

# *Ohio Conference of Plasterers and Cement Masons Health and Welfare Fund*

3660 Stutz Dr., Suite 101, Canfield, Ohio 44406  
Telephone: (330) 779-8860 ▪ Toll Free 1-800-435-2388

## **MEMORANDUM**

TO: Non-Medicare Retirees and Dependents  
FROM: The Board of Trustees  
RE: Monthly Premium Rate for 2027  
DATE: October 2026

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As previously advised, the Board of Trustees has established a policy that all family members participating in the early retiree program be charged the same rate for coverage that the active participant pays for Mid-Plan coverage. As a result of changes to the active Mid-Plan cost of coverage the following rates will be billed or reflected as a reduction on your monthly pension check effective January 1, 2027. The table below also reflects the current premium and the 2027 premium if you elected Dental/Vision coverage. Enrollment forms to elect Dental and Vision for 2027 were previously provided and need returned by November 15, 2026.

| <b><i>Medical/Rx Only<br/>Rate through<br/>12/31/26</i></b> | <b><i>Medical /Rx<br/>+ Dental &amp; Vision<br/>Rate through<br/>12/31/26<br/>(if elected)</i></b> | <b><i>Medical/Rx Only<br/>Rate through<br/>12/31/27</i></b> | <b><i>Medical /Rx<br/>+ Dental &amp; Vision<br/>Rate through<br/>12/31/27<br/>(if elected)</i></b> |
|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| \$1,025.00                                                  | \$1,118.00                                                                                         | \$1,062.50                                                  | \$1,177.50                                                                                         |

Enclosed you will find the Summary of Benefits and Coverage (SBC) which outlines the medical and prescription benefits for 2027. The benefits remain unchanged from the prior year.

The Trustees will continue to annually review the historical and projected costs of the plan and monitor the health of the plan and make changes necessary to provide comprehensive coverage for you and your dependents.

The Trustees are confident that if you were to shop for medical insurance in the marketplace, you would find that even with this change in rate, the cost is extremely competitive versus a plan with similar coverage.

If you have any questions, please contact the Fund Office at 330-779-8860.



**Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services**  
**OHIO CONFERENCE OF PLASTERERS AND CEMENT MASONS:**  
**CLASS I MID PLAN & CLASS II, CLASS III, EARLY RETIREES, AND DEPENDENTS**

**Coverage Period: 01/01/2027-12/31/2027**  
**Coverage for: Single or Family | Plan Type: PPO**



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. See [www.ohcementmasonsbenefits.org](http://www.ohcementmasonsbenefits.org) or call 1-330-779-8860. 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.healthcare.gov](http://www.healthcare.gov) or call 1-800-318-2596 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                         | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | <a href="#">Network</a> : \$500 per individual, \$1,000 per family<br><a href="#">Out-of-Network</a> : \$1,000 per individual, \$2,000 per family                                                                                                                               | Generally, you must pay all of the costs from <a href="#">providers</a> 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> .                                                                                                                                                                                                           |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Network</a> office visits for illness or injury, <a href="#">network preventive care</a> , telemedicine visits, Minute Clinic (CVS retail clinic) visits, and <a href="#">prescription drugs</a> 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Are there other <a href="#">deductibles</a> for specific services?              | Yes, Dental: \$50 per individual; \$150 per family                                                                                                                                                                                                                              | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | <a href="#">Network</a> : \$3,000 per individual, \$6,000 per family<br><a href="#">Out-of-Network</a> : \$6,000 per individual, \$12,000 per family                                                                                                                            | 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.                                                                                                                                                                                                                                                                                                                                                            |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance billing</a> charges (unless <a href="#">balance billing</a> is prohibited), <a href="#">prescription drugs</a> , and health care this <a href="#">plan</a> doesn't cover.                                                        | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-833-639-1634 for a list of <a href="#">network providers</a> .                                                                                                                                            | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to                                       | No.                                                                                                                                                                                                                                                                             | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

see a [specialist](#)?



