
 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 1-800-424-3405 or visit [www.ncscbf.com](http://www.ncscbf.com). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary>, call 1-800-318-2596, or call the Fund Office at 1-800-424-3405 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <u>deductible</u>?</b></p>	<p><u>In-Network Provider</u>:  <b>\$200</b> Individual / <b>\$600</b> Family;  <u>Out-of-Network Provider</u>:  <b>\$400</b> Individual / <b>\$1,200</b> Family.</p>	<p>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 this <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>.</p>
<p><b>Are there services covered before you meet your <u>deductible</u>?</b></p>	<p>Yes. Unless otherwise specified, the following do not count toward the <u>deductible</u>: <u>Preventive care</u>, hospice care, home health care, and skilled nursing facility care.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copay</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a>.</p>
<p><b>Are there other <u>deductibles</u> for specific services?</b></p>	<p>Yes. <b>\$50</b> every 2 calendar years for <b>Delta Dental</b> Dental Care Benefits. There are no other specific <u>deductibles</u>.</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.</p>
<p><b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b></p>	<p>Medical: <u>In-Network Provider</u>:  <b>\$1,500</b> Individual / <b>\$4,500</b> Family;  <u>Out-of-Network Provider</u>:  <b>\$2,500</b> Individual / <b>\$7,500</b> Family.  <u>Prescription Drugs</u>:  <b>\$5,350</b> Individual/ <b>\$9,200</b> Family.</p>	<p>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 limit</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>

Important Questions	Answers	Why This Matters:
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Penalty for each non-emergency hospital confinement or inpatient surgical procedure which is not precertified as required; <u>coinsurance</u> for <u>out-of-network preventive care</u> and routine physical exams; amounts in excess of the maximum for <u>out-of-network</u> chiropractic visits; <u>premiums</u> , <u>balance billing</u> charges, and health care this <u>plan</u> does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket-limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. For a list of <u>network providers</u> , visit: <a href="http://www.anthem.com">www.anthem.com</a> .	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 charge</u> 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a referral.

 All copay 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)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care <u>provider's office</u> or <u>clinic</u></b>	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	30% <u>coinsurance</u>	No charge for Anthem LiveHealth Online visit.
	<u>Specialist</u> visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Chiropractor and acupuncture - <u>In-Network</u> : 10% <u>coinsurance</u> <u>Out-of-Network</u> : 30% <u>coinsurance</u> Chiropractor visits are payable for the treatment of musculoskeletal and neuromusculoskeletal conditions and are limited to \$40/visit and 26 visits per calendar year. Chiropractic care is not payable for infants and dependent children age 5 and under, unless medical necessity is established by a physician, and is payable only for the

\*For more information about limitations and exceptions, see the plan or policy document at [www.ncscbf.com](http://www.ncscbf.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions*, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				treatment of documented injuries for dependent children ages 6 to 12, unless medical necessity is established by a physician. Acupuncture is limited to \$500/year.
	<u>Preventive care/screening/immunization</u>	No charge for ACA <u>preventive services</u>	Not covered	Well child care age 2 and over by <u>out-of-network provider</u> payable in full up to \$200/calendar year (excess at 80% <u>coinsurance</u> ). Routine physical exams for employee and dependent spouse by <u>out-of-network provider</u> payable in full up to \$531/calendar year (excess at 80% <u>coinsurance</u> ). Routine colonoscopy and EKGs by <u>out-of-network provider</u> covered at 10% <u>coinsurance</u> , no <u>deductible</u> . Certain immunizations by <u>out-of-network provider</u> covered at 100%. You may have to pay for services that aren't <u>preventive</u> . Ask your provider if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> recommended.
<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.express-scripts.com">www.express-scripts.com</a> .	Generic drugs	\$8 <u>copay</u> /prescription (retail); \$16 <u>copay</u> /prescription (mail order)	Not covered	Covers up to a 30-day supply (retail); 90-day supply (mail order); 30-day supply (specialty pharmacy). Drugs excluded from the <u>Plan's Formulary</u> are not covered unless approved in advance through a <u>Formulary</u> exception process managed by Express Scripts. No charge for <u>ACA preventive care</u> drugs with a physician's written prescription, except no prescription required for emergency contraceptives (Plan B). Smoking cessation products limited to two 90-day supplies per 365-day period.
	Brand name drugs	Greater of \$15 or 25% of cost, to maximum of \$35/prescription (retail) and greater of \$30 or 25% of cost, to maximum of \$70/prescription (mail order)	Not covered	
	<u>Specialty medications</u> (through specialty pharmacy)	25% of cost, to maximum of \$50/prescription	Not covered	

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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)	Non-Network Provider (You will pay the most)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> for certain outpatient surgeries/procedures recommended. <u>Preauthorization</u> recommended for prophylactic mastectomies.
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$150 <u>copay</u> /visit, then 10% <u>coinsurance</u>	\$150 <u>copay</u> /visit, then 10% <u>coinsurance</u>	<u>Copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
	<u>Urgent care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification required for non-emergency hospital stay (and emergency admissions within 48 hours) or additional 5% <u>coinsurance</u> , up to \$500 maximum penalty.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification required for non-emergency inpatient surgery (or emergency surgery within 48 hours) or additional 5% <u>coinsurance</u> , up to \$500 maximum penalty. <u>Preauthorization</u> recommended for prophylactic mastectomies.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification required for non-emergency hospital stay (and emergency admissions within 48 hours) or additional 5% <u>coinsurance</u> , up to \$500 maximum penalty.
<b>If you are pregnant</b>	Office visits	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification required for hospital stay in excess of 48 hours following vaginal delivery or 96 hours following a C-section, or additional 5% <u>coinsurance</u> , up to \$500 maximum penalty. <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	

