




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 the Fund Office at 215-568-3262. 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/](http://www.healthcare.gov/sbc-glossary/) or by calling 1-800-275-2583 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<u>In-Network</u> : \$0 <u>Out-of-Network</u> : \$250/Individual, \$500/Family	<u>In-Network</u> : See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. <u>Out-of-Network</u> : Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	<u>In-Network</u> : Not Applicable <u>Out-of-Network</u> : Yes. <u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u> .	<u>In-Network</u> : This <u>plan</u> does not have a <u>deductible</u> . <u>Out-of-Network</u> : This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	<u>In-Network Providers</u> : \$6,750/Individual, \$13,500/Family; <u>Prescription Drugs</u> : \$1,950/Individual, \$3,900/Family; <u>Out-of-Network Providers</u> : \$6,750/Individual, \$13,500/Family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, <u>balance-billing</u> charges, penalties for failure to obtain precertification, health care this <u>plan</u> doesn't cover, and dental/vision benefits under separately administered <u>Plans</u> . Additionally, the <u>Out-of-Network deductible</u> does not count towards the <u>out-of-pocket limit</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.ibx.com/find_a_provider">www.ibx.com/find_a_provider</a> or call 1-800-275-2583 for a list of participating <u>providers</u> . For a list of participating Behavioral Health /Substance Abuse Program <u>providers</u> , call MH Consultants, Inc. at 1-800-255-3081	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Patient-Centered Medical Home (PCMH): \$10 <u>copay</u> /visit; Non-PCMH <u>Primary Care Provider</u> (PCP): \$20 <u>copay</u> /visit	30% <u>coinsurance</u> , <u>deductible</u> does not apply	Each covered person must choose and use a <u>Primary Care Provider</u> (PCP) or Patient-Centered Medical Home (PCMH).
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit  Chiropractic care (spinal manipulation): \$20 <u>copay</u> /visit	30% <u>coinsurance</u>	PCP <u>referral</u> required for radiology, physical therapy, occupational therapy, spinal manipulations and acupuncture. Spinal manipulations limited to 10 visits/year. Acupuncture limited to 18 visits/year.
	<u>Preventive care/screening/immunization</u>	No charge	30% <u>coinsurance</u> , <u>deductible</u> does not apply	Subject to age and frequency limits. Vaccinations for travel and employment not covered. You may have to pay for service's that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.

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 test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge	30% <u>coinsurance</u>	PCP/PCMH <u>referral</u> required for <u>diagnostic tests</u> and imaging. All services must be furnished at PCP/PCMH designated site. Services obtained without <u>referral</u> subject to 30% <u>coinsurance</u> and <u>deductible</u> . Additionally, failure to pre-certify imaging will result in a 20% reduction of benefits.
	Imaging (CT/PET scans, MRIs)	No charge	30% <u>coinsurance</u>	
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com">http://www.caremark.com</a>	Generic drugs	Retail (30-day supply): \$7 <u>copay</u> /script; Home delivery and CVS retail pharmacies (90-day supply): \$14 <u>copay</u> /script	Not covered	No charge for ACA generic preventive medications and contraceptives (or brand-named if a generic is medically inappropriate) with a prescription. Mandatory generic feature: If you request a <u>formulary</u> brand name drug when a generic equivalent is available, you will pay the brand name <u>copay</u> plus the difference in cost between the brand name drug and the generic drug. 90-day supply available for maintenance medications only; may be filled at CVS retail pharmacies. Use of other pharmacy chains or local pharmacies to fill 90-day supply not covered. Some non-preventive <u>prescription drugs</u> and supplies not covered.
	<u>Formulary</u> brand drugs	Retail (30-day supply): \$22 <u>copay</u> /script; Home delivery and CVS retail pharmacies (90-day supply): \$44 <u>copay</u> /script	Not covered	
	Non- <u>formulary</u> brand drugs	Not Covered	Not covered	You must pay 100% of these costs, even <u>In-Network</u> .
	<u>Specialty drugs</u>	Self-administered <u>specialty drugs</u> : Generic drug \$7 <u>copay</u> /script; <u>Formulary</u> brand name drug: \$22 <u>copay</u> /script; Non- <u>formulary</u> brand name: Not Covered	Not covered	Failure to obtain prior authorization for self-administered brand drugs (specialty or non-specialty), which require prior authorization will result in denial of <u>claim</u> . Professionally administered specialty injectable <u>drugs</u> are covered by the medical <u>plan</u> . <u>In-Network</u> administration is covered at \$75 <u>copay</u> /administration and <u>Out-of-Network</u> administration at 30% <u>coinsurance</u> after <u>deductible</u> . Failure to pre-certify professionally administered <u>specialty drugs</u> will result in a 20% reduction of benefits.

