


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, see <http://www.tbtfund.org> or call the TBT Plan Administration Office at 1-800-533-0119. 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 <http://www.tbtfund.org> or call the TBT Plan Administration Office at 1-800-533-0119 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For <u>network providers</u> : \$0 . For <u>out-of-network providers</u> : \$100 /individual or \$200 /family per calendar year.	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 plan, each family member must meet their own individual <u>deductible</u> until the total amount of deductible expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. For <u>network providers</u> : preventive care, <u>preauthorized</u> inpatient and outpatient hospital and surgery, chiropractic, mental health, alcohol/chemical dependency treatment and certain other services.	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.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$1,500 /individual or \$3,000 /family per calendar year. Single accident limit \$100 / family.	The <u>out-of-pocket limit</u> is the most you could pay in a calendar year for covered services.

What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance billing</u> charges, <u>copayments</u> on certain services, health care this <u>plan</u> doesn't cover, and penalties for failure to obtain <u>preauthorization</u> for certain services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.bcbs.com or call 1-800-810-2583 for <u>network providers</u> . (California residents, call 1-888-887-3725.) For Plan information about <u>network providers</u> and <u>out-of-network providers</u> , call the TBT Plan Administration Office at 1-800-533-0119.	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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 provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Plan does not pay for out-of-network charges that are higher than <u>Usual, Customary & Reasonable (UCR)</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>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</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 office</u> or clinic	Primary care visit to treat an injury or illness	\$10 <u>copayment</u> per visit	15% <u>coinsurance</u> of <u>UCR</u> charges	None
	<u>Specialist</u> visit	\$10 <u>copayment</u> per visit	15% <u>coinsurance</u> of <u>UCR</u> charges	Chiropractic: limited to 20 visits per diagnosis up to \$2,000 per calendar year. Hearing aids: limited to \$1,500 per ear every three calendar years.

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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)	
	<u>Preventive care/screening/immunization</u>	\$10 <u>copayment</u> per visit	15% <u>coinsurance</u> of <u>UCR</u> charges	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 test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	15% <u>coinsurance</u> of <u>UCR</u> charges	None
	Imaging (CT/PET scans, MRIs)	No charge	15% <u>coinsurance</u> of <u>UCR</u> charges	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.tbtfund.org or www.OptumRx.com or call 1-800-797-9791.	Generic drugs	\$5 <u>copayment</u> per prescription	By reimbursement only. \$5 <u>copayment</u> per prescription. You also pay the cost difference between <u>network provider</u> and <u>out-of-network</u> costs.	Covers up to 30-day supply (retail or mail order). If brand drug ordered when generic drug is available, you pay cost difference plus per prescription. Mail order required after second fill for maintenance drugs (90-day supply) with <u>copayment</u> of \$0 for generic drug and \$15 for brand drug.
	Preferred brand drugs	\$20 <u>copayment</u> per prescription	By reimbursement only. \$20 <u>copayment</u> per prescription. You also pay the cost difference between <u>network provider</u> and <u>out-of-network</u> costs.	
	Non-preferred brand drugs	Not covered	Not covered	Not covered
	<u>Specialty drugs</u>	No charge	Not covered	<u>Preauthorization</u> is required for <u>specialty drugs</u> and many injectable medications.

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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 don't get <u>preauthorization</u> by the <u>plan's</u> Specialty Pharmacy Program, these drugs are not covered. They are not available through retail pharmacies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	15% <u>coinsurance</u> of <u>UCR</u> charges	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> by the <u>plan's</u> medical review organization, benefits could be reduced by 10% of the total cost of services.
	Physician/surgeon fees	No charge	15% <u>coinsurance</u> of <u>UCR</u> charges	None
If you need immediate medical attention	<u>Emergency room care</u>	\$50 <u>copayment</u> per visit	\$50 <u>copayment</u> per visit for amounts above <u>UCR</u> charges	None
	<u>Emergency medical transportation</u>	No charge	15% <u>coinsurance</u> of <u>UCR</u> charges	Ambulance or air ambulance for convenience not covered.
	<u>Urgent care</u>	\$10 copayment	15% <u>coinsurance</u> of <u>UCR</u> charges	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	15% <u>coinsurance</u> of <u>UCR</u> charges	<u>Preauthorization</u> is required for non-emergency hospital stay (& within 72 hours if emergency). If you don't get <u>preauthorization</u> by the <u>plan's</u> medical review organization, benefits could be reduced by 10% of the total cost of services.
	Physician/surgeon fees	No charge	15% <u>coinsurance</u> of <u>UCR</u> charges	None

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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	\$10 <u>copayment</u> per visit	15% <u>coinsurance</u> of <u>UCR</u> charges	None
	Inpatient services	No charge.	15% <u>coinsurance</u> of <u>UCR</u> charges	<u>Preauthorization</u> is required for non-emergency hospital stay (& within 72 hours if emergency). If you don't get <u>preauthorization</u> by the <u>plan's</u> medical review organization, benefits could be reduced by 10% of the total cost of services.
If you are pregnant	Office visits	No charge	15% <u>coinsurance</u> of <u>UCR</u> charges	Maternity care may include tests and services described elsewhere in the SBC (such as ultrasound).
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	15% <u>coinsurance</u> of <u>UCR</u> charges	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> by the <u>plan's</u> medical review organization, benefits could be reduced by 10% of the total cost of services.
	<u>Rehabilitation services</u>	No charge		
	<u>Habilitation services</u>	Not covered	Not covered	
	<u>Skilled nursing care</u>	No charge	15% <u>coinsurance</u> of <u>UCR</u> charges	

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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)	
	<u>Durable medical equipment</u>	No charge	15% <u>coinsurance</u> of <u>UCR</u> charges	Covered for rental or <u>preauthorized</u> purchase.
	<u>Hospice services</u>	No charge	15% <u>coinsurance</u> of <u>UCR</u> charges	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> by the <u>plan's</u> medical review organization, benefits could be reduced by 10% of the total cost of services.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Coverage provided under a separate vision plan.
	Children's glasses	Not covered	Not covered	Coverage provided under a separate vision plan.
	Children's dental check-up	Not covered	Not covered	Coverage provided under a separate dental 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.)

- Cosmetic surgery
- Dental care (covered under a separate dental plan)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (covered under a separate vision plan)
- Weight loss programs

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

- Acupuncture (preauthorization required)
- Bariatric surgery (preauthorization required)
- Chiropractic care (see limitations on page 2)
- Hearing aids (see limitations on page 2)
- Infertility treatment (preauthorization required)
- Private duty nursing
- Routine foot care

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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-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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance,

Language Access Services

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-533-0119.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-533-0119.

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

* For more information, see the summary plan description materials at <http://www.tbtfund.org> or call the TBT Plan Administration Office at 1-800-533-0119.



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 <u>deductible</u>	\$0
■ <u>Specialist</u>	\$10
■ Hospital (facility)	0%
■ Other	0%

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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$40
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$100

Managing Joe's type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist</u>	\$10
■ Hospital (facility)	0%
■ Other	0%

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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$510
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$570

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist</u>	\$10
■ Hospital (facility)	0%
■ Other	0%

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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$180
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$180

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

