Tri-County Building Trades Health Fund

WELCOME TO OPEN ENROLLMENT

(Actives)

The open enrollment period is open from November 1 through November 30. If you choose to make any changes to your benefit plan, you must complete your enrollment information by **November 30, 2023. Open enrollment is also available on the member portal at www.tricountyhf.com.** You can complete the enrollment on the website or return the election form and vital form to American Benefit Corporation, Attention Tri County Open Enrollment, 9200 US Rt. 60, Ona, WV 25545

If you timely complete your enrollment information, your new benefit coverage options shall become effective for services provided on or after January 1. If you do not make an election during the open enrollment period, you will keep the coverage you had the previous year. **Please be aware that enrollment into an Optional Benefits Package cannot be revoked until the next open enrollment period.**

To participate in open enrollment, please follow the following steps:

- Review the plans and options available to you.
- If you wish to change your plan, make your election on the portal prior to November 30, 2023.
- Verify your dependents and make any necessary changes
- Update your beneficiary and other insurance information.
- Call American Benefit Corporation if you have any questions at 866-313-2088.

Please remember, enrollment into an Optional Benefits Package cannot be revoked until the next open enrollment period.

If you have any questions, please call your benefits administrator, American Benefit Corporation at 866-313-2088.

*The purpose of this mailing is purely informational. Receipt of this mailing does not guarantee benefits or eligibility under The Plan.

Tri-County Building Trades Health Fund

Member Portal

Website & Mobile App Now Available

Use this QR Code to download the mobile app.

https://members.tricountyhf.com

Dear Member,

Your member portal is available at the website address listed above. The Tri-County Members app where you can readily access most of the features of the website on your cellphone is also available. Easily download the app by using the QR Code above.

In addition to accessing your benefit and contribution information, you can make self-pays on the website either by credit/debit card or setting up ACH payment. Once you've logged in, click the Payments link and follow the steps to select your choice of payment.

As always, should you have questions or need assistance, please reach out to our American Benefit Corporation team at 866-313-2088 Monday-Friday, 8:30am – 5:00pm.

Useful Website & App Features

- Eligibility and Anthem ID Card
- Covered Family Members
- Accumulators and Past Claims
- HRA Balance
- HRA Reimbursement Form

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ACTIVE PARTICIPANTS

SCHEDULE OF BENEFITS

This Schedule of Benefits provides you and your Eligible Dependents with a summary of the benefits covered under the Tri-County Building Trades Health Fund. Generally, you will have three (3) plan design options from which to choose. These plans include the Premier Plan, Standard Plan and the Basic Plan. The Standard Plan shall be the default plan design if you do not choose one. Please be advised that your Plan design and optional choices are subject to change. The Amounts listed in the Schedule of Benefits reflect the amount that the Plan covers unless noted otherwise. For a complete description of the benefits covered, review the Explanation of Medical Benefits section, beginning at Page 39. Please note that all payments made for medical benefits are based upon Usual, Customary and Reasonable Charges ("UCR") and Medical Necessity.

If a change in benefits is made, the change will generally become effective for death, accidents and illnesses which occur or begin on or after the effective date of the change. For medical treatments, the change will become effective for treatments or services received on or after the effective date of the change, unless the Board of Trustees expressly provides otherwise.

	PREMIER PLAN		**STANDARD PLAN**		**BASIC PLAN**	
MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Deductibles	$400/person	$800/person	$500/person	$1,000/person	$1,100/person	$2,200/person
	$800/family	$1,600/family	$1,000/family	$2,000/family	$2,200/family	$4,400/family
Out-of-Pocket Maximums (Includes deductibles)	$1,500/person $3,000/family	$3,000/person $6,000/family	$3,000/person $6,000/family	$6,000/person $12,000/family	$4,000/person $8,000/family	$8,000/person $16,000/family
CARE IN HOSPITAL						
Care-In-Hospital (Semi Private Room)	90%	70%UCR	80%	60%UCR	70%	50%UCR
Surgery	90%	70%UCR	80%	60%UCR	70%	50%UCR
Anesthesia	90%	70%UCR	80%	60%UCR	70%	50%UCR
Assistant Surgeon	90%	70%UCR	80%	60%UCR	70%	50%UCR
In-Hospital Physician	90%	70%UCR	80%	60%UCR	70%	50%UCR
Diagnostic Lab/X-Ray	90%	70%UCR	80%	60%UCR	70%	50%UCR
Respiratory Therapy	90%	70%UCR	80%	60%UCR	70%	50%UCR
Acute Kidney Dialysis	90%	70%UCR	80%	60%UCR	70%	50%UCR
Maternity Care	90%	70%UCR	80%	60%UCR	70%	50%UCR
Organ Transplant Benefits	90%	70%UCR	80%	60%UCR	70%	50%UCR
	PREMIER PLAN		**STANDARD PLAN**		**BASIC PLAN**	
MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**MEDICAL BENEFITS**	**IN-NETWORK**	**OUT-OF-NETWORK**
OUTPATIENT CARE						
Pre-Admission Testing	90%	70%UCR	80%	60%UCR	70%	50%UCR
Surgery	90%	70%UCR	80%	60%UCR	70%	50%UCR
(All Related Expenses) Diagnostic Lab/X-Ray	90%	70%UCR	80%	60%UCR	70%	50%UCR

