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/ or by calling 1-800-275-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $0 Out-of-Network: $250/Individual, $500/Family	In-Network: See the Common Medical Events chart below for your costs for services this plan covers. Out-of-Network: 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?	In-Network: Not Applicable Out-of-Network: Yes. Preventive care and primary care office visits are covered before you meet your deductible.	In-Network: This plan does not have a deductible. Out-of-Network: 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?	In-Network Providers: $6,750/Individual, $13,500/Family, Prescription Drugs: $1,950/Individual, $3,900/Family; Out-of-Network Providers: $6,750/Individual, $13,500/Family	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, balance-billing charges, penalties for failure to obtain precertification, health care this plan doesn't cover, and dental/vision benefits under separately administered plans. Additionally, the Out-of-Network deductible does not count towards the out-of-pocket limit.	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.ibx.com or call 1-800-275-2583 for a list of participating providers. For a list of participating Behavioral Health /Substance Abuse Program providers, call MH Consultants, Inc. at 1-800-255-3081	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?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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	Patient-Centered Medical Home (PCMH): $10 copay/visit; Non-PCMH Primary Care Provider (PCP): $20 copay/visit	30% coinsurance, deductible does not apply	Each covered person must choose and use a Primary Care Provider (PCP) or Patient-Centered Medical Home (PCMH).
	Specialist visit	$20 copay/visit Chiropractic care (spinal manipulation): $20 copay/visit	30% coinsurance	PCP referral required for radiology, physical therapy, occupational therapy, spinal manipulations and acupuncture. Spinal manipulations limited to 10 visits/year. Acupuncture limited to 18 visits/year.
	Preventive care/screening/ immunization	No charge	30% coinsurance, deductible does not apply	Subject to age and frequency limits. Vaccinations for travel and employment not covered. 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)	No charge	30% coinsurance	PCP/PCMH referral required for diagnostic tests and imaging. All services must be furnished at PCP/PCMH designated site. Services obtained without referral subject to 30% coinsurance after deductible. Additionally, failure to pre-certify imaging will result in a 20% reduction of benefits.
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	

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 More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	Retail (30-day supply): $7 copay/script; Home delivery and CVS retail pharmacies (90-day supply): $14 copay/script	Not covered	No charge for ACA generic preventive medications and contraceptives (or brand-name if a generic is medically inappropriate) with a prescription. Mandatory generic feature: If you request a formulary brand name drug when a generic equivalent is available, you will pay the brand name copay 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 prescription drugs and supplies not covered.
	Formulary brand drugs	Retail (30-day supply): $22 copay/script; Home delivery and CVS retail pharmacies (90-day supply): $44 copay/script	Not covered	
	Non-formulary brand drugs	Not Covered	Not covered	You must pay 100% of these costs, even In-Network.
	Specialty drugs	Self-administered specialty drugs: Generic drug $7 copay/script; Formulary brand name drug: $22 copay/script; Non-formulary 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 claim. Professionally administered specialty injectable drugs are covered by the medical plan. In-Network administration is covered at $75 copay/administration and Out-of-Network administration at 30% coinsurance after deductible. Failure to pre-certify professionally administered specialty drugs will result in a 20% reduction of benefits.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	Failure to pre-certify certain procedures will result in a 20% reduction of benefits.
	Physician/surgeon fees	No charge	30% coinsurance	

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	Visits 1 & 2: $100 copay/visit; All other visits: $200 copay/visit	Visits 1 & 2: $100 copay/visit; All other visits: $200 copay/visit	Copay waived if admitted to hospital.
	Emergency medical transportation	Emergency and elective (non-emergency) transportation: No charge	Emergency transportation: No charge; Elective (non-emergency) transportation: 30% coinsurance	Failure to pre-certify elective (non-emergency) transportation will result in a 20% reduction of benefits.
	Urgent care	$40 copay/visit	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	Failure to pre-certify elective (non-emergency) admissions will result in a 20% reduction of benefits. Knee and hip replacements: For services performed at In-Network Blue Distinction Centers+: No charge; For services performed at other In-Network facilities: 30% coinsurance, after deductible. Knee and hip replacements not covered Out-of-Network. All Out-of-Network care limited to 70 days/per calendar year
	Physician/surgeon fees	No charge	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $20 copay/visit; Other outpatient services: No charge	Office visits and other outpatient services: 30% coinsurance	None
	Inpatient services	No charge	30% 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)	
If you are pregnant	Office visits	No charge	30% coinsurance	Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Depending on the type of services, a copay, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	No charge	30% coinsurance	Pre-notification requested.
	Childbirth/delivery facility services	No charge	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Failure to pre-certify home health care will result in a 20% reduction of benefits. Up to 200 visits per year.
	Rehabilitation services	$20 copay/visit	Not covered	PCP/PCMH referral required for physical and occupational therapy. Physical, occupational and speech therapy each limited to 30 visits/year. All habilitation visits count toward rehabilitation visit limits.
	Habilitation services	$20 copay/visit	Not covered	
	Skilled nursing care	No charge	Not covered	Failure to pre-certify skilled nursing care will result in a 20% reduction of benefits. Limited to 60 days/per year.
	Durable medical equipment	No charge	Not covered	Failure to pre-certify certain equipment will result in a 20% reduction of benefits.
	Hospice services	No charge	Not covered	Failure to pre-certify hospice services will result in a 20% reduction of benefits. Limited to 210 days per lifetime.
If your child needs dental or eye care	Children's eye exam	No charge	Charges over $30 plan 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 plan allowance	Charges over $60 plan allowance for lenses (single vision, bifocal or trifocal) and charges over $60 plan allowance for frames	
	Children's dental check-up	No charge	Charges over plan 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.)

- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs (except as required as a preventive benefit under the ACA)

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

- Acupuncture (limited to 18 visits per year)
- Bariatric surgery
- Chiropractic care (Spinal manipulations limited to 10 treatments/year)
- Dental care (Adult) (Limited to $1,000/year)
- Hearing aids (Limited to 2 per lifetime)
- Private-duty nursing (Limited to 360 hours/year)
- Routine eye care (Adult) (Limited to once every 24 months)
- Routine foot care

There is a monthly premium required to add a child/children to the plan.

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 the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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: 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 wwww.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) copay** **$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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

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) copay** **$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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$840
Coinsurance	$0
What isn't covered	
Limits or exclusions	$470
The total Joe would pay is	**$1,310**

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

- **The plan's overall deductible** **$0**
- **Specialist copay** **$20**
- **Hospital (facility) copay** **$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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$270
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$270**

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