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                                                                                                                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                       |                                                         | <a href="#">Network Provider</a><br>(You will pay the least)                                                           | <a href="#">Out-of-Network Provider</a><br>(You will pay the most)                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                    |
| <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        | 20% <a href="#">coinsurance</a> after \$20 <a href="#">copay</a> per visit. <a href="#">Deductible</a> does not apply. | 40% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>                                                                                                                                                                                               | 20% <a href="#">coinsurance</a> after \$20 <a href="#">copay</a> per visit for non-LiveHealth telehealth physician visits ( <a href="#">copayment</a> waived for Anthem LiveHealth telehealth physician visits); Diagnostic labs paid in full after <a href="#">copay</a> is paid. |
|                                                                                                                                                                                                                       | <a href="#">Specialist</a> visit                        | \$20 <a href="#">copay</a> per visit. <a href="#">Deductible</a> does not apply.                                       | 40% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>                                                                                                                                                                                               | None.                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                       | <a href="#">Preventive care/screening</a> /immunization | No charge. <a href="#">Deductible</a> does not apply.                                                                  | 40% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>                                                                                                                                                                                               | You may have to pay for services that aren't preventative. Ask your <a href="#">provider</a> if the services needed are preventative. Then check what your <a href="#">plan</a> will pay for.                                                                                      |
| <b>If you have a test</b>                                                                                                                                                                                             | <a href="#">Diagnostic test</a> (x-ray, blood work)     | 20% <a href="#">coinsurance</a>                                                                                        | 40% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>                                                                                                                                                                                               | Effective May 1, 2022, charges from <a href="#">out-of-network providers</a> rendered at an in- <a href="#">network</a> facility will be covered at the in- <a href="#">network</a> rate.                                                                                          |
|                                                                                                                                                                                                                       | Imaging (CT/PET scans, MRIs)                            | 20% <a href="#">coinsurance</a>                                                                                        | 40% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>                                                                                                                                                                                               | See Note above.                                                                                                                                                                                                                                                                    |
| <b>If you need drugs to treat your illness or condition</b><br>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 and Brand Name Drugs                      | 20% <a href="#">coinsurance</a> (retail and mail order); <a href="#">deductible</a> does not apply                     | You must submit <a href="#">claim</a> for reimbursement of the amount the <a href="#">plan</a> would have paid for the drug (retail or mail order) in <a href="#">network</a> minus 20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply | Retail: 34-day or 90-day supply; Mail Order: 90-day supply.<br><br>If a brand name drug is prescribed "Dispense as Written" and a generic equivalent is available, you pay the cost difference between the brand and generic drug plus 20% <a href="#">coinsurance</a> .           |
|                                                                                                                                                                                                                       | <a href="#">Specialty drugs</a>                         | 20% <a href="#">coinsurance</a> (retail and mail order); <a href="#">deductible</a> does not apply                     |                                                                                                                                                                                                                                                                 | Your <a href="#">cost sharing</a> does not count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                  |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                 | Facility fee (e.g., ambulatory surgery)                 | 20% <a href="#">coinsurance</a>                                                                                        | 40% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>                                                                                                                                                                                               | None                                                                                                                                                                                                                                                                               |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                            |                                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                           |
|---------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | <a href="#">Network Provider</a><br>(You will pay the least) | <a href="#">Out-of-Network Provider</a><br>(You will pay the most) |                                                                                                                                                                                                                                                                                  |
|                                                                           | center)<br>Physician/surgeon fees (Outpatient)   | 20% <a href="#">coinsurance</a>                              | 40% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>  | None                                                                                                                                                                                                                                                                             |
| If you need immediate medical attention                                   | <a href="#">Emergency room services</a>          | 20% <a href="#">coinsurance</a>                              | 20% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>  | 40% <a href="#">coinsurance</a> applies for non-emergency medical conditions in ER. Effective May 1, 2022, the <a href="#">Plan</a> will cover all <a href="#">emergency services</a> at <a href="#">Out-of-Network</a> Emergency Rooms at the in- <a href="#">network</a> rate. |
|                                                                           | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a>                              | 20% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>  | Effective May 1, 2022, the <a href="#">Plan</a> will cover all emergency air ambulance services at the in- <a href="#">network</a> rate.                                                                                                                                         |
|                                                                           | <a href="#">Urgent care</a>                      | 20% <a href="#">coinsurance</a>                              | 40% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>  | None                                                                                                                                                                                                                                                                             |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a>                              | 40% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>  | None                                                                                                                                                                                                                                                                             |
|                                                                           | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>                              | 40% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>  | None                                                                                                                                                                                                                                                                             |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | 20% <a href="#">coinsurance</a>                              | 40% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>  | None                                                                                                                                                                                                                                                                             |
|                                                                           | Inpatient services                               | 20% <a href="#">coinsurance</a>                              | 40% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>  | None                                                                                                                                                                                                                                                                             |
| If you are pregnant                                                       | Office visits                                    | 20% <a href="#">coinsurance</a>                              | 40% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>  | Coverage for subscriber and subscriber spouse only.                                                                                                                                                                                                                              |
|                                                                           | Childbirth/delivery professional services        | 20% <a href="#">coinsurance</a>                              | 40% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>  | Coverage for subscriber and subscriber spouse only.                                                                                                                                                                                                                              |
|                                                                           | Childbirth/delivery facility services            | 20% <a href="#">coinsurance</a>                              | 40% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>  | Coverage for subscriber and subscriber spouse only.                                                                                                                                                                                                                              |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | 20% <a href="#">coinsurance</a>                              | 40% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>  | Limited to 40 visits per calendar year.                                                                                                                                                                                                                                          |
|                                                                           | <a href="#">Rehabilitation services</a>          | 20% <a href="#">coinsurance</a>                              | 40% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>  | None                                                                                                                                                                                                                                                                             |
|                                                                           | <a href="#">Habilitation services</a>            | 20% <a href="#">coinsurance</a>                              | 40% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>  | None                                                                                                                                                                                                                                                                             |