Emergency Care (within 72 hours of accident/acute illness/life threatening)	90% After $250.00 Co-Pay but co-pay is waived if emergency care is for accidental injury or if admitted.	70% After $250.00 Co-Pay but co-pay is waived if emergency care is for accidental injury or if admitted.	80% After $250.00 Co-Pay but co-pay is waived if emergency care is for accidental injury or if admitted.	60% After $250.00 Co-Pay but co-pay is waived if emergency care is for accidental injury or if admitted.	70% After $250.00 Co-Pay but co-pay is waived if emergency care is for accidental injury or if admitted.	50% After $250.00 Co-Pay but co-pay is waived if emergency care is for accidental injury or if admitted.
Non-Emergency Care in Emergency Room/Facility	90% after $250.00 co-pay	70% UCR after $250.00 copay	80% after $250.00 co-pay	60% UCR after $250.00 co-pay	70% after deductible is met and $250.00 co-pay	50% UCR after deductible is met and $250.00 co-pay
Urgent Care Facility	100% after $20.00 co-pay	70%UCR	100% after $20.00 co-pay	60%UCR	100% after $20.00 co-pay	50%UCR
Occupational/Physical/ Speech/Respiratory Therapies	90%	70%UCR	80%	60%UCR	70%	50%UCR
Acute Kidney Dialysis	90%	70%UCR	80%	60%UCR	70%	50%UCR
Second Surgical Opinion	90%	70%UCR	80%	60%UCR	70%	50%UCR
Sleep Disorders – Evaluation and Treatment	90%	70%UCR	80%	60%UCR	70%	50%UCR
Diabetes Education	90%	70%UCR	80%	60%UCR	70%	50%UCR
MENTAL HEALTH						
Primary Care Provider Visit/Outpatient Psychotherapy Visit	100% after $20.00 co-pay	70%UCR	100% after $20.00 co-pay	60%UCR	100% after $20.00 co-pay	50%UCR
Inpatient/Outpatient Treatment Program	90%	70%UCR	80%	60%UCR	70%	50%UCR
ALCOHOL/SUBSTANCE ABUSE						
Primary Care Provider Visit/Outpatient Psychotherapy Visits	100% after $20.00 co-pay	70%UCR	100% after $20.00 co-pay	60%UCR	100% after $20.00 co-pay	50%UCR
Inpatient Care/Outpatient Treatment Program	90%	70%UCR	80%	60%UCR	70%	50%UCR

	PREMIER PLAN		STANDARD PLAN		BASIC PLAN	
MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**MEDICAL BENEFITS**	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICIAN'S OFFICE						
Visits for Illness/Injury	100% after $20.00 co-pay	70%UCR	100% after $20.00 co-pay	60%UCR	100% after $20.00 co-pay	50%UCR
Allergy Testing/Treatment	90%	70%UCR	80%	60%UCR	70%	50%UCR
Occupational/Physical/Speech/Respiratory Therapies	90%	70%UCR	80%	60%UCR	70%	50%UCR
Surgery (all related expenses)	90%	70%UCR	80%	60%UCR	70%	50%UCR
Diagnostic Lab/X-Ray	90%	70%UCR	80%	60%UCR	70%	50%UCR
Diabetes Education	90%	70%UCR	80%	60%UCR	70%	50%UCR
PREVENTIVE CARE						
Physical Exam/Immunizations/ Prostate/Mammogram/ Gynecological Exam/Pap Test (limited to 1 per calendar year, based upon age requirements)	100%	70%UCR	100%	60%UCR	100%	50%UCR
Routine Colonoscopy (1 per calendar year, based upon age requirements)	100%	70%UCR	100%	60%UCR	100%	50%UCR
Well Child (birth to age 1 year, including immunizations)	100%	70%UCR	100%	60%UCR	100%	50%UCR
AFFILIATES						
Chiropractic Services	90%	80%UCR	80%	60%UCR	70%	50%UCR
Podiatry Services	90%	80%UCR	80%	60%UCR	70%	50%UCR
OTHER SERVICES						
Skilled Nursing Facility (Pre-Approval Required)	90%	70%UCR	80%	60%UCR	70%	50%UCR
Private Duty Nursing (Pre-Approval Required)	90%	70%UCR	80%	60%UCR	70%	50%UCR
Home Health Care (Pre-Approval Required)	90%	70%UCR	80%	60%UCR	70%	50%UCR
Hospice Care (Pre-Approval Required)	90%	70%UCR	80%	60%UCR	70%	50%UCR
Durable Medical Equipment	90%	70%UCR	80%	60%UCR	70%	50%UCR
Ambulance (up to 2 trips per confinement)	90%	70%UCR	80%	60%UCR	70%	50%UCR
Injectable Medications	90%	70%UCR	80%	60%UCR	70%	50%UCR
Gym Membership (Actives Only)	Up to $200 per year per Participant or, if the Participant has family coverage, up to $200 per year per family for reimbursement of the basic membership cost to a recognized gym or fitness facility (i.e., YMCA, Planet Fitness)					

PRESCRIPTIONS			
Prescriptions	Managed Prescription Drug Program	Managed Prescription Drug Program	Managed Prescription Drug Program
Out-of-Pocket Maximums	$4,150/person	$4,150/person	$4,150/person
	$8,300/family	$8,300/family	$8,300/family
HEARING BENEFITS			
Hearing Benefits – all services, exams, fitting and appliances	50% of costs up to $3,000.00 every three years	50% of costs up to $3,000.00 every three years	50% of costs up to $3,000.00 every three years
ACCIDENTAL DEATH BENEFIT			
Active Participants	N/A	N/A	N/A
ACCIDENTAL DISMEMBERMENT			
Active Participant (loss of both feet, both hands, one foot, one hand, one hand or foot and loss of sight in one eye or loss of sight in both eyes)	N/A	N/A	N/A
Active Participant (loss of one hand, one foot, or sight in one eye)	N/A	N/A	N/A

OPTIONAL PACKAGES

	OPTION 1	OPTION 2
Dental Benefits	Preventative & Diagnostic Services 100% Restorative Services 80% up to $2,000 per Family per year	Preventative & Diagnostic Services 100% Restorative Services 80% up to $4,000 per Family per year
Vision Benefits	80% up to $600 per Family per year	80% up to $1,200 per Family per year
Short Term Disability (Active Participants Only)	$425 per week/up to 26 weeks	$525 per week/up to 26 weeks
Additional Death Benefits	$25,000 per Active Participant	$25,000 per Active Participant
Active Participant (loss of both feet, both hands, or sight in both eyes, one hand and one foot, one hand and sight of one eye, or one foot and sight of one eye, speech and hearing in both ears)	$5,000	$5,000
Active Participant (loss of one hand, one foot, or sight in one eye)	$2,500	$2,500

