**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?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Participating providers: $1,000/individual or $2,000/family for Medical/MHSA, $6,000/individual or $12,000/family for Prescription, and $1,000/individual or $2,000/family for ambulance benefits. For non-participating providers: $25,000/individual or $50,000/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 (i.e. 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 Teladoc 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 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. |
| **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 | ----------none---------- |
| | Preferred brand drugs | 25% coinsurance (Max of $75.00 for 30 day or $150.00 for 90 day) | Not Covered | ----------none---------- |
| | 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 | ----------none---------- |

[* 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 | Ground - No Charge<br>Air - 10% coinsurance | Ground - No Charge<br>Air - 10% coinsurance | Ground coverage is covered through the Fund office up to $1,000 per trip.<br>Air coverage is provided through Independence Administrators with no limit. |
| | 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. Telemedicine visits provided through Teladoc with no charge. All other providers are subject to coinsurance. |
| | 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 | |

[* 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 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. |
| | 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 |
| | Durable medical equipment | 10% coinsurance | 50% coinsurance | ----------none---------- |
| | Hospice services | 10% coinsurance | 50% coinsurance | ----------none---------- |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | Not Covered | Contact Fund Office for coverage limitations |
| | Children's glasses | $100 Allowance | Not Covered | Additional $50 allowance if purchased through Visionworks. |
| | Children's dental check-up | No Charge | Not Covered | 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)

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

**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 732-417-3900. 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.

**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 (215) 568-0430.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (215) 568-0430.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (215) 568-0430.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (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 | $200 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$320** |

### 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 | $0 |
| Copayments | $10 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$210** |

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