the mail order program or a participating 90-day retail pharmacy
	Preferred brand drugs	\$25 copay (30-day retail) / \$85 copay (90-day retail) / \$55 copay (mail order)		\$25 copay (30-day retail) / \$85 copay (90-day retail)		

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More information about <b>prescription drug coverage</b> is available at <a href="http://www.egtrust.org">www.egtrust.org</a>	Non-preferred brand drugs	\$40 copay (30-day retail) / \$130 copay (90-day retail) / \$100 copay (mail order)		\$40 copay (30-day retail) / \$130 copay (90-day retail)		after 2 fills at a retail pharmacy. No charge for preventive drugs. For injectables, you pay applicable copay + 3%.
	Specialty drugs	Must be purchased directly through Specialty Pharmacy and limited to a 30-day supply.				
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$250 copay/occurrence + 15% coinsurance	\$250 copay/occurrence + 20% coinsurance	\$550 copay/occurrence + 35% coinsurance	\$550 copay/occurrence + 45% coinsurance	Precertification required. Failure to precertify will result in a 50% reduction of covered expenses (up to a max of \$250).
	Physician/surgeon fees	15% coinsurance	20% coinsurance	35% coinsurance	45% coinsurance	
<b>If you need immediate medical attention</b>	Emergency room services	\$300 copay/visit + 15% coinsurance	\$300 copay/visit + 15% coinsurance	\$300 copay/visit + 15% coinsurance	\$300 copay/visit + 15% coinsurance	One copay will apply if you admitted to hospital as an inpatient.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	Tier 3 and 4 subject to Tier 2 out-of-pocket maximum.
	Urgent Care	\$40 copay/visit + 10% coinsurance	\$40 copay/visit + 10% coinsurance	\$40 copay/visit + 10% coinsurance	\$40 copay/visit + 10% coinsurance	Deductible does not apply.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250 copay/admission + 15% coinsurance	\$250 copay/admission + 20% coinsurance	\$550 copay/admission + 35% coinsurance	\$550 copay/admission + 45% coinsurance	Precertification required. Failure to precertify will result in a 50% reduction of covered expenses (up to a max of \$250).
	Physician/surgeon fee	15% coinsurance	20% coinsurance	35% coinsurance	45% coinsurance	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	15% coinsurance	20% coinsurance	35% coinsurance	45% coinsurance	Limited to 52 visits per calendar year.
	Mental/Behavioral health inpatient services	\$250 copay/admission + 15% coinsurance	\$250 copay/admission + 20% coinsurance	\$550 copay/admission + 35% coinsurance	\$550 copay/admission + 45% coinsurance	Precertification required. Failure to precertify will result in a 50% reduction of covered expenses (up to a max of \$250). Limited to 50 days

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use a Tier 3 – Non-Participating Providers	Your Cost if You Use Tier 4 – Non-Participating Providers in Metro St. Louis	Limitations & Exceptions
						lifetime maximum.
	Substance use disorder outpatient services	15% coinsurance	20% coinsurance	35% coinsurance	45% coinsurance	Limited to 52 visits per calendar year.
	Substance use disorder inpatient services	\$250 copay/ admission + 15% coinsurance	\$250 copay/ admission + 20% coinsurance	\$550 copay/ admission + 35% coinsurance	\$550 copay/ admission + 45% coinsurance	Precertification required. Failure to precertify will result in a 50% reduction of covered expenses (up to a max of \$250). Limited to 50 days lifetime maximum.
<b>If you are pregnant</b>	Prenatal and postnatal care	15% coinsurance	20% coinsurance	35% coinsurance	45% coinsurance	There is no charge and the deductible does not apply to preventive prenatal care and certain breastfeeding support and supplies from a participating provider.
	Delivery and all inpatient services	\$250 copay/ admission + 15% coinsurance (facility) / 15% coinsurance (physician)	\$250 copay/ admission + 20% coinsurance (facility) / 20% coinsurance (physician)	\$550 copay/ admission + 35% coinsurance (facility) / 315% coinsurance (physician)	\$550 copay/ admission + 45% coinsurance (facility) / 45% coinsurance (physician)	Precertification required for inpatient Hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section).
<b>If you need help recovering or have other special health needs</b>	Home health care	15% coinsurance	20% coinsurance	35% coinsurance	45% coinsurance	Precertification required. Failure to precertify will result in a 50% reduction of covered expenses (max of \$250). Failure to precertify will result in a \$250 penalty.
	Rehabilitation services	15% coinsurance	20% coinsurance	35% coinsurance	45% coinsurance	Includes physical, speech & occupational therapy. Precertification required. Failure to precertify will result in a 50% reduction of covered expenses (up to a max of \$250).
	Habilitation services	15% coinsurance	20% coinsurance	35% coinsurance	45% coinsurance	-----none-----
	Skilled nursing	15% coinsurance	20% coinsurance	35% coinsurance	45% coinsurance	Precertification required. Failure to

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	care					precertify will result in a 50% reduction of covered expenses (up to a max of \$250).
	Durable medical equipment	15% coinsurance	20% coinsurance	35% coinsurance	45% coinsurance	Precertification required for any item in excess of \$500. Failure to precertify will result in a 50% reduction of covered expenses (up to a max of \$250).
	Hospice service	15% coinsurance	20% coinsurance	35% coinsurance	45% coinsurance	Precertification required. Failure to precertify will result in a 50% reduction of covered expenses (max of \$250).
<b>If your child needs dental or eye care</b>	Eye exam	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
	Glasses	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

### Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (except for hospice)
- Routine eye care(Adult & Child)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (for the treatment of morbid obesity only)
- Chiropractic care
- Infertility treatment

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the Care Coordinators at 855-452-9997. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file **a grievance**. For questions about your rights, this notice, or assistance, you can contact the Care Coordinators at 855-452-9997 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

(Español): Para obtener asistencia en Español, llame al 1-800-378-1179.

(Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

(Chinese): (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-378-1179.

(Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-378-1179.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

Having a baby  
 (normal delivery – Tier 1)

- Amount owed to providers: \$7,540
- Plan pays \$5,680
- Patient pays \$1,860

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

Patient pays:

Deductibles	\$1,200
Copays	\$270
Coinsurance	\$240
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,860</b>

Managing type 2 diabetes  
 (routine maintenance of  
 a well-controlled condition – Tier 1)

- Amount owed to providers: \$5,400
- Plan pays \$4,020
- Patient pays \$1,380

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

Patient pays:

Deductibles	\$600
Copays	\$550
Coinsurance	\$150
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,380</b>



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- Coverage examples are based on single and family coverage.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from Tier 1 providers. If the patient had received care from participating or non-participating **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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