



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 by calling 1-877-698-3863. 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.com](http://www.healthcare.gov/sbc-glossary.com) or call 1-800-698-3863 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>In-Network and Out-of-Network: Combined</b> \$750 Individual/\$1,500 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>In-Network and Out-of-Network: Combined</b> \$2,000 Individual/\$4,000 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, deductible, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.excellusbcbs.com">www.excellusbcbs.com</a> or call 1-877-650-5840 for a list of network providers.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	20% coinsurance/visit	20% coinsurance	_____none_____
	<a href="#">Specialist</a> visit	20% coinsurance/visit	20% coinsurance	_____none_____
	<a href="#">Preventive care/screening/immunization</a>	No charge	20% coinsurance	_____none_____
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% coinsurance/visit	20% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	20% coinsurance/visit	20% coinsurance	_____none_____
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	\$9 copayment (retail)/ \$2 copayment (mail order)	Not Covered	Mail Order is Mandatory on all Maintenance Prescriptions.  If a Brand name medication is received and a generic equivalent is available, the participant must pay the Brand name copay PLUS the difference in the cost between the generic equivalent and the Brand name medication.
	Preferred brand drugs	\$18 copayment (retail) / \$36 copayment (mail order)	Not Covered	
	Non-preferred brand drugs	\$35 copayment (retail) / \$70 copayment (mail order)	Not Covered	
	<a href="#">Specialty drugs</a>	Preferred or Non-Preferred copayment as stated above.	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance/visit	20% coinsurance	_____none_____
	Physician/surgeon fees	20% coinsurance/visit	20% coinsurance	_____none_____
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% coinsurance Waived if admitted	20% coinsurance	_____none_____
	<a href="#">Emergency medical transportation</a>	20% coinsurance/visit	20% coinsurance	_____none_____
	<a href="#">Urgent care</a>	20% coinsurance/visit	20% coinsurance	_____none_____

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)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance/visit	20% coinsurance	Must be pre-certified.
	Physician/surgeon fees	20% coinsurance/visit	20% coinsurance	—————none—————
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% coinsurance/visit	20% coinsurance	—————none—————
	Inpatient services	20% coinsurance/visit	20% coinsurance	Must be pre-certified.
<b>If you are pregnant</b>	Office visits	20% coinsurance/visit	20% coinsurance	—————none—————
	Childbirth/delivery professional services	20% coinsurance/visit	20% coinsurance	—————none—————
	Childbirth/delivery facility services	20% coinsurance/visit	20% coinsurance	Must be pre-certified
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% coinsurance/visit	20% coinsurance	Must be pre-certified, Maximum of 40 visits per year.
	<a href="#">Rehabilitation services</a>	20% coinsurance/visit	20% coinsurance	Physical and occupational therapy limited to 24 visits per year.
	<a href="#">Habilitation services</a>	20% coinsurance/visit	20% coinsurance	—————none—————
	<a href="#">Skilled nursing care</a>	20% coinsurance/visit	20% coinsurance	Must be pre-certified
	<a href="#">Durable medical equipment</a>	20% coinsurance/visit	20% coinsurance	—————none—————
	<a href="#">Hospice services</a>	20% coinsurance/visit	20% coinsurance	—————none—————
<b>If your child needs dental or eye care</b>	Children's eye exam	20% coinsurance/visit	20% coinsurance	—————none—————
	Children's glasses	Not covered through the medical plan		
	Children's dental check-up	Not covered through the medical plan.		

## 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](#).)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Chiropractic Care
- Hearing Aids
- Non-emergency care when traveling outside the U.S.

**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: Your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565. 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](http://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 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 by calling **1-877-698-3863** or you can contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

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

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist</a> 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$750
Copayments	\$0
Coinsurance	\$1,100
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,910</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist</a> 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$750
Copayments	\$0
Coinsurance	\$660
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,470</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist</a> 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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$750
Copayments	\$0
Coinsurance	\$210
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$960</b>