**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 Fund Office at 215-568-0430 or visit us at www.carpenters.fund. 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 **215-568-0430** to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For participating providers: $0/individual or $0/family. For non-participating providers $10,000/individual or $20,000/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. Preventive care, emergency room services, pediatric eye and dental care. | 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?** | Yes. $100 for durable medical equipment. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | Participating providers: $2,000/individual or $4,000/family for Medical/MHSA, $5,450/individual or $10,900/family for Prescription, and $1,100/individual or $2,200/family for In-House Essential Benefits. For non-participating providers: $15,000/individual or $30,000/family for Medical/MHSA. | 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?** | Premiums, out-of-network balance-billing charges, health care this plan doesn't cover, and penalties for failure to obtain precertification for services. | 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.myibxtpa.com or call 1-800-810-BLUE for a list of medical network providers, call 1-800-255-3081 for a list of Behavioral Health providers, for all other Benefit Providers call the Fund Office at (215) 568-0430. | 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 | 10% coinsurance | 50% coinsurance | Telemedicine visits provided through MD Live with no charge. All other providers are subject to coinsurance. |
| | Specialist visit | 10% coinsurance | 50% coinsurance | |
| | Acupuncture, Osteopathic and Chiropractic Manipulation | 10% coinsurance | 50% coinsurance | Coverage applies for expenses incurred on the advice of a legally qualified physician only. |
| | Preventive care/screening/ immunization | No Charge | 50% coinsurance, deductible does not apply | Age and frequency schedules may apply. You may need 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 | 50% coinsurance | $0 copay with HCSC Network for x-rays. $0 copay with Blue Cross for Blood Work processed through LabCorp. |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 50% coinsurance | Precertification required; failure to obtain precertification will result in no payment. $0 copay with HCSC Network. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.express-scripts.com | Generic drugs | $5 copay/prescription for 30 day<br>$10 copay/prescription for 90 day | Not Covered | Coverage is limited to $2,000 per script. |
| | Preferred brand drugs | 25% coinsurance (Max of $75.00 for 30 day or $150.00 for 90 day) | Not Covered | Coverage is limited to $2,000 per script. |
| | Non-preferred brand drugs | 40% coinsurance (No Max) | Not Covered | |
| | Specialty drugs | 25% coinsurance (Max of $75.00 for 30 day or $150.00 for 90 day) | Not Covered | Coverage is limited to $2,000 per script. |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 50% coinsurance | Some outpatient surgeries require precertification. A complete list of surgeries requiring precertification is available at www.myibxtpa.com; failure to obtain precertification will result in no payment. |
| | Physician/surgeon fees | 10% coinsurance | 50% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | 10% coinsurance | 10%, no deductible | Your costs for Emergency Room services are not waived if you are admitted to the hospital. |
| | Emergency medical transportation | No Charge | No Charge | Coverage is limited to $500.00 per trip. |
| | Urgent care | 10% coinsurance | 50% coinsurance | Your costs for urgent care are based on care received at a designated urgent care center or facility, not your physician's office. Costs may vary depending on where you receive care. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 50% coinsurance | Precertification required; failure to obtain precertification will result in no payment. |
| | Physician/surgeon fees | 10% coinsurance | 50% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 10% coinsurance | 50% coinsurance | Contact Mental Health Consultants at (215) 343-8987 |
| | Inpatient services | 10% coinsurance | 50% coinsurance | |
| **If you are pregnant** | Office visits | 10% coinsurance | 50% coinsurance | Your cost is for first OB visit only. |
| | Childbirth/delivery professional services | 10% coinsurance | 50% coinsurance | Pre-notification requested. Maternity Benefits for dependent daughters not covered. |
| | Childbirth/delivery facility services | 10% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 50% coinsurance | ----------none---------- |
| | Rehabilitation services | 10% coinsurance | 50% coinsurance | Coverage is limited to: Speech Therapy: 20 visits per benefit period; Physical/Occupational Therapies: 30 visits combined per benefit period. All visit limits combined in- and out-of-network. $0 copay with Progress Physical Therapy |
| | Habilitation services | 10% coinsurance | 50% coinsurance | |
| | Skilled nursing care | 10% coinsurance | 50% coinsurance | Coverage is limited to 120 day limit per benefit period combined in and out- of-network. Precertification required |