| Common Medical Event                   | Services You May Need                  | What You Will Pay                                                                |                                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                   |
|----------------------------------------|----------------------------------------|----------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                        | <u>Network Provider</u><br>(You will pay the least)                              | <u>Out-of-Network Provider</u><br>(You will pay the most) |                                                                                                                                                                                                                                                          |
|                                        | <u>Skilled nursing care</u>            | 20% <u>coinsurance</u>                                                           | 40% <u>coinsurance</u> of <u>allowed amount</u>           | None                                                                                                                                                                                                                                                     |
|                                        | <u>Durable medical equipment (DME)</u> | 20% <u>coinsurance</u>                                                           | 40% <u>coinsurance</u> of <u>allowed amount</u>           | None                                                                                                                                                                                                                                                     |
|                                        | <u>Hospice services</u>                | 20% <u>coinsurance</u>                                                           | 40% <u>coinsurance</u> of <u>allowed amount</u>           | None                                                                                                                                                                                                                                                     |
| If your child needs dental or eye care | Children's eye exam                    | One exam every 12 months; \$0 copay                                              |                                                           | Dental and Vision Coverage is a voluntary program that you purchase through your Dollar Bank <u>Out-of-Network</u> allowances vary by materials (lens/contacts). Coverage is not available if you decline dental and vision coverage at Open Enrollment. |
|                                        | Children's glasses                     | One pair of lenses every 12 months: \$180 frame allowance & \$0 lens/frame copay |                                                           |                                                                                                                                                                                                                                                          |
|                                        | Children's dental check-up             | 100%                                                                             |                                                           |                                                                                                                                                                                                                                                          |

## 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
- Cosmetic surgery (except for [reconstructive surgery](#) following mastectomy)
- Hearing aids
- Infertility treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Bariatric Surgery
- Chiropractic care (limited to 12 visits per calendar year, 20% [coinsurance](#) for in-[network](#) and 40% [coinsurance Out-of-Network](#))
- Dental Care (Adult and Child, if purchased at open enrollment)
- Private-duty nursing
- Routine eye care (Adult and Child, if purchased at open enrollment)

**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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>. 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 330-779-8860 or visit <https://www.ourbenefitoffice.com/ohcementmasons/Benefits/MedicalBenefits.aspx>. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>.

### 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 Services:** Language Access Services: Um Helf in Deitsch zu greige, rull dei Anthem Sales Representative, Drupp Blan Sponsor odder die Member Service uff dei ID karate aa. (Pennsylvania Dutch)

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

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## 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 [network provider](#) pre-natal care and a hospital delivery)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$20  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <a href="#">Cost Sharing</a>      |               |
|-----------------------------------|---------------|
| <a href="#">Deductibles</a>       | \$500         |
| <a href="#">Copayments</a>        | \$0           |
| <a href="#">Coinsurance</a>       | \$2,400       |
| What isn't covered                |               |
| Limits or exclusions              | \$60          |
| <b>The total Peg would pay is</b> | <b>\$2,60</b> |

### Managing Joe's type 2 Diabetes

(a year of routine [network provider](#) care of a well-controlled condition)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$20  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 20%   |

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment \(DME\)](#) (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$500          |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$900          |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,620</b> |

### Mia's Simple Fracture

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

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$20  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 20%   |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment \(DME\)](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <a href="#">Cost Sharing</a>      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$500        |
| <a href="#">Copayments</a>        | \$60         |
| <a href="#">Coinsurance</a>       | \$400        |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$960</b> |

# Ohio Conference of Plasterers and Cement Masons Health and Welfare Fund

3660 Stutz Drive, Suite 101 • Canfield, Ohio 44406  
Telephone: (330) 779-8860 • Toll Free 1-800-435-2388

## Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

**English ATTENTION:** If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call (330) 270-0453 or speak to your provider.

