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, please contact the **Fund Office** at 419-662-1388 or visit www.nwoppfringes.org. For questions about prescription drug coverage, please call 1-855-896-9779. 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 call the Fund Office to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$400** person / **$1,200** family Does not apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your 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 services covered before you meet your deductible?	Yes. In-network **preventive care**, office visits and prescription drugs 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?	There are no other specific **deductibles**.	You don't have to meet specific **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For in-network providers **$9,450** person / **$18,900** 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. There is a separate **coinsurance limit** of **$1,500**/person and **$3,000**/family that accumulates toward the **out-of-pocket limit**.
What is not included in the out-of-pocket limit?	Premiums, self-payments, balance billed charges, dental, vision and health care this plan does not cover.	Even though you may be required to 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.frontpathcoalition.org or call 1-419-891-5206** for a list of participating 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 participating for **providers** in their **network**. See chart starting on page 2 for how this plan pays different kinds of **providers**.
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 permission from this plan.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	30% coinsurance	Pre-certification required for high-cost drugs administered on-site. For pre-certification, please call 855-248-1859.
	Specialist visit	20% coinsurance	30% coinsurance	Chiropractic care is limited to 12 visits per year. Acupuncture is not covered. Pre-certification required for high-cost drugs administered on-site. For pre-certification, please call 855-248-1859.
	Preventive care/screening/ immunization	No charge	30% coinsurance	Benefits covered at 100% in-network. Limitations may apply on number of visits.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	---none---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com or by calling 1-855-896-9779.	Generic drugs	$10.00 ($20 for 90-day mail order)	$10.00 (90-day supply unavailable out-of-network)	Pre-certification required for non-compound and non-specialty drugs costing $5,000 or more, compound drugs costing $100 or more and high-cost drugs administered on-site.
	Preferred brand drugs	$35.00 ($70 for 90-day mail order)	$35.00 (90-day supply unavailable out-of-network)	
	Non-preferred brand drugs	$70.00 ($140 for 90-day mail order)	$70.00 (90-day supply unavailable out-of-network)	
	Specialty drugs	20% of total cost up to $210	N/A	Pre-certification required for non-compound and non-specialty drugs costing $5,000 or more, compound drugs costing $100 or more and high-cost drugs administered on-site. Specialty drugs not covered out-of-network, unless unavailable at an in-network pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Pre-certification required for high-cost drugs administered on-site. For pre-certification, please call 855-248-1859.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	---none---
If you need immediate medical attention	Emergency room care	$100 copay plus 20% coinsurance	$100 copay plus 20% coinsurance	Copay waived if admitted to hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	---none---
	Urgent care	20% coinsurance	20% coinsurance	---none---

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Pre-certification required for non-emergencies and high-cost drugs administered on-site. For pre-certification, please call 855-248-1859.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	Pre-certification required out-of-network and for high-cost drugs administered on-site. For pre-certification, please call 1-855-248-1859. Some services require case management. Please call the Fund Office at 419-662-1388 for more information.
	Inpatient services	20% coinsurance	30% coinsurance	
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	Includes covered services provided by a certified nurse midwife. Mothers who are dependent children will only be covered for prenatal and postnatal preventive services to the extent required by federal law. Pre-certification required for high-cost drugs administered on-site. For pre-certification, please call 855-248-1859.Please contact the Fund office for more information.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	Mothers who are dependent children are excluded from delivery and inpatient services. Pre-certification required for hospital stay in excess of 48 hours for vaginal delivery, 96 hours for cesarean delivery and for high-cost drugs administered on-site. For pre-certification, please call 1-855-248-1859.
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Pre-certification required. To obtain pre-certification, please call 1-855-248-1859.
	Rehabilitation services	20% coinsurance	30% coinsurance	Pre-certification required for physical therapy after the 24th visit. To obtain pre-certification, please call 1-855-248-1859.
	Habilitation services	20% coinsurance	30% coinsurance	---none---
	Skilled nursing care	20% coinsurance	30% coinsurance	Pre-certification required. To obtain pre-certification, please call 855-248-1859.
	Durable medical equipment	20% coinsurance	30% coinsurance	Prescription must be sent with claim. Pre-certification required. To obtain pre-certification, please call 1-855-248-1859.
	Hospice services	20% coinsurance	30% coinsurance	Pre-certification required. To obtain pre-certification, please call 1-855-248-1859.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Covered	Covered	Exam is covered once annually.
	Children's glasses	Covered	Covered	Covered once annually.
	Children's dental check-up	Covered	Covered	Exam is covered twice annually.

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.)

- Acupuncture
- Non-medically necessary cosmetic surgery
- Infertility treatment
- Non-Emergency Care when traveling outside the U.S.
- Weight loss programs
- Bariatric surgery
- Long term care

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

- Hearing aids
- Chiropractic care (limited to 12 visits per year)
- Routine foot care
- Private duty nursing (pre-certification required)
- Dental and routine eye care covered under a separate plan. Please contact the Fund Office for more information.
- If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, co-payments, or co-insurance, or benefits not otherwise covered.

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 Centers for Medicare & Medicaid Services – Office of COBRA Continuation Coverage at 1-866-444-3272. 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 on how 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 Fund Office at 419-662-1388.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

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 *[cost sharing]***	**20%**
■ **Hospital (facility) *[cost sharing]***	**20%**
■ **Other *[cost sharing]***	**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	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,900**

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 *[cost sharing]***	**20%**
■ **Hospital (facility) *[cost sharing]***	**20%**
■ **Other *[cost sharing]***	**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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$0
Coinsurance	$650
What isn't covered	
Limits or exclusions	$300
The total Joe would pay is	**$1,350**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	**$400**
■ **Specialist *[cost sharing]***	**20%**
■ **Hospital (facility) *[cost sharing]***	**20%**
■ **Other *[cost sharing]***	**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	**$1,350**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$0
Coinsurance	$550
What isn't covered	
Limits or exclusions	$25
The total Mia would pay is	**$975**

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