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

| 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) | |
| | Durable medical equipment | $100 deductible with 20% coinsurance | $100 deductible with 20% coinsurance | Coverage is limited to Plan payment up to $1,200.00 per appliance |
| | Hospice services | 10% coinsurance | 50% coinsurance | ----------none---------- |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | 100% after Plan allowance | Contact Fund Office for coverage limitations |
| | Children's glasses | No Charge | 100% after Plan allowance | Contact Fund Office for coverage limitations |
| | Children's dental check-up | No Charge | 100% after Plan allowance | Contact Fund Office for coverage limitations |

**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
- Infertility treatment
- Long-term care
- Maternity Benefits for dependent daughters
- Routine foot care
- Weight Loss Programs

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

- Acupuncture
- Bariatric surgery
- Chiropractic Care
- Dental Care (Adult)
- Hearing aids
- Non-emergency care when traveling outside the U.S. (For details, see www.myibxtpa.com)
- Private-duty nursing
- Routine Eye Care (Adult)

**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: 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 the Fund Office at 215-568-0430. You may also contact the U.S. Dept. of Labor Employee Benefits Security Administration at 1-866-444-3272. As an alternative, the Pennsylvania Department of Insurance can also provide assistance. Please contact them at 1-877-881-6388.

**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.

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

**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: The Fund cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (215) 568-0430.

Chinese:
The Fund 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (215) 568-0430

Vietnamese: The Fund tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (215) 568-0430.

Russian: The Fund соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (215) 568-0430.

Pennsylvania Dutch: The Fund iss willich, die Gsetze (federal civil rights) vun die Owwerichkeet zu folliche un duht alle Leit behandle in der seem Weg. Es macht nix aus, vun wellem Schtamm ebber beikummt, aus wellem Land die Voreldre kumme sinn, was fer en Elt ebber hot, eb ebber en Mann iss odder en Fraa, verkrippelt iss odder net. Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call (215) 568-0430.

Korean:
은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (215) 568-0430 번으로 전화해 주십시오.

Italian: The Fund è conforme a tutte le leggi federali vigenti in materia di diritti civili e non pone in essere discriminazioni sulla base di razza, colore, origine nazionale, età, disabilità o sesso.
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (215) 568-0430.

Arabic:
يلتزم Fund. بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.
يلتزم The Fund بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم 215-568-0430-
هاتف الصم والبكم:

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

French: The JuFund respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handica
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.  Appelez le (215) 568-0430.

German: The Fund erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.
ACHTUNG:Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.  Rufnummer: (215) 568-0430.

Gujarti:
The Fund
ફંડ ફેડરલ નાગરિક અધિકાર કાયદા લાગુ સાથે સુસંગત છે અને જાતિ, રંગ, રાષ્ટ્રીય મૂળ, ઉંમર, અપંગતા અથવા લિંગના આધારે ભેદભાવ નથી. સાવધાની: જો તમે સ્પેનિશ બોલે છે, તમે ઉપલબ્ધ મફત ભાષા સહાય સેવાઓ છે. કૉલ (215) 568-0430.

Polish: The Fund postępuje zgodnie z obowiązującymi federalnymi prawami obywatelskimi i nie dopuszcza się dyskryminacji ze względu na rasę, kolor skóry, pochodzenie, wiek, niepełnosprawność bądź płeć.
UWAGA:  Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.  Zadzwoń pod numer
(215) 568-0430.

French Creole: The Fund konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.
ATANSYON:  Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.
Rele (215) 568-0430.

Mon-Khmer (Cambodian):
The Fund អនុវត្តតាមច្បាប់សិទ្ធិពលរដ្ឋនៃសហព័ន្ធដែលសមរម្យនិងមិនមានការរើសអើងលើមូលដ្ឋាន នៃពូជសាសន៍ ពណ៌សម្បុរ សញ្ជាតិដើម អាយុ ពិការភាព ឬភេទ។

ប្រយ័ត្ន៖  បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។  ចូរ ទូរស័ព្ទ
(215) 568-0430.

Portuguese: The Fund  cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base na raça, cor, nacionalidade, idade, deficiência ou sexo.
ATENÇÃO:  Se fala português, encontram-se disponíveis serviços linguísticos, grátis.  Ligue para (215) 568-0430.

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

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

## 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 | $0 |
| 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** | **$12,700** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $10 |
| Coinsurance | $1,300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,370** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| 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 | $0 |
| Copayments | $100 |
| Coinsurance | $900 |
| *What isn't covered* | |
| Limits or exclusions | $800 |
| **The total Joe would pay is** | **$1,800** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| 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 | $100 |
| Copayments | $10 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$310** |

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