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 American Benefit Corporation at 1-800-778-6118. 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 http://www.healthcare.gov/sbc-glossary/ or call 1-800-778-6118 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500** per person/**$1,000** per family (PPO); **$1,000** per person/**$2,000** per family (Non-PPO).	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 **in-network office visits** and **in-network preventive care** 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?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**$3,000** per person/**$6,000** per family (PPO); **$6,000** per person/**$12,000** per family (Non-PPO).	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Morbid obesity payments, prescription drug **copays**, **pre-certification** penalties, **premiums**, **balance-billing** 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. See www.anthem.com or call 1-800-810-2583 for a list of **network providers**.	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**). Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). 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 **copay**/office visit; **deductible** does not apply	40% **coinsurance**	----------none----------**
	Specialist visit	20% **coinsurance**	40% **coinsurance**	Chiropractic treatments subject to utilization review after 26 visits.**
	Preventive care/screening/ immunization	No charge; **deductible** does not apply	40% **coinsurance**	You may have to pay for services that aren't preventive. Ask your **provider** if the services needed are preventive. Then check what your **plan** will pay for.**
If you have a test	Diagnostic test (x-ray, blood work)	20% **coinsurance**	40% **coinsurance**	**Pre-certification** required ($250 penalty).**
	Imaging (CT/PET scans, MRIs)	20% **coinsurance**	40% **coinsurance**	**Pre-certification** required ($250 penalty).**
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.empirxhealth.com	Generic drugs	Lesser of $10 or 20% **copay** (retail); Lesser of $25 or 20% **copay** (mail)		**$5,450** per person/**$10,900** per family **prescription drug out-of-pocket limits**.** Retail prescriptions: copays shown for 34-day supply, 90-day supply of maintenance medications available at retail at a lesser of coinsurance or three times retail dollar copay for generic and the greater of coinsurance or three times retail dollar copay for preferred and non-preferred brand drugs; mail order prescriptions limited to 90-day supply. **Preauthorization** may be required for certain drugs and not all drugs are covered.
	Preferred brand drugs	Greater of $20 or 30% **copay** (retail); $45 **copay** (mail)		
	Non-preferred brand drugs	Greater of $30 or 40% **copay** (retail); $70 **copay** (mail)		
	Specialty drugs	20% **copay** (generic drugs) 30% **copay** (preferred brand drugs) 40% **copay** (non-preferred brand drugs)		Specialty drugs are limited to 30-day supply and must be filled through EmpiRx.** Certain specialty drugs that have been specifically designated for financial assistance by the Fund's specialty drug case manager are

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)	
				subject to a higher copayment. If you choose not to enroll in the Specialty Drug Advocacy Program, the co-insurance or out-of-pocket cost for specialty drugs will be 100% of the pharmacy billed charges.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **coinsurance**	40% **coinsurance**	**Pre-certification** required ($250 penalty).**
	Physician/surgeon fees	20% **coinsurance**	40% **coinsurance**	
If you need immediate medical attention	Emergency room care	20% **coinsurance** after $250 **copay**/emergency room visit; **deductible** does not apply	20% **coinsurance** after $250 **copay**/emergency room visit; **deductible** does not apply	**Copayment** is waived if admitted to hospital.** **Coinsurance** amounts apply after emergency room **copayment** for non-emergency care provided in emergency room.**
	Emergency medical transportation	20% **coinsurance**	40% **coinsurance** for ground ambulance 20% **coinsurance** for air ambulance	Limited to two trips per confinement.**
	Urgent care	$20 **copay**/office visit; **deductible** does not apply	40% **coinsurance**	----------none----------**
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **coinsurance**	40% **coinsurance**	**Pre-certification** required ($250 penalty)**
	Physician/surgeon fees	20% **coinsurance**	40% **coinsurance**	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% **coinsurance**	40% **coinsurance**	$20 **copay** for office visits.**
	Inpatient services	20% **coinsurance**	40% **coinsurance**	----------none----------**
If you are pregnant	Office visits	No charge	40% **coinsurance**	**Cost sharing** does not apply for **preventive services**.** Expenses related to the pregnancy of a Dependent child are not covered (except for **preventive services**).
	Childbirth/delivery professional services	20% **coinsurance**	40% **coinsurance**	
	Childbirth/delivery facility services	20% **coinsurance**	40% **coinsurance**	

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 need help recovering or have other special health needs	Home health care	20% **coinsurance**	40% **coinsurance**	Must be provided by a qualified **Home Health Care** Agency and prescribed in writing by a Physician; **pre-certification** required ($250 penalty).**
	Rehabilitation services	20% **coinsurance**	40% **coinsurance**	**Pre-certification** required ($250 penalty).**
	Habilitation services	20% **coinsurance**	40% **coinsurance**	
	Skilled nursing care	20% **coinsurance**	40% **coinsurance**	Care must be certified by a **Physician** and not for the purpose of custodial care; **pre-certification** required ($250 penalty).**
	Durable medical equipment	20% **coinsurance**	40% **coinsurance**	**Pre-certification** required ($250 penalty).**
	Hospice services	20% **coinsurance**	40% **coinsurance**	Patient's life expectancy must not exceed six months and care must be provided by a Hospice Organization (as defined by the **Plan**); **pre-certification** required ($250 penalty).**
If your child needs dental or eye care	Children's eye exam	20% **coinsurance**	20% **coinsurance**	**$600**/family calendar year limit (Option 1); **$1,200**/family calendar year limit (Option 2).**
	Children's glasses	20% **coinsurance**	20% **coinsurance**	
	Children's dental check-up	20% **coinsurance; no charge** for preventive and diagnostic services	20% **coinsurance; no charge** for preventive and diagnostic services	**$2,000**/family calendar year limit (Option 1); **$4,000**/family calendar year limit (Option 2).**

**Amounts paid by the Participant for Internal Revenue Code Section 213(d) expenses may be reimbursed from the Participant's HRA.

