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, contact the Trust Fund Office at **1-775-826-7200**. 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.https://www.healthcare.gov/sbc-glossary or call **1-775-826-7200** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300**/individual or **$600**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes.** Certain Preventive care, specific outpatient lab procedures (performed in Lab Corp., Renown or Quest labs), and mail order 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/ but contact the **Trust Fund Office** for specific covered preventive services under this plan.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers **up to $2,000**/ Individual; for out-of-network providers **No Limit**/ Individual.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Balance-billing charges, coinsurance, deductibles, and penalties for failure to obtain pre-authorization for services, and mail order prescription drug charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	**Yes.** Call **1-775-826-7200** for a list of network providers or e-mail csmart@bpareno.com.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing) subject to this plan's **Schedule of Allowance**. Check with your provider before you get services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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 of network contract rate.	30% coinsurance of non-network fee schedule plus any charges above fee schedule.	Limited to allowed amount network contract rate or non-network fee schedule. Effective March 18, 2020 through public health emergency period only, if in-person or telehealth visit results in an order for COVID-19 test, covered at no cost. If receive test non-PPO network, cash price of test must be posted on providers public website.
	Specialist visit	20% coinsurance of network contract rate	30% coinsurance of non-network fee schedule plus any charges above fee schedule.	None.
	Preventive care/screening/ immunization	20% coinsurance of network contract rate after deductible. (No Cost for Covid-19 vaccinations).	30% coinsurance of non-network fee schedule plus any charges above fee schedule. (No Cost for Covid-19 vaccinations).	Limited to allowed amount network contract rate or non-network fee schedule. Colonoscopy every 5 years (for ages 50 & older). Routine physical exam limited to 1 exam, 10 routine labs and 1 basic x-ray/year. Deductible does not apply to routine physical & labs & x-ray. No Immunizations for Adults except for shingles vaccination (See pages 17 & 58 of the Plan Document for details). **During public health emergency period no cost-sharing for coverage of COVID-19 vaccinations inc. booster shots and no prior auth. required.**
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance of network contract rate. (No Cost for Covid-19 Testing).	30% coinsurance of non-network fee schedule plus any charges above fee schedule. (No Cost for Covid-19 Testing).	Network services received at LabCorp, Renown & Quest covered at No charge & deductible does not apply. **During the public health emergency period only, COVID-19 testing and screening is covered at no cost.**
	Imaging (CT/PET scans, MRIs)			Pre-certification required by Professional Review Organization.
If you need drugs to treat your illness or condition	Generic drugs	20% coinsurance after deductible (retail); $40 or cost whichever less (mail	30% coinsurance up to non-network allowable amount plus any charges above (retail);	Covers up to a 90-day supply except for insulin & diabetic supplies (retail subscription); 90 day supply maintenance drugs (mail order prescription). Deductible

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

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)	
More information about **prescription drug coverage** is available at www.optumrx.com.		order)	Not Covered (mail order)	does not apply to Mail Order.
	Preferred brand drugs	20% coinsurance after deductible (retail); $80 or cost whichever less (mail order)	30% coinsurance up to non-network allowable amount plus any charges above (retail); Not Covered (mail order)	Covers up to a 90-day supply except for insulin & diabetic supplies (retail subscription); 90 day supply maintenance drugs (mail order prescription). Deductible does not apply to Mail Order.
	Non-preferred brand drugs Specialty drugs	20% coinsurance after deductible (retail); $80 or cost whichever less (mail order)	30% coinsurance up to non-network allowable amount plus any charges above (retail); Not Covered (mail order)	Covers up to a 90-day supply except for insulin & diabetic supplies (retail subscription); 90 day supply maintenance drugs (mail order prescription). Deductible does not apply to Mail Order. Pre-authorization required for Specialty Drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance of network contract rate	30% coinsurance of non-network fee schedule plus any charges above fee schedule.	Pre-authorization required. Certain **non-emergency services** & ancillary services (ex. emergency medicine, anesthesia, pathology, radiology, lab, neonatology, assistant surgeon, hospitalist or intensivist services) received by out-of-network provider at ambulatory surgery center you cannot be billed more than the plan's network contract rate. However, there are certain other non-emergency services at these network facilities, you can give written consent to be balance billed. Contact the Trust Fund Office for more information.
	Physician/surgeon fees	20% coinsurance of network contract rate	30% coinsurance of non-network fee schedule plus any charges above fee schedule.	Limited to allowed amount network contract rate or non-network fee schedule.
If you need immediate medical attention	Emergency room care	20% coinsurance of network contract rate	Per No Surprise Act, same as Network provider & based on recognized amount.	No. Pre-authorization required & No balance billing. During public health emergency period, COVID-19 treatment covered in same manner as other medically necessary treatment per Plan rules. Any cost-sharing will count towards any Plan applicable deductible or out-of-pocket limit . For recognized amount see Plan Rules. Emergency includes treatment received in Independent Free standing emergency department.
	Emergency medical transportation	20% coinsurance of network contract rate	For ground ambulance, 30% coinsurance of non-network	For covered air ambulance, any cost-sharing will count towards any Plan applicable deductible or out-of-pocket

