**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. 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 contact the Fund Office at 1-800-424-3405 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network Provider: **$200** Individual / **$600** Family; Out-of-Network Provider: **$400** Individual / **$1,200** Family. | 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 this 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. Unless otherwise specified, the following do not count toward the deductible: Preventive care, hospice care, home health care, and skilled nursing facility care. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copay 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?** | Yes. **$50** every 2 calendar years for **Delta Dental** Dental Care Benefits for Classes P and S only. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | Medical: In-Network Provider: **$1,500** Individual / **$4,500** Family; Out-of-Network Provider: **$2,500** Individual / **$7,500** Family. Prescription Drugs: **$5,350** Individual/ **$9,200** 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. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is not included in the out-of-pocket limit?** | Penalty for each non-emergency hospital confinement or inpatient surgical procedure which is not precertified as required; coinsurance for out-of-network preventive care and routine physical exams; amounts in excess of the maximum for out-of-network chiropractic visits; premiums, balance billing charges, and health care this plan does not cover. | 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. For a list of network providers, visit: www.anthem.com. | 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?** | No. | You can see the specialist 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) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 10% coinsurance | 30% coinsurance | No charge for LiveHealth Online visit. |
| | Specialist visit | 10% coinsurance | 30% coinsurance | Chiropractor and acupuncture - In-Network: 10% coinsurance Out-of-Network: 30% coinsurance 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 treatment |

*For more information about limitations and exceptions, see the plan or policy document at 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) | |
| | | | | of documented injuries for dependent children ages 6 to 12, unless medical necessity is established by a physician. Acupuncture is limited to $500/year. |
| | Preventive care/screening/ immunization | No charge for ACA preventive services | Not covered | Well child care age 2 and over by out-of-network provider payable in full up to $200/calendar year (excess at 80% coinsurance). Routine physical exams for employee and dependent spouse by out-of-network provider payable in full up to $531/calendar year (excess at 80% coinsurance). Routine colonoscopy and EKGs by out-of-network provider covered at 10% coinsurance, no deductible. Certain immunizations by out-of-network provider covered at 100%. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance | 30% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 30% coinsurance | Preauthorization recommended. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.express-scripts.com. | Generic drugs | $8 copay/prescription (retail);<br>$16 copay/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 Plan's Formulary are not covered unless approved in advance through a Formulary exception process managed by Express Scripts. No charge for ACA preventive care 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 (retail) and greater of $30 or 25% of cost, to maximum of $70(mail order) per prescription | Not covered | |
| | Specialty medications (through specialty pharmacy) | 25% of cost, to maximum of $50/prescription | Not covered | |

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

*For more information about limitations and exceptions, see the plan or policy document at 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) | |
| **If you need help recovering or have other special health needs** | Home health care | No charge | No charge | Preauthorization recommended. |
| | Rehabilitation services | 10% coinsurance | 30% coinsurance | Preauthorization recommended for physical therapy and occupational therapy after initial evaluation and 8 sessions. Precertification required for inpatient rehabilitation or additional 5% coinsurance, up to $500 maximum penalty. |
| | Habilitation services | Not covered | Not covered | Not covered |
| | Skilled nursing care | No charge | No charge | Limited to 30 days per period of disability. Precertification required or additional 5% coinsurance, up to $500 maximum penalty. |
| | Durable medical equipment | 10% coinsurance | 30% coinsurance | Preauthorization for certain equipment recommended. CPAP, BiPAP, and AutoPAP supplies covered up to $200/year. |
| | Hospice services | No charge | No charge | Preauthorization recommended for home hospice. Precertification required for hospice care in a hospice facility or additional 5% coinsurance, up to $500 maximum penalty. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | Up to $42 allowance | In-Network: No maximum for 1 exam per calendar year, up to age 19. (Classes P and S only.) |
| | Children's glasses | Frames: $130 allowance, then 20% off any balance<br>Lenses: No charge (for single/bifocal/trifocal) | Frames: Up to $45 allowance<br>Lenses: Up to $40/single, $60/bifocal, $80/trifocal allowances | In-Network only: 1 eyeglass lens enhancement allowed every 2 calendar years at no extra cost.<br>Contact lenses: 1 pair every 2 calendar years with varying allowances between In-Network and Out-of-Network. (Classes P and S only.) |
| | Children's dental check-up – **Delta Dental** | $50 deductible every 2 calendar years, then 10% coinsurance | $50 deductible every 2 calendar years, then 10% coinsurance | Limited to 2 check-ups per year, up to age 19, not subject to deductible or maximum. (Classes P and S only.) |
| | Children's dental check-up – **CarePlus Dental** | No charge | Not covered | Calendar year maximum does not apply (Classes P and S only.) |

*For more information about limitations and exceptions, see the plan or policy document at 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 are up to $2,000/lifetime (Classes P and S only)
- Dental care with **CarePlus Dental**, up to $2,000 per calendar year (Classes P and S only)
- Hearing aids, limited to one per ear / 3 years, up to $2,000
- Routine eye care (Adult, Classes P and S only)

**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 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, 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.

**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.*

*For more information about limitations and exceptions, see the plan or policy document at www.ncscbf.com.

## 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*)

| | |
|---|---|
| **Total Example Cost** | **$11,470** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $200 |
| Copays | $0 |
| Coinsurance | $1,000 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,260** |

### 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)*

| | |
|---|---|
| **Total Example Cost** | **$6,140** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $200 |
| Copays | $700 |
| Coinsurance | $290 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$1,250** |

### 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)*

| | |
|---|---|
| **Total Example Cost** | **$1,530** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $200 |
| Copays | $150 |
| Coinsurance | $190 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$540** |

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.

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: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-424-3405.

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

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht 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: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-424-3405.

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

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