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.)

- Cosmetic Surgery (unless as a result of an accidental injury)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss program (except for pre-authorized weight loss medications for obesity)

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

- Acupuncture
- Bariatric surgery (Must be 18 years of age and **pre-certification** required ($250 penalty))
- Dental care (Adult) (**$2,000**/family calendar year limit under Option 1; **$4,000**/family calendar year limit under Option 2)
- Hearing aids (No charge up to $3,000;
- Private-duty nursing (**pre-certification** required ($250 penalty))
- Routine eye care (Adult) (**$600**/family calendar year limit under Option 1; **$1,200**/family calendar year limit under Option 2)

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care (subject to utilization review after 26 visits)	limited to one hearing aid per ear for any 36 consecutive month period)	• Routine foot care

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 www.dol.gov/ebsa/healthreform. 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 American Benefit Corporation at 1-800-778-6118. You may also contact the 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.

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

* For more information about limitations and exceptions, see the plan or policy document at www.tricountyhf.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	**$500**
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	$500
Copayments	$0
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,960**

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

The plan's overall deductible	**$500**
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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

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

The plan's overall deductible	**$500**
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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,150**

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

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 American Benefit Corporation at 1-800-778-6118. 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 http://www.heathcare.gov/sbc-glossary/ or call 1-800-778-6118 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,100** per person/**$2,200** per family (PPO); **$2,200** per person/**$4,400** per family (Non-PPO).	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 **in-network office visits** and **in-network preventive care** 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?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**$4,000** per person/**$8,000** per family (PPO); **$8,000** per person/**$16,000** per family (Non-PPO).	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Morbid obesity payments, prescription drug **copays**, **pre-certification** penalties, **premiums**, **balance-billing** 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. See www.anthem.com or call 1-800-810-2583 for a list of **network providers**.	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**). Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). 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 **copay**/office visit; **deductible** does not apply	50% **coinsurance**	----------none----------**
	Specialist visit	30% **coinsurance**	50% **coinsurance**	Chiropractic treatments subject to utilization review after 26 visits.**
	Preventive care/screening/ immunization	No charge; **deductible** does not apply	50% **coinsurance**	You may have to pay for services that aren't preventive. Ask your **provider** if the services needed are preventive. Then check what your **plan** will pay for.**
If you have a test	Diagnostic test (x-ray, blood work)	30% **coinsurance**	50% **coinsurance**	**Pre-certification** required ($250 penalty).**
	Imaging (CT/PET scans, MRIs)	30% **coinsurance**	50% **coinsurance**	**Pre-certification** required ($250 penalty).**
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.empirxhealth.com	Generic drugs	Lesser of $10 or 20% **copay** (retail); Lesser of $25 or $20 **copay** (mail)		**$5,450** per person/**$10,900** per family **prescription drug out-of-pocket limits**.** Retail prescriptions: copays shown for 34-day supply, 90-day supply of maintenance medications available at retail at a lesser of coinsurance or three times retail dollar copay for generic and the greater of coinsurance or three times retail dollar copay for preferred and non-preferred brand drugs; mail order prescriptions limited to 90-day supply. **Preauthorization** may be required for certain drugs and not all drugs are covered.
	Preferred brand drugs	Greater of $20 or 30% **copay** (retail); $45 **copay** (mail)		
	Non-preferred brand drugs	Greater of $30 or 40% **copay** (retail); $70 **copay** (mail)		
	Specialty drugs	20% **copay** (generic drugs) 30% **copay** (preferred brand drugs) 40% **copay** (non-preferred brand drugs)		Specialty drugs limited to 30-day supply and must be filled through EmpiRx Health.** Certain specialty drugs that have been specifically designated for financial assistance by the Fund's specialty drug case manager are

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)	
				subject to a higher copayment. If you choose not to enroll in the Specialty Drug Advocacy Program, the co-insurance or out-of-pocket cost for specialty drugs will be 100% of the pharmacy billed charges.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% **coinsurance**	50% **coinsurance**	**Pre-certification** required ($250 penalty).**
	Physician/surgeon fees	30% **coinsurance**	50% **coinsurance**	
If you need immediate medical attention	Emergency room care	30% **coinsurance** after $250 **copay**/emergency room visit; **deductible** does not apply	30% **coinsurance** after $250 **copay**/emergency room visit; **deductible** does not apply	**Copayment** is waived if admitted to hospital.** **Coinsurance** amounts apply after emergency room **copayment** for non-emergency care provided in emergency room.**
	Emergency medical transportation	30% **coinsurance**	50% **coinsurance** for ground ambulance 30% **coinsurance** for air ambulance	Limited to two trips per confinement.**
	Urgent care	$20 **copay**/office visit; **deductible** does not apply	50% **coinsurance**	----------none----------**
If you have a hospital stay	Facility fee (e.g., hospital room)	30% **coinsurance**	50% **coinsurance**	**Pre-certification** required ($250 penalty)**
	Physician/surgeon fees	30% **coinsurance**	50% **coinsurance**	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% **coinsurance**	50% **coinsurance**	$20 **copay** for office visits.**
	Inpatient services	30% **coinsurance**	50% **coinsurance**	----------none----------**
If you are pregnant	Office visits	No charge	50% **coinsurance**	**Cost sharing** does not apply for **preventive services**.** Expenses related to the pregnancy of a Dependent child are not covered (except for **preventive services**).
	Childbirth/delivery professional services	30% **coinsurance**	50% **coinsurance**	
	Childbirth/delivery facility services	30% **coinsurance**	50% **coinsurance**	