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)	No charge	30% <u>coinsurance</u>	Failure to pre-certify certain procedures will result in a 20% reduction of benefits.
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	Visits 1 & 2: \$100 <u>copay</u> /visit; All other visits: \$200 <u>copay</u> /visit	Visits 1 & 2: \$100 <u>copay</u> /visit; All other visits: \$200 <u>copay</u> /visit	<u>Copay</u> waived if admitted to hospital. Professional/physician charges may be billed separately.
	<u>Emergency medical transportation</u>	Emergency and elective (non-emergency) transportation: No charge	Emergency transportation: No charge; Elective (non-emergency) transportation: 30% <u>coinsurance</u>	Failure to pre-certify elective (non-emergency) transportation will result in a 20% reduction of benefits.
	<u>Urgent care</u>	\$40 <u>copay</u> /visit	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% <u>coinsurance</u>	Failure to pre-certify elective (non-emergency) admissions will result in a 20% reduction of benefits. Knee and hip replacements: For services performed at <u>In-Network</u> Blue Distinctions Centers+ facilities No charge; For services performed at other <u>In-Network</u> facilities: 30% <u>coinsurance</u> . Knee and hip replacements not covered <u>Out-of-Network</u> . <u>Out-of-Network</u> care limited to 70 days per calendar year
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance use services	Outpatient services	Office visits: \$20 <u>copay</u> /visit; Other outpatient services: No charge	Office visits and other outpatient services: 30% <u>coinsurance</u>	None
	Inpatient services	No charge	30% <u>coinsurance</u>	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)	
If you are pregnant	Office visits	No charge	30% <u>coinsurance</u>	Maternity care may include test and services described somewhere else in the SBC (e.g., ultrasound). Depending on the type of services, a <u>copay</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.  Pre-notification requested.
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	No charge	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	30% <u>coinsurance</u>	Failure to pre-certify <u>home health care</u> will result in a 20% reduction of benefits. Up to 200 visits per year.
	<u>Rehabilitation services</u>	\$20 <u>copay</u> /visit	Not covered	
	<u>Habilitation services</u>	\$20 <u>copay</u> /visit	Not covered	PCP/PCMH <u>referral</u> required for physical and occupational therapy. Physical, occupational and speech therapy each limited to 30 visits/ per year. All habilitation visits count toward rehabilitation visit limits.
	<u>Skilled nursing care</u>	No charge	Not covered	
	<u>Durable medical equipment</u>	No charge	Not covered	Failure to pre-certify <u>skilled nursing care</u> will result in a 20% reduction of benefits. Limited to 60 days/per year.
	<u>Hospice services</u>	No charge	Not covered	Failure to pre-certify certain equipment will result in a 20% reduction of benefits.
If your child needs dental or eye care	Children's eye exam	No charge	Charges over \$30 <u>plan</u> allowance	Vision benefits separately administered by NVA. Limited to 1 eye exam every 12 months. Also limited to 1 complete pair of eye glasses every 12 months. A \$120 allowance for contact lenses may be elected as an alternative to glasses.
	Children's glasses	Charges over \$120 <u>plan</u> allowance	Charges over \$60 <u>plan</u> allowance for lenses (single vision, bifocal or trifocal) and charges over \$60 <u>plan</u> allowance for frames	
	Children's dental check-up	No charge	Charges over <u>plan</u> allowance	Dental benefits separately administered by Delta Dental. Limited to 1 dental check-up every 6 months.

## 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.)		
<ul style="list-style-type: none"><li>• Cosmetic surgery</li><li>• Infertility treatment</li></ul>	<ul style="list-style-type: none"><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Weight loss programs (except as required as a preventive benefit under the ACA)</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"><li>• Acupuncture (limited to 18 visits per year)</li><li>• Bariatric surgery</li><li>• Chiropractic care (Spinal manipulations limited to 10 treatments/year)</li></ul>	<ul style="list-style-type: none"><li>• Dental care (Adult) (Limited to \$1,000/year)</li><li>• Hearing aids (Limited to 2 per lifetime)</li><li>• Private-duty nursing (Limited to 360 hours/year)</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult) (Limited to once every 24 months)</li><li>• Routine foot care</li></ul>

**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 available from the Fund Office at 215-568-3262. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://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](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 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: IBC at 1-800-ASK-BLUE or the Fund Office at Service Employees International Union Local 32 BJ District 36 BOLR Welfare Fund, 1515 Market Street, Suite 1020, Philadelphia, PA, 19102 or via phone at 215-568-3262. You may also contact the U.S. Dept. of Labor Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-671-5276.

————— *To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.* —————

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 copay \$20
- Hospital (facility) coinsurance 0%
- Other copay (Non-PCMH PCP) \$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>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$70</b>

**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 copay \$20
- Hospital (facility) coinsurance 0%
- Other copay (Non-PCMH PCP) \$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>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$840
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$470
<b>The total Joe would pay is</b>	<b>\$1,310</b>

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

- The plan's overall deductible \$0
- Specialist copay \$20
- Hospital (facility) coinsurance 0%
- Other copay (Non-PCMH PCP) \$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>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$270
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$270</b>