




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 visit ewtrusts.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.
	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, Pneumonia and Flu vaccination (See pages 17 & 58 of the Plan Document for details). Through 12/31/2025 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 Lab & Quest covered at No charge & deductible does not apply. Through 12/31/2025, 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 More information about prescription drug coverage is available at www.optumrx.com .	Generic drugs	20% coinsurance after deductible (retail); \$40 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.
	Preferred brand drugs	20% coinsurance after deductible (retail); \$80 or cost	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

Commented [LC1]: Need to find out from Jake does he want to extend this another year through 2025? The board previously extended through 12/31/2024.

Commented [LC2]: Same thing here need to find out if Jake and Board want to extend another year.

[* 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)	
		whichever less (mail order)	Not Covered (mail order)	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 . 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 fee schedule plus any charges above fee schedule except covered Air Ambulance same as network provider & based on recognized amount .	For covered air ambulance, any cost-sharing will count towards any Plan applicable deductible or out-of-pocket limit & No balance billing .
	Urgent care	20% coinsurance of network contract rate	Per No Surprise Act, same as Network provider & based on	Any cost-sharing will count towards any Plan applicable deductible or out-of-pocket limit . No Pre-authorization

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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)	
			recognized amount .	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 20% (substance use) coinsurance of network contract rate	30% (mental health) or 30% (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. Out-of-network provider emergency services covered same as network provider & based on recognized amount .
	Inpatient services	20% (mental health) or 20% (substance use) coinsurance of network contract rate	30% (mental health) or 30% (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 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 . No Pre-authorization required for epidurals.
	Childbirth/delivery professional services	20% coinsurance of network contract rate	30% coinsurance of non-network fee schedule plus any charges above fee schedule.	
	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	Home health care	20% coinsurance of	30% coinsurance of non-	Limited to allowed amount network contract rate or non-

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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)	
recovering or have other special health needs		network contract rate	network fee schedule plus any charges above fee schedule.	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	No Pre-authorization required.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Coverage limited to 1 exam/year.
	Children's glasses	No Charge	No Charge	Coverage limited to one pair of glasses/year or 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:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> Children's Eye Exam & Frames (you pay 100%) Cosmetic Surgery Infertility Treatment 	<ul style="list-style-type: none"> Long Term Care Routine Foot Care 	<ul style="list-style-type: none"> Weight Loss Programs (except medically necessary nutritional counseling) Dialysis

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Acupuncture (if provided by physician or certified acupuncturist; limited 15 visits/year) 	<ul style="list-style-type: none"> Dental Care (Adults \$3,000 limit & Dependent Children Under Age 19 No Limit) 	<ul style="list-style-type: none"> Private Duty Nursing (subject to Plan rules) Routine Eye Care (Adult & Dependents)

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

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

- Bariatric Surgery
- Chiropractic Care (for vertebrae, spine, back 7 neck only; limited 15 visits/year)
- 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)

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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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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	None
Coinsurance	\$2,000
<i>What isn't covered</i>	
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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	None
Coinsurance	\$1,420
<i>What isn't covered</i>	
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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	None
Coinsurance	\$320
<i>What isn't covered</i>	
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.