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 need help recovering or have other special health needs	Home health care	30% **coinsurance**	50% **coinsurance**	Must be provided by a qualified **Home Health Care** Agency and prescribed in writing by a Physician; **pre-certification** required ($250 penalty).**
	Rehabilitation services	30% **coinsurance**	50% **coinsurance**	**Pre-certification** required ($250 penalty).**
	Habilitation services	30% **coinsurance**	50% **coinsurance**	
	Skilled nursing care	30% **coinsurance**	50% **coinsurance**	Care must be certified by a **Physician** and not for the purpose of custodial care; **pre-certification** required ($250 penalty).**
	Durable medical equipment	30% **coinsurance**	50% **coinsurance**	**Pre-certification** required ($250 penalty).**
	Hospice services	30% **coinsurance**	50% **coinsurance**	Patient's life expectancy must not exceed six months and care must be provided by a Hospice Organization (as defined by the **Plan**); **pre-certification** required ($250 penalty).**
If your child needs dental or eye care	Children's eye exam	20% **coinsurance**	20% **coinsurance**	**$600**/family calendar year limit (Option 1); **$1,200**/family calendar year limit (Option 2).**
	Children's glasses	20% **coinsurance**	20% **coinsurance**	
	Children's dental check-up	20% **coinsurance; no charge** for preventive and diagnostic services	20% **coinsurance; no charge** for preventive and diagnostic services	**$2,000**/family calendar year limit (Option 1); **$4,000**/family calendar year limit (Option 2).**

**Amounts paid by the Participant for Internal Revenue Code Section 213(d) expenses may be reimbursed from the Participant's HRA.

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.)

- Cosmetic surgery (unless as a result of an accidental injury)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss program (except for pre-authorized weight loss medications for obesity)

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

- Acupuncture
- Bariatric surgery (Must be 18 years of age and **pre-certification** required ($250 penalty))
- Chiropractic care (subject to utilization review after 26 visits)
- Dental care (Adult) (**$2,000**/family calendar year limit under Option 1; **$4,000**/family calendar year limit under Option 2)
- Hearing aids (No charge up to $3,000; limited to one hearing aid per ear for any 36 consecutive month period)
- Private-duty nursing (**pre-certification** required ($250 penalty))
- Routine eye care (Adult) (**$600**/family calendar year limit under Option 1; **$1,200**/family calendar year limit under Option 2)
- Routine foot care

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

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 www.dol.gov/ebsa/healthreform. 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 American Benefit Corporation at 1-800-778-6118. You may also contact the 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.

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

* For more information about limitations and exceptions, see the plan or policy document at www.tricountyhf.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	**$1,100**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$0
Coinsurance	$2,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

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

The plan's overall deductible	**$1,100**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	$1,100
Copayments	$200
Coinsurance	$700
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

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

The plan's overall deductible	**$1,100**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,350
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,750**

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

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 American Benefit Corporation at 1-800-778-6118. 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/sbc-glossary/ or call 1-800-778-6118 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$400** per person/**$800** per family (PPO); **$800** per person/**$1,600** per family (Non-PPO).	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 **in-network office visits** and **in-network preventive care** 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?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**$1,500** per person/**$3,000** per family (PPO); **$3,000** per person/**$6,000** per family (Non-PPO).	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Morbid obesity payments, prescription drug **copays**, **pre-certification** penalties, **premiums**, **balance-billing** 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. See www.anthem.com or call 1-800-810-2583 for a list of **network providers**.	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**). Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). 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 **copay**/office visit; **deductible** does not apply	30% **coinsurance**	----------none----------**
	Specialist visit	10% **coinsurance**	30% **coinsurance**	Chiropractic treatments subject to utilization review after 26 visits.**
	Preventive care/screening/ immunization	No charge; **deductible** does not apply	30% **coinsurance**	You may have to pay for services that aren't preventive. Ask your **provider** if the services needed are preventive. Then check what your **plan** will pay for.**
If you have a test	Diagnostic test (x-ray, blood work)	10% **coinsurance**	30% **coinsurance**	**Pre-certification** required ($250 penalty).**
	Imaging (CT/PET scans, MRIs)	10% **coinsurance**	30% **coinsurance**	**Pre-certification** required ($250 penalty).**
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.empirxhealth.com	Generic drugs	Lesser of $10 or 20% **copay** (retail); Lesser of $25 or 20% **copay** (mail)		**$5,450** per person/**$10,900** per family **prescription drug out-of-pocket limits**.** Retail prescriptions: copays shown for 34-day supply, 90-day supply of maintenance medications available at retail at a lesser of coinsurance or three times retail dollar copay for generic and the greater of coinsurance or three times retail dollar copay for preferred and non-preferred brand drugs; mail order prescriptions limited to 90-day supply. **Preauthorization** may be required for certain drugs and not all drugs are covered.
	Preferred brand drugs	Greater of $20 or 30% **copay** (retail); $45 **copay** (mail)		
	Non-preferred brand drugs	Greater of $30 or 40% **copay** (retail); $70 **copay** (mail)		
	Specialty drugs	20% **copay** (generic drugs) 30% **copay** (preferred brand drugs) 40% **copay** (non-preferred brand drugs)		Specialty drugs limited to 30-day supply and must be filled through EmpiRx.** Certain specialty drugs that have been specifically designated for financial assistance by the Fund's specialty drug case manager are

