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, call (855) 837-3528. 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 https://www.healthcare.gov/sbc-glossary/ or call (855) 837-3528 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $500/individual or $1,000/family Out-of-Network: $500/individual or $1,250 family *Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.*	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 unless 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. In-network Preventive Care, primary care visits, specialist visits, and Dental 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?	Yes. Out-of-Network Dental Benefits - $50/person and $100/family each calendar year. 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?	In-Network Medical: $3,500/individual or $7,000/family Prescription: $5,700/individual or $11,400/family Out-of-Network Medical: $5,000/individual or $10,000/family Prescription: No limit *Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.*	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?	Out-of-network charges in excess of plan allowances, 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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes*. See www. ibxtpa.com or call (833) 242-3330 for a list of network providers. **Out-of-Network providers* may be treated as *In-Network providers* as required by No Surprises Act.*	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 copayment/visit,	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	In-network not subject to deductible. Teladoc – no copayment, deductible or coinsurance. Teladoc is an In-Network Benefit only – no coverage for any telemedicine program other than Teladoc.
	Specialist visit	$40 copayment/visit		
	Preventive care/screening/ immunization	No charge	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	In-network providers not subject to the deductible. Plan covers preventive services and supplies required by ACA. Age and frequency guidelines apply to covered preventive care. 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 after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	----------none----------
	Imaging (CT/PET scans, MRIs)			

*For more information about limitations and exceptions, see summary plan description (SPD).

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 drugs to treat your illness or condition For more information about **prescription drug coverage** contact the Fund Office at(855) 837-3528.	Generic drugs	Retail - $20 copayment/ prescription (for 1st 3 fills of same drug); 100% up to $100 copayment/ prescription (for 4th or more fills of same drug) Smart 90 / Mail Order - $50 copayment/prescription	Submit original receipts to Fund Office for reimbursement, which will not exceed the amount the Fund would have paid an in-network pharmacy.	Maintenance drugs must be filled through the Smart 90 Retail or Mail Order Program. Retail is up to 90-day supply. Mail Order is up to 90-day supply. If generic equivalent is available; you will be required to pay the price difference between the generic drug and the preferred brand name drug unless Physician requests brand-name drug. Clinical programs for some classes of drugs include prior authorization, step therapy, and/or quantity limits. Certain weight loss drugs may be covered.*
	Preferred drugs	Retail - $40 copayment/ prescription (for 1st 3 fills of same drug); 100% up to $100 copayment/ prescription (for 4th or more fills of same drug) Smart 90 / Mail Order - $100 copayment/prescription		
	Non-Preferred brand drugs	Retail - $80 copayment/ prescription (for 1st 3 fills of same drug); 100% up to $100 copayment/ prescription (for 4th or more fills of same drug) Smart 90 / Mail Order - $200 copayment/prescription		
	Specialty drugs	25% coinsurance up to $200		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	----------none----------
	Physician/surgeon fees			

*For more information about limitations and exceptions, see summary plan description (SPD).

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 immediate medical attention	Emergency room care	$250 copayment/visit, then 20% coinsurance after deductible	$250 copayment/visit, then 20% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	$250 copayment waived if the patient is admitted to the hospital or if the reason for the visit to the emergency room is due to an accidental injury or life-threatening condition.
	Emergency medical transportation	20% coinsurance after deductible	Ground: 40% coinsurance based on Applicable Medicare Rate after deductible Air: 20% coinsurance (lesser of billed charges or the Qualified Payment Amount) unless otherwise required by No Surprises Act	To and from the hospital for a covered inpatient admission or initial treatment of an Emergency Medical Condition provided by a hospital or a government-certified ambulance service.
	Urgent care	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Teladoc – no copayment, deductible or coinsurance. Teladoc is an In-Network Benefit only – no coverage for any telemedicine program other than Teladoc.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Benefits based on hospital's average semi-private room rate. Prior authorization required.
	Physician/surgeon fees			----------none----------

*For more information about limitations and exceptions, see summary plan description (SPD).

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 mental health, behavioral health, or substance abuse services	Outpatient services	In-office physician visit: primary care: $20 copayment/visit; Specialist: $40 copayment/visit 20% coinsurance after deductible for all other outpatient services.	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Teladoc – no copayment, deductible or coinsurance. Teladoc is an In-Network Benefit only – no coverage for any telemedicine program other than Teladoc. Care or treatment must be administered by a medical doctor, psychiatrist, clinical psychologist or licensed practitioner including a licensed social worker.
	Inpatient services	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Prior authorization required. Residential Treatment Facility covered in-network only and limited to 60 days per year.
If you are pregnant	Office visits	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Maternity care may include tests and services described elsewhere in this document (i.e., ultrasound). Cost sharing does not apply to preventive services. Depending on the type of services, coinsurance or a deductible may apply. Newborn care is not provided for the newborns of Dependent Children. Maternity care is provided for Dependent Children.
	Childbirth/delivery professional services	20% coinsurance after deductible		
	Childbirth/delivery facility services	20% coinsurance after deductible		Inpatient stay of at least 48 hours for the mother and newborn child following a vaginal delivery or at least 96 hours for the mother and newborn child following a cesarean section delivery. Pregnancy of a dependent child is covered.

*For more information about limitations and exceptions, see summary plan description (SPD).

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 after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Limit 40 visits per year.
	Rehabilitation services			----------none----------
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	20% coinsurance after deductible	Not covered	Prior authorization required. Limit 60 days per calendar year.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Includes rental fees not to exceed purchase price. Expenses for special fittings, adaptations, maintenance, or repairs are not covered.
	Hospice services			Must be provided at freestanding hospice facility or by a hospice program sponsored by a hospital or Home Health Care Agency. Hospice services may be received in a private residence.
If your child needs dental or eye care	Children's eye exam	No charge for children up to age 19		Limited to once every 12 months. This plan covers certain preventive services without cost-sharing and before you meet your deductible, including vision screening for all children. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits.
	Children's glasses	No charge for medically necessary services for children up to age 19		Limited to once every 24 months. This plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits
	Children's dental check-up	No charge for preventive services up to age 19		Cleanings and exams limited to two per year. Preventive dental services are not subject to dental deductible.

*For more information about limitations and exceptions, see summary plan description (SPD).

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
- Cosmetic surgery (unless Medically Necessary)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S. (see www.bcbsglobalcore.com)
- Routine foot care
- Weight loss programs (ESI weight management program only)

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

- Bariatric surgery (if Plan guidelines are met)
- Chiropractic care (25 visits per year)
- Dental care (adult)
- Hearing aids
- Private-duty nursing (if Plan guidelines are met; 90 visits per Plan year)
- 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: Department of Labor's Employee Benefits Security Administration at (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 (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 at (855) 837-3528 or the Department of Labor's Employee Benefits Security Administration at (866) EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Para obtener asistencia en Español, llame al (855) 837-3528.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf (855) 837-3528 uff.

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 summary plan description (SPD).

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 copayment	$40
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,970**

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 copayment	$40
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	$600
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,200**

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

The plan's overall deductible	$500
Specialist copayment	$40
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	$500
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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