**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 deductible?** | For network providers: **$0.**<br>For out-of-network providers: **$100** /individual or **$200**/family per calendar year. | 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?** | Yes. For network providers: preventive care, preauthorized inpatient and outpatient hospital and surgery, chiropractic, mental health, alcohol/chemical dependency treatment and certain other services. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. |
| **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?** | **$1,500**/individual or **$3,000**/family per calendar year. Single accident limit **$100** / family. | The out-of-pocket limit is the most you could pay in a calendar year for covered services. |

| | | |
|---|---|---|
| **What is not included in the out-of-pocket limit?** | Premiums, balance billing charges, copayments on certain services, health care this plan doesn't cover, and penalties for failure to obtain preauthorization for certain services. | 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.bcbs.com or call 1-800-810-2583 for network providers. (California residents, call 1-888-887-3725.)<br>For Plan information about network providers and out-of-network providers, call the TBT Plan Administration Office at 1-800-533-0119. | 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). Plan does not pay for out-of-network charges that are higher than Usual, Customary & Reasonable (UCR). 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 | $10 copayment per visit | 15% coinsurance of UCR charges | None |
| | Specialist visit | $10 copayment per visit | 15% coinsurance of UCR 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. |

* 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.

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

* 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.

| 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 preauthorization by the plan's 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% coinsurance of UCR charges | Preauthorization is required. If you don't get preauthorization by the plan's medical review organization, benefits could be reduced by 10% of the total cost of services. |
| | Physician/surgeon fees | No charge | 15% coinsurance of UCR charges | None |
| **If you need immediate medical attention** | Emergency room care | $50 copayment per visit | $50 copayment per visit for amounts above UCR charges | None |
| | Emergency medical transportation | No charge | 15% coinsurance of UCR charges | Ambulance or air ambulance for convenience not covered. |
| | Urgent care | $10 copayment | 15% coinsurance of UCR charges | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge | 15% coinsurance of UCR charges | Preauthorization is required for non-emergency hospital stay (& within 72 hours if emergency). If you don't get preauthorization by the plan's medical review organization, benefits could be reduced by 10% of the total cost of services. |
| | Physician/surgeon fees | No charge | 15% coinsurance of UCR charges | 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 need mental health, behavioral health, or substance abuse services** | Outpatient services | $10 copayment per visit | 15% coinsurance of UCR charges | None |
| | Inpatient services | No charge. | 15% coinsurance of UCR charges | Preauthorization is required for non-emergency hospital stay (& within 72 hours if emergency). If you don't get preauthorization by the plan's medical review organization, benefits could be reduced by 10% of the total cost of services. |
| **If you are pregnant** | Office visits | No charge | 15% coinsurance of UCR 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** | Home health care | No charge | 15% coinsurance of UCR charges | Preauthorization is required. If you don't get preauthorization by the plan's medical review organization, benefits could be reduced by 10% of the total cost of services. |
| | Rehabilitation services | No charge | | |
| | Habilitation services | Not covered | Not covered | Not covered |
| | Skilled nursing care | No charge | 15% coinsurance of UCR charges | Preauthorization is required. If you don't get preauthorization by the plan's medical review organization, benefits could be reduced by 10% of the total cost of services. |

| 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) | |
| | Durable medical equipment | No charge | 15% coinsurance of UCR charges | Covered for rental or preauthorized purchase. |
| | Hospice services | No charge | 15% coinsurance of UCR charges | Preauthorization is required. If you don't get preauthorization by the plan's 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

**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.* ———————————

**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** | **$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** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $40 |
| Coinsurance | $0 |
| *What isn't covered* | |
| 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 deductible** | **$0** |
| ■ **Specialist** | **$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** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $510 |
| Coinsurance | $0 |
| *What isn't covered* | |
| 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 deductible** | **$0** |
| ■ **Specialist** | **$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** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $180 |
| Coinsurance | $0 |
| *What isn't covered* | |
| 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.