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)	
				subject to a higher copayment. If you choose not to enroll in the Specialty Drug Advocacy Program, the co-insurance or out-of-pocket cost for specialty drugs will be 100% of the pharmacy billed charges.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% **coinsurance**	30% **coinsurance**	**Pre-certification** required ($250 penalty).**
	Physician/surgeon fees	10% **coinsurance**	30% **coinsurance**	
If you need immediate medical attention	Emergency room care	10% **coinsurance** after $250 **copay**/emergency room visit; **deductible** does not apply	10% **coinsurance** after $250 **copay**/emergency room visit; **deductible** does not apply	**Copayment** is waived if admitted to hospital.** **Coinsurance** amounts apply after emergency room **copayment** for non-emergency care provided in emergency room.**
	Emergency medical transportation	10% **coinsurance**	30% **coinsurance** for ground ambulance 10% **coinsurance** for air ambulance	Limited to two trips per confinement.**
	Urgent care	$20 **copay**/office visit; **deductible** does not apply	30% **coinsurance**	----------none----------**
If you have a hospital stay	Facility fee (e.g., hospital room)	10% **coinsurance**	30% **coinsurance**	**Pre-certification** required ($250 penalty)**
	Physician/surgeon fees	10% **coinsurance**	30% **coinsurance**	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% **coinsurance**	30% **coinsurance**	$20 **copay** for office visits.**
	Inpatient services	10% **coinsurance**	30% **coinsurance**	----------none----------**
If you are pregnant	Office visits	No charge	30% **coinsurance**	**Cost sharing** does not apply for **preventive services**.** Expenses related to the pregnancy of a Dependent child are not covered (except for **preventive services**).
	Childbirth/delivery professional services	10% **coinsurance**	30% **coinsurance**	
	Childbirth/delivery facility services	10% **coinsurance**	30% **coinsurance**	

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 need help recovering or have other special health needs	Home health care	10% **coinsurance**	30% **coinsurance**	Must be provided by a qualified **Home Health Care** Agency and prescribed in writing by a Physician; **pre-certification** required ($250 penalty).**
	Rehabilitation services	10% **coinsurance**	30% **coinsurance**	**Pre-certification** required ($250 penalty).**
	Habilitation services	10% **coinsurance**	30% **coinsurance**	
	Skilled nursing care	10% **coinsurance**	30% **coinsurance**	Care must be certified by a **Physician** and not for the purpose of custodial care; **pre-certification** required ($250 penalty).**
	Durable medical equipment	10% **coinsurance**	30% **coinsurance**	**Pre-certification** required ($250 penalty).**
	Hospice services	10% **coinsurance**	30% **coinsurance**	Patient's life expectancy must not exceed six months and care must be provided by a Hospice Organization (as defined by the **Plan**); **pre-certification** required ($250 penalty).**
If your child needs dental or eye care	Children's eye exam	20% **coinsurance**	20% **coinsurance**	**$600**/family calendar year limit (Option 1); **$1,200**/family calendar year limit (Option 2).**
	Children's glasses	20% **coinsurance**	20% **coinsurance**	
	Children's dental check-up	20% **coinsurance; no charge** for preventive and diagnostic services	20% **coinsurance; no charge** for preventive and diagnostic services	**$2,000**/family calendar year limit (Option 1); **$4,000**/family calendar year limit (Option 2).**

**Amounts paid by the Participant for Internal Revenue Code Section 213(d) expenses may be reimbursed from the Participant's HRA.

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.)

- Cosmetic surgery (unless as a result of an accidental injury)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss program (except for pre-authorized weight loss medications for obesity)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric surgery (Must be 18 years of age and **pre-certification** required ($250 penalty)) ** • Chiropractic care (subject to utilization review after 26 visits)	• Dental care (Adult) (**$2,000**/family calendar year limit under Option 1; **$4,000**/family calendar year limit under Option 2) • Hearing aids (No charge up to $3,000; limited to one hearing aid per ear for any 36 consecutive month period)	• Private-duty nursing (**pre-certification** required ($250 penalty)) • Routine eye care (Adult) (**$600**/family calendar year limit under Option 1; **$1,200**/family calendar year limit under Option 2) • Routine foot care

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 www.dol.gov/ebsa/healthreform. 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 American Benefit Corporation at 1-800-778-6118. You may also contact the 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.

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

About these Coverage Examples:

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

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 coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$600
Copayments	$0
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

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 coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$600
Copayments	$200
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,620**

Mia's Simple Fracture

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

The plan's overall deductible	**$400**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$850
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
0The total Mia would pay is	**$1,650**

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

VSP VISION SAVINGS PASS

VSP® Vision Savings Pass™ is a discount vision program that offers immediate savings on eye care and eyewear. This is not an insurance plan.

SEE THE SAVINGS

- Access to discounts through a trusted, private-practice VSP network doctor
- One rate of $50 for an eye exam[1]
- Special pricing on complete pairs of glasses and sunglasses
- 15% savings on a contact lens exam[2]
- Unlimited use on materials throughout the year
- Exclusive Member Extras, like special offers

UNLIMITED ANNUAL MATERIAL USE[3]

Your VSP Vision Savings Pass can be used as often as you like throughout the year. With the best choices in eyewear, we make it easy to find the perfect frame that's right for you, your family, and your budget. Choose from great brands like bebe, CALVIN KLEIN, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more.[4]

MEMBER OUT-OF-POCKET COST	
WellVision Exam®	• $50 with purchase of a complete pair of prescription glasses. • 20% savings without purchase. • Once every calendar year.
Retinal Screening	• Guaranteed pricing with WellVision Exam, not to exceed $39.
Lenses	• With purchase of a complete pair of prescription glasses; Single vision $40, lined trifocals $75, lined bifocals $60.
Lens Enhancements	• Average savings of 20–25% on lens enhancements such as progressive, scratch-resistant, and anti-reflective coatings.
Frames	• 25% savings when a complete pair of prescription glasses is purchased.
Sunglasses	• 20% savings on unlimited non-prescription sunglasses from any VSP doctor within 12 months of your last WellVision Exam.
Contact Lenses	• 15% savings on contact lens exam (fitting and evaluation).
Laser Vision Correction	• Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.

