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.egtust.org** or by calling the Care Coordinators at **855-452-9997**.

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	For preferred **providers**: **$300** person /**$900** family (with wellness requirement) **$400** person / **$1,200** family (without wellness requirement) For non-preferred **providers**: **$800** person / **$2,400** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there other **deductibles** for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an **out-of-pocket limit** on my expenses?	Yes. For preferred **providers**: **$1,200** person/**$2,400** family (deductible & coinsurance) **$2,500** person / **$5,000** family (deductible, coinsurance and copays) For non-preferred **providers**: **$4,500** person / **$9,000** family	The **out-of-pocket limit** 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 **out-of-pocket limit**?	*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 **out-of-pocket limit.**
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 *specific* covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. See **www.egtrust.org** or call **855-452-9997** for a list of preferred **providers**.	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or preferred for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a **specialist**?	No (but you may receive a discount for obtaining a referral).	You can see the **specialist** 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 **excluded services**.

Questions: Call the Care Coordinators at **855-452-9997** or visit us at **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** or call your employer 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-preferred **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-preferred **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 preferred **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Providers	Your Cost If You Use a Non-Preferred Providers	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or an illness	$25 copay/visit	30% 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% coinsurance	
	Other practitioner office visit	50% coinsurance for chiropractor & acupuncture	50% coinsurance for chiropractor & acupuncture	Maximum calendar year benefit of $750.
	Preventive care/ screening/immunization	No Charge	30% coinsurance	Deductible does not apply for preferred providers.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	There is no charge for lab work received from a network independent lab provider and the deductible does not apply.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Precertification required. Failure to precertify will result in a 50% reduction of covered expenses (up to a max of $250).
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.egtrust.org	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)	Maintenance drugs must be filled through the mail order program after 2 fills at a retail pharmacy. No charge for preventive drugs. Specialty drugs must be purchased directly through the Specialty Pharmacy and are limited to a 30-day supply.
	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)	
	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)	
	Specialty drugs	Copay + 3% coinsurance, up to a maximum of $150/month	Not Covered	

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Providers	Your Cost If You Use a Non-Preferred Providers	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/occurrence + 10% coinsurance	$550 copay/occurrence + 30% coinsurance	Precertification required. Failure to precertify will result in a 50% reduction of covered expenses (up to a max of $250).
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room services	$300 copay/visit + 15% coinsurance	$300 copay/visit + 15% coinsurance	Deductible does not apply. Non-preferred providers paid at the preferred provider level of benefits. Copay waived if admitted to the hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Non-preferred providers paid at the preferred provider level of benefits.
	Urgent Care	$40 copay/visit + 10% coinsurance	$40 copay/visit + 10% coinsurance	Deductible does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission + 10% coinsurance	$550 copay/ admission + 30% coinsurance	Precertification required. Failure to precertify will result in a 50% reduction of covered expenses (up to a max of $250).
	Physician/surgeon fee	10% coinsurance	30% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	30% coinsurance	Limited to a combined 52 visits per calendar year with substance use disorders.
	Mental/Behavioral health inpatient services	$250 copay/ admission + 10% coinsurance (facility) / 10% coinsurance (professional fees)	$550 copay/ admission + 30% coinsurance (facility) / 30% coinsurance (professional fees)	Precertification required. Failure to precertify will result in a 50% reduction of covered expenses (up to a max of $250). Limited to a combined 50 days lifetime maximum with substance use disorders.
	Substance use disorder outpatient services	10% coinsurance	30% coinsurance	Limited to a combined 52 visits per calendar year with mental/behavioral health.
	Substance use disorder inpatient services	$250 copay/ admission + 10% coinsurance (facility) / 10% coinsurance (professional fees)	$550 copay/ admission + 30% coinsurance (facility) / 30% coinsurance (professional fees)	Precertification required. Failure to precertify will result in a 50% reduction of covered expenses (up to a max of $250). Limited to a combined 50 days lifetime maximum with mental/behavioral health.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Providers	Your Cost If You Use a Non-Preferred Providers	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	10% coinsurance	30% coinsurance	There is no charge and the deductible does not apply to preventive prenatal care and certain breastfeeding support and supplies from a preferred provider**.**
	Delivery and all inpatient services	$250 copay/ admission + 10% coinsurance (facility) / 10% coinsurance (professional fees)	$550 copay/ admission + 30% coinsurance (facility) / 30% coinsurance (professional fees)	Precertification required for inpatient Hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (C-section). Failure to precertify will result in a 50% reduction of covered expenses (max of $250).
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Precertification required. Failure to precertify will result in a 50% reduction of covered expenses (max of $250).
	Rehabilitation services	10% coinsurance	30% coinsurance	Includes physical, speech & occupational therapy.
	Habilitation services	10% coinsurance	30% coinsurance	----------none----------
	Skilled nursing care	10% coinsurance	30% coinsurance	Precertification required. Failure to precertify will result in a 50% reduction of covered expenses (up to a max of $250).
	Durable medical equipment	10% coinsurance	30% 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	10% coinsurance	30% coinsurance	Precertification required. Failure to precertify will result in a 50% reduction of covered expenses (max of $250). Bereavement counseling is excluded.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	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.)

- Bereavement counseling
- 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.)

- Acupuncture
- 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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.

Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431.

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, kwiijigo 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.

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.

Having a baby (normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $6,060**
- **Patient pays $1,480**

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
Total	**$7,540**
Patient pays:	
Deductibles	$400
Copays	$270
Coinsurance	$660
Limits or exclusions	$150
Total	**$1,480**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,080**
- **Patient pays $1,320**

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
Total	**$5,400**
Patient pays:	
Deductibles	$400
Copays	$720
Coinsurance	$120
Limits or exclusions	$80
Total	**$1,320**

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 coverage only.
- The patient's condition was not an excluded 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 _Name **providers**. If the patient had received care from preferred or non-preferred **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.