\*For more information about limitations and exceptions, see the plan or policy document at [www.ncscbf.com](http://www.ncscbf.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions*, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	No charge	<u>Preauthorization</u> recommended.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> recommended for physical therapy and occupational therapy after initial evaluation and 8 sessions. Precertification required for inpatient rehabilitation or additional 5% <u>coinsurance</u> , up to \$500 maximum penalty.
	<u>Habilitation services</u>	Not covered	Not covered	Not covered
	<u>Skilled nursing care</u>	No charge	No charge	Limited to 30 days per period of disability. Precertification required or additional 5% <u>coinsurance</u> , up to \$500 maximum penalty.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> for certain equipment recommended. CPAP, BiPAP, and AutoPAP supplies covered up to \$200/year.
	<u>Hospice services</u>	No charge	No charge	<u>Preauthorization</u> recommended for home hospice. Precertification required for hospice care in a hospice facility or additional 5% <u>coinsurance</u> , up to \$500 maximum penalty.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Up to \$42 allowance	<u>In-Network</u> : No maximum for 1 exam per calendar year, up to age 19. (No coverage for Class E.)
	Children's glasses	Frames: \$130 allowance, then 20% off any balance Lenses: No charge (for single/bifocal/trifocal)	Frames: Up to \$45 allowance Lenses: Up to \$40/single, \$60/bifocal, \$80/trifocal allowances	<u>In-Network</u> only: 1 eyeglass lens enhancement allowed every 2 calendar years at no extra cost. Contact lenses: 1 pair every 2 calendar years with varying allowances between <u>In-Network</u> and <u>Out-of-Network</u> . (No coverage for Class E.)
	Children's dental check-up – <b>Delta Dental</b>	\$50 <u>deductible</u> every 2 calendar years, then 10% <u>coinsurance</u>	\$50 <u>deductible</u> every 2 calendar years, then 10% <u>coinsurance</u>	Limited to 2 check-ups per year, up to age 19, not subject to deductible or maximum. (No coverage for Class E.)
	Children's dental check-up – <b>CarePlus Dental</b>	No charge	Not covered	Calendar year maximum does not apply (No coverage for Class E.)

\*For more information about limitations and exceptions, see the plan or policy document at [www.ncscbf.com](http://www.ncscbf.com).

## 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.)

- Bariatric surgery
- Cosmetic surgery, except for the repair or reconstruction of injuries within 12 months of the date of the injury or breast reconstruction following mastectomy
- Habilitation services
- Infertility treatment (only infertility testing covered up to \$4,000/lifetime)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs, except physician services, lab work, and patient education in a medical setting for treatment of morbid obesity are covered up to \$500/lifetime subject to certain criteria

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

- Acupuncture, subject to medical guidelines which specify certain conditions and diagnoses for which acupuncture is recognized to be effective, up to \$500/year
- Chiropractic care for treatment of musculoskeletal and neuromusculoskeletal conditions, up to \$40/visit and 26 visits per calendar year
- Dental care with **Delta Dental**, up to \$2,400 every 2 calendar years and orthodontic up to \$2,000/lifetime (No coverage for Class E)
- Dental care with **CarePlus Dental**, up to \$2,000 per calendar year (No coverage for Class E)
- Hearing aids, limited to one per ear / 3 years, up to \$2,000
- Routine eye care (No coverage for Class E)

**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 the Department of Labor's Employee Benefits Security Administration is 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa>. 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), call 1-800-318-2596, or call the Fund Office at 1-800-424-3405.

**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 Plan Administrator at 1-800-424-3405, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa).

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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.

—————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, copays 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 \$200
- Specialist copay \$0
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

**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>\$11,470</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$200
Copays	\$0
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,260</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$200
- Specialist copay \$0
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

**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>\$6,140</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$200
Copays	\$700
Coinsurance	\$290
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,250</b>

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

- The plan's overall deductible \$200
- Specialist copay \$0
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

**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>\$1,530</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$200
Copays	\$150
Coinsurance	\$190
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$540</b>

The Plan offers a Health Reimbursement Account that you can use to pay deductibles, copays and coinsurance amounts and other medical expenses that are not covered by the Plan or another source. You may file for reimbursement for some of these expenses, as permitted by the Plan's Health Reimbursement Account.

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

## NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY SERVICES

The North Central States Regional Council of Carpenters' Health Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Fund provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats) as well as language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages. If you need these services, please contact the Fund Office.

If you believe the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-424-3405.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-424-3405.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-424-3405。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.

Rufnummer: 1-800-424-3405.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-424-3405.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-424-3405-1.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-424-3405 번으로 전화해 주십시오.

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-424-3405.

ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-424-3405.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-424-3405.

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kantscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-424-3405.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-424-3405.

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PAUNAWA. Rung nang sasanta ka ng Tagalog, Tagalog nang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-424-3405.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-424-3405.