HOW TO USE YOUR VSP VISION SAVINGS PASS

1. Find a VSP network doctor at **vsp.com** or call **800.877.7195**.
2. Tell your VSP network doctor that you're a VSP member to save immediately on an eye exam[1] and eyewear.
3. Take advantage of your VSP Vision Savings Pass over and over—use is unlimited on materials.[3]

SEE WHY WE'RE CONSUMERS'
#1 CHOICE
IN VISION CARE.[5]

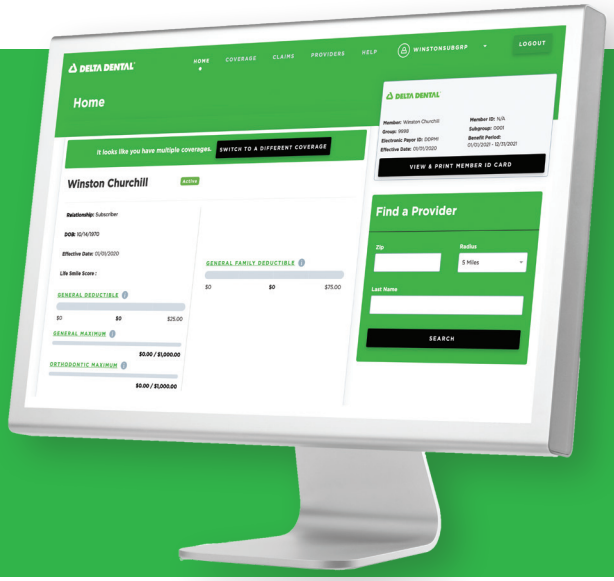
Enjoy better value and savings.
Contact us at vsp.com or 800.877.7195

1. This cost is only available with the purchase of a complete pair of prescription glasses; otherwise, you'll receive 20% savings on an eye exam only. **2**. Applies only to contact lens exam, not materials. You are responsible for 100% of the contact lens material cost. **3**. Unlimited use is for materials only. An eye exam is limited to once a year per member. **4**. Brands subject to change. **5**. National Vision Plan Member Research, 2017.

THIS PLAN IS NOT INSURANCE and is not intended to replace health insurance. This plan is not a Qualified Health Plan under the Affordable Care Act. THIS IS NOT A MEDICARE PRESCRIPTION DRUG PLAN. There is no cost to join this discount program. The plan provides discounts at certain health care providers for services. The range of discounts will vary depending on the type of provider and service. Plan members are obligated to pay for all health care services but will receive a discount from those health care providers who have agreed to provide discounts. The plan and its administrators have no liability for providing or guaranteeing service by providers or the quality of service rendered by providers. This plan is not available in Washington. Void where prohibited.

DELTA DENTAL®

Stay Informed About Your Dental Benefits With Member Portal



Member Portal is designed to give you 24/7 access to important information regarding your dental benefits.

Use this secure online tool for access to eligibility information, current benefits information, claims information and more.

Once you have logged in to Member Portal, remember to sign up for electronic delivery of Explanation of Benefits (EOB) statements. You will be able to view your EOBs online and print copies when necessary.

All users must first register to gain access to the Member Portal. Privacy of your online benefit information is assured through highly secure encryption technology.

Get started today

1. Visit **www.memberportal.com**.
2. Log in.
   NOTE: Member Portal has replaced Consumer Toolkit®. If you currently have a Consumer Toolkit account, your username and password for Consumer Toolkit will work for Member Portal.
   - If you have already registered, enter your credentials and click the “Login” button.
   - If you are new to Member Portal, click the “Sign up!” link to register.
     NOTE: You will need the subscriber’s (the person whose name is on the benefit package) member ID. The member ID is an assigned number unique to the subscriber. In most cases, the member ID is the same as the subscriber’s Social Security number.
3. Complete required fields and follow the on-screen instructions.
4. Select your own username and password to access the site.

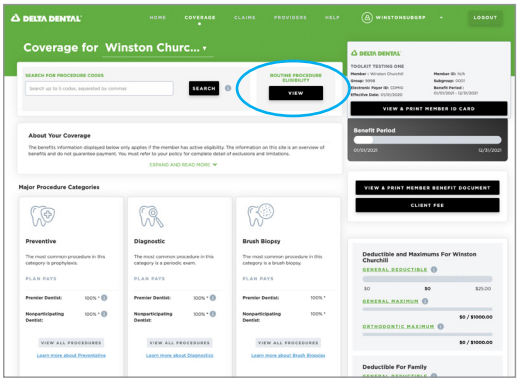
Additional help can be accessed through the Help menu within Member Portal. If you need further assistance, call Toolkit Support at 866-356-0301.

See reverse for additional features.

Member Portal features

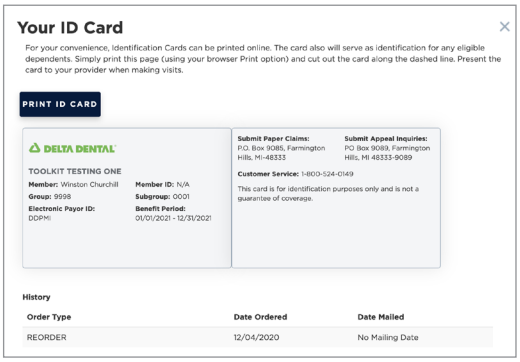
Find your benefits

Confirm eligibility and review benefits by clicking the **Coverage** link at the top.