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)	
			fee schedule plus any charges above fee schedule except covered Air Ambulance same as network provider & based on recognized amount..	limit & No balance billing.
	Urgent care	20% coinsurance of network contract rate	Per No Surprise Act, same as Network provider & based on recognized amount.	Any cost-sharing will count towards any Plan applicable deductible or out-of-pocket limit . No Pre-authorization required & No balance billing.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance of network contract rate	30% coinsurance of non-network fee schedule plus any charges above fee schedule.	Pre-authorization required. Certain **non-emergency services** & ancillary services (ex. emergency medicine, anesthesia, pathology, radiology, lab, neonatology, assistant surgeon, hospitalist or intensivist services) received by out-of-network provider at network hospital you cannot be billed more than the plan's network contract rate. However, there are certain other non-emergency services at these network facilities, you can give written consent to be balance billed. Contact the Trust Fund Office for more information.
	Physician/surgeon fees	20% coinsurance of network contract rate	30% coinsurance of non-network fee schedule plus any charges above fee schedule.	Limited to allowed amount network contract rate or non-network fee schedule.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% (mental health) or 25% (substance use) coinsurance of network contract rate	30% (mental health) or 25% (substance use) coinsurance of non-network fee schedule plus any charges above fee schedule.	Limited to allowed amount network contract rate or non-network fee schedule. No outpatient care in an acute hospital solely for detoxification. Out-of-network provider emergency services covered same as network provider & based on recognized amount.
	Inpatient services	20% (mental health) or 25% (substance use) coinsurance of network contract rate	30% (mental health) or 25% (substance use) coinsurance of non-network fee schedule plus any charges above fee schedule.	Limited to allowed amount network contract rate or non-network fee schedule. Pre-certification required by Professional Review Organization. Out-of-network provider emergency services covered same as network provider & based on recognized amount.
If you are pregnant	Office visits	20% coinsurance of network contract rate	30% coinsurance of non-network fee schedule plus any charges above fee schedule.	Limited to allowed amount network contract rate or non-network fee schedule. Cost sharing does not apply to certain preventive services. Depending on the type of

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

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)	
	Childbirth/delivery professional services	20% coinsurance of network contract rate	30% coinsurance of non-network fee schedule plus any charges above fee schedule.	services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Out-of-network emergency services covered same as network provider & based on recognized amount.
	Childbirth/delivery facility services	20% coinsurance of network contract rate	30% coinsurance of non-network fee schedule plus any charges above fee schedule.	
If you need help recovering or have other special health needs	Home health care	20% coinsurance of network contract rate	30% coinsurance of non-network fee schedule plus any charges above fee schedule.	Limited to allowed amount network contract rate or non-network fee schedule.
	Rehabilitation services	20% coinsurance of network contract rate	30% coinsurance of non-network fee schedule plus any charges above fee schedule.	Limited to allowed amount network contract rate or non-network fee schedule.
	Habilitation services	20% coinsurance of network contract rate	30% coinsurance of non-network fee schedule plus any charges above fee schedule.	Limited to allowed amount network contract rate or non-network fee schedule.
	Skilled nursing care	20% coinsurance of network contract rate	30% coinsurance of non-network fee schedule plus any charges above fee schedule.	100 days/confinement. Successive periods of confinement must be separated by 30 days.
	Durable medical equipment	No Charge; Deductible does not apply	30% coinsurance of non-network fee schedule plus any charges above fee schedule.	Limited to rental fee up to purchase price. Limited to allowed amount network contract rate or non-network fee schedule.
	Hospice services	No Charge; Deductible does not apply	No Charge plus any charges above fee schedule; Deductible does not apply	Limited to $10,000 maximum/year.
If your child needs dental or eye care	Children's eye exam	100% coinsurance of PPO contract	100% coinsurance of non-network fee schedule	Coverage limited to 1 exam/year.
	Children's glasses	100% coinsurance of PPO contract	100% coinsurance of non-network fee schedule plus any charges above fee schedule.	Coverage limited to one pair of glasses/year and one contact/year. Overages are patient's responsibility and not covered by the Plan.
	Children's dental check-up	10% coinsurance of Dental PPO contract	20% coinsurance of non-network fee schedule plus any charges above fee schedule.	No calendar maximum for dependent children up to age 19 but $3,000 maximum if over age 19 through age 25. Orthodontic Limit $2,500 per dependent child.

Excluded Services & Other Covered Services:

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

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Children's Eye Exam & Frames (you pay 100%) • Cosmetic Surgery • Infertility Treatment	• Long Term Care • Routine Foot Care	• Weight Loss Programs • Dialysis

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (if provided by physician or certified acupuncturist; limited 15 visits/year) • Bariatric Surgery • Chiropractic Care (for vertebrae, spine, back 7 neck only; limited 15 visits/year)	• Dental Care (Adults $3,000 limit & Dependent Children Under Age 19 No Limit) • Hearing Aid (limited to one every 3 years and $5,000 per pair and $2,500 per ear maximum) • Non-emergency care when traveling outside the U.S. (subject to Plan rules)	• Private Duty Nursing (subject to Plan rules) • Routine Eye Care (Adult & Dependents)

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: **Benefit Plan Administrator** at 1-775-826-7200 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-775-826-7200

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

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	**$300**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$300
Copayments	None
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	n/a
The total Peg would pay is	**$2,300**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$300**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$300
Copayments	None
Coinsurance	$1,420
What isn't covered	
Limits or exclusions	n/a
The total Joe would pay is	**$1,720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$300**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$300
Copayments	None
Coinsurance	$320
What isn't covered	
Limits or exclusions	n/a
The total Mia would pay is	**$620**

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