**Español (Spanish) ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al (330) 270-0453 o hable con su proveedor.

**中文 (Chinese) 注意:** 如果您说[中文], 我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以无障碍格式提供信息。致电 (330) 270-0453 或咨询您的服务提供商。

**Tiếng Việt (Vietnamese) LƯU Ý:** Nếu bạn nói một ngôn ngữ khác, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các dịch vụ và trợ giúp bổ sung phù hợp để cung cấp thông tin ở các định dạng có thể truy cập cũng có sẵn miễn phí. Gọi (330) 270-0453 hoặc nói chuyện với nhà cung cấp của bạn.

**Tagalog (Tagalog) PAALALA:** Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyon tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa (330) 270-0453 o makipag-usap sa iyong provider.

**한국어 (Korean) 주의:** [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. (330) 270-0453 번으로 전화하거나 서비스 제공업체에 문의하십시오.

**Հայերեն (Armenian) ՈՒՇԱԴՐՈՒԹՅՈՒՆ:** Եթե խոսում եք այլ լեզվով, ձեզ հասանելի են անվճար լեզվակալան աջակցության ծառայություններ: Մատչելի ձևաչափերով տեղեկատվություն տրամադրելու համար համապատասխան օժանդակ օժանդակ վիճակներն ու ծառայությունները նույնպես հասանելի են անվճար: Չանգահարեք (330) 270-0453 կամ խոսեք ձեր մատակարարի հետ

**فارسی (Persian) توجه:** اگر به زبان دیگری صحبت می کنید، خدمات کمکی و کمکی مناسب کمک زبان رایگان برای شما در دسترس است. خدمات کمکی و کمکی مناسب برای ارائه اطلاعات در قالب های قابل دسترس نیز به صورت رایگان در دسترس هستند. با (330) 270-0453 تماس بگیرید یا با ارائه دهنده خود صحبت کنید.

**РУССКИЙ (Russian) ВНИМАНИЕ:** Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону (330) 270-0453 или обратитесь к своему поставщику услуг.

**日本語 (Japanese) 注意:** 別の言語を話す場合は、無料の言語支援サービスをご利用いただけます。アクセシブルな形式で情報を提供するための適切な補助手段やサービスも無料でご利用いただけます。(330) 270-0453 に電話するか、プロバイダーにお問い合わせください。

**العربية (Arabic) تنبيه:** إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم (330) 270-0453 أو تحدث إلى مقدم الخدمة.

**ਗੁਰਮੁਖੀ (Punjabi) ਧਿਆਨ ਦਿਓ:** ਜੇਕਰ ਤੁਸੀਂ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਦੁਕਵੀਆਂ ਸਹਾਇਕ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। (330) 270-0453 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।

**ខ្មែរ (Khmer) យកចិត្តទុកដាក់:** ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយភាសាគតិកិច្ចអាចរកបានសម្រាប់អ្នក។ ជំនួយ និងសេវាជំនួយសមស្របដើម្បីផ្តល់ព័ត៌មានក្នុងទម្រង់ដែលអាចចូលប្រើបានក៏អាចរកបានដោយគតិកិច្ចផងដែរ។ ទូរស័ព្ទទៅ (330) 270-0453 ឬនិយាយទៅកាន់អ្នកផ្តល់សេវាបស់អ្នក។

**Hmoob (Hmong) CEEB TOOM:** Yog tias koj hais lwm hom lus, muaj kev pabcuam lus pub dawb rau koj. Cov kev pabcuam tsim nyog thiab cov kev pabcuam los muab cov ntaub ntawv hauv cov qauv siv tau kuj muaj pub dawb. Hu rau (330) 270-0453 lossis tham nrog koj tus kws kho mob.

**हिंदी (Hindi) ध्यान दें:** यदि आप दूसरी भाषा बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक उपकरण और सेवाएँ भी निःशुल्क उपलब्ध हैं। (330) 270-0453 पर कॉल करें या अपने प्रदाता से बात करें।

**ภาษาไทย (Thai) หมายเหตุ:** หากคุณพูดภาษาอื่น คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี นอกจากนี้ ยังมีบริการช่วยเหลือและบริการเสริมที่เหมาะสมเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่ายอีกด้วย โปรดโทร (330) 270-0453 หรือพูดคุยกับผู้ให้บริการของคุณ