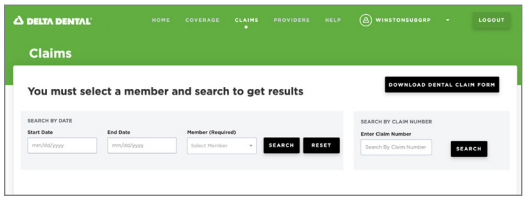
Print ID card

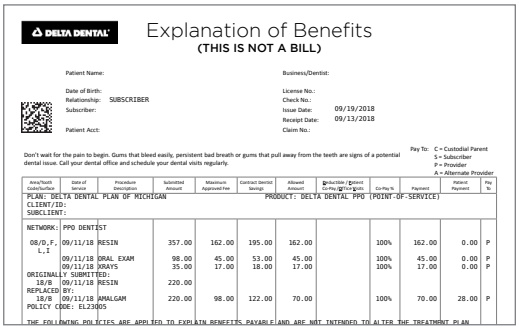
View and print your ID card 24/7 by following the **Print ID Card** link.



View your EOBs

Review and print EOBs by clicking the **Claims** link and entering the dates and patient's name.

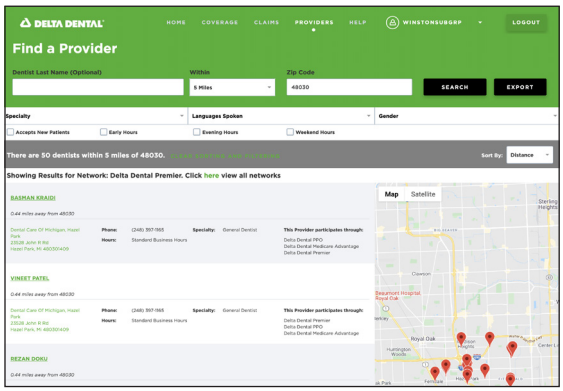




Find a dentist

Use the **Find a Provider** link to select your Delta Dental network and find a participating dentist near you.

Nationwide, three out of four dentists participate in of Delta Dental networks, which means members have lots of choices nearby.



TRI-COUNTY BUILDING TRADES HEALTH FUND

3150 US RT. 60
ONA, WV 25545
866-313-2088

ELECTION FORM – Active

Rates Effective 1/1/2024

MEDICAL BENEFITS (choose only one):

*Includes Medical/Prescription

	Single Coverage	Family Coverage
PREMIUM PLAN	**$1,958.00** _____	**$2,480.00** _____
STANDARD PLAN	**$1,220.00** _____	**$1,394.00** _____
BASIC PLAN	**$1,100.00** _____	**$1,308.00** _____

TOTAL OF MEDICAL ELECTION: _____

OPTIONAL PACKAGE BENEFITS (choose only one):

*Includes Dental/Vision/Lasik/Short-Term Disability/Death Benefit/Accidental Dismemberment

	Single Coverage	Family Coverage
NO OPTION	**$ 0.00** _____	**$ 0.00** _____
OPTION 1	**$58.00** _____	**$105.00** _____
OPTION 2	**$90.00** _____	**$167.00** _____

TOTAL OF OPTIONAL ELECTION: _____

TOTAL ELECTION AMOUNT: _____
(ADD TOTAL OF MEDICAL & OPTIONAL ELECTIONS)

By signing this form, I acknowledge that I have reviewed the enclosed information and understand that the Plan encourages participants to use providers (doctors, hospitals, etc.) that participate in the Fund's PPO network. I understand that I may be responsible for additional costs that result when I choose to use a provider outside of the Fund's network. I also understand that my election cannot be changed until the next Open Enrollment period unless I have a qualifying event.

Participant's Name: _____ _____
(Print)

Participant's Signature: _____

Participant's Social Security #: _____ _____

Date: _____ _____ _____

TRI-COUNTY BUILDING TRADES HEALTH FUND

3150 US Rt. 60
Ona, WV 25545
P: (866)313-2088 F: (304)525-6005

VITAL INFORMATION FORM

MEMBER INFORMATION

Name: _____ SSN: _____-_____-_____

Address: _____

Date of Birth: _____ Gender: _____ Phone: _____

Marital Status (Circle One): Single Married Divorced Separated Widowed

Date of Marriage/Divorce/Separation: _____

Current Status (Circle One): Active Retired Disabled COBRA Surviving Spouse

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DEPENDENT INFORMATION (INCLUDE SPOUSE)

Full Name	Relation	Date of Birth	SSN

***** Please include copies of your marriage certificate and birth certificates for all eligible dependents.**

BENEFICIARIES INFORMATION

Please fill out the following for your Primary Beneficiaries:

Full Name	Relation	Date of Birth	SSN	Address	% of Benefit

Please fill out the following for your Secondary Beneficiaries:

Full Name	Relation	Date of Birth	SSN	Address	% of Benefit

*****If you have listed a minor as a Primary of Secondary Beneficiary, you must complete the following Designation of Guardian/Custodian Information as well.**

GUARDIAN/CUSTODIAN INFORMATION

Under the "Uniformed Transfer to Minors Act", I do hereby designate the following as guardian/custodian of my minor child/children, who is/are named as a beneficiary.

Guardian Full Name: _____ SSN: _____-_____-_____

Guardian Address: _____

Guardian Phone: _____ Date of Birth: _____

OTHER INSURANCE INQUIRY

Please complete this portion of the form if you, your spouse, or any of your dependents have other insurance coverage, or if there has been any change in other insurance coverage.

If there is no other insurance for you, your spouse, or your dependents initial here _____ and skip to the Member Statement portion below.

General Information:

Name of Other Insured Person: _____ Relation: _____

Date of Birth: _____ Other Insurance Name: _____

Other Insurance Address: _____

Other Insurance Phone: _____ Policy/Group Number: _____

Effective Date of Coverage: _____ Is Insurance Active (Yes/No)? _____

Termination Date (If Applicable): _____ Coverage Type (Circle One): Single Family

Type of Coverage (Circle All that Apply): Medical Dental Vision Prescription

List Full Name(s) of All Dependents Covered Under This Insurance:

_____ _____

_____ _____

_____ _____

_____ _____

Member Statement:

*The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I **must** notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage.*

Any materials submitted by myself or on behalf of any eligible person that contain a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any matter.

_____ _____

Member Signature Date