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, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/health-care-law-protections/summary-of-benefits-and-coverage/ or call 1-800-424-3405 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network Provider: **$250** Individual / **$750** Family; Out-of-Network Provider: **$800** Individual / **$2,400** 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: LiveHealth Online, 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: **$3,000** Individual / **$6,000** Family; Out-of-Network Provider: **$6,000** Individual / **$12,000** Family. Prescription Drugs: **$2,000** Individual / **$4,000** 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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Precertification penalties; certain specialty medications, 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.

Important Questions	Answers	Why This Matters:
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 Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
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 Anthem LiveHealth Online visit.
	Specialist visit	20% coinsurance	40% 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. Unless medical necessity is established, chiropractic care is not covered for dependent children age 12 and under, except treatment of documented injuries for dependent children ages 6 to 12 is covered. Acupuncture is limited to $500/year.
	Preventive care/screening/ immunization	No charge for ACA preventive services	Not covered, except as noted	No charge for well child care from birth to age 18 by out-of-network provider. 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 20% 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	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	work)			
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization recommended
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	30-day supply: greater of $5 or 10% of cost/prescription (retail); 90-day supply: greater of $15 or 10% of cost/prescription (Smart-90 retail or mail order)	Not covered	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. Maintenance drugs are available at retail for up to a 90-day supply only at a Smart-90 Retail Network pharmacy (currently Walgreens).
	Brand drugs	30-day supply: greater of $5 or 20% of cost/prescription(retail) 90-day supply: greater of $15 or 20% of cost/prescription (Smart-90 retail or mail order)	Not covered	
	Specialty drugs	Greater of $5 or 20% of cost/prescription	Not covered	
	Non-select specialty drugs	30% of the amount listed on the SaveOnSP Specialty Drug List	Not covered	The SaveOnSP Specialty Drug list is available at www.saveonsp.com/carpenters. Copays do not count toward deductible or out-of-pocket limits.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization for certain outpatient surgeries/procedures recommended.
If you need immediate medical attention	Emergency room care	$150 copay/visit, then 20% coinsurance	$150 copay/visit, then 20% coinsurance	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification required for non-emergency inpatient surgery (or emergency surgery within 48 hours) or additional 5% coinsurance, up to $500 maximum penalty.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	No charge for Anthem LiveHealth Online visit.
	Inpatient services	20% coinsurance	40% 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	20% coinsurance	40% 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. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Preauthorization recommended.
	Rehabilitation services	20% coinsurance	40% coinsurance	Preauthorization recommended for physical therapy and occupational therapy after initial evaluation and 8 sessions. No charge for Sword Health virtual physical therapy program. 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	20% coinsurance	40% coinsurance	Preauthorization for certain equipment

* 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 Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
				recommended. CPAP, BiPAP, and AutoPAP supplies covered up to $400/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 $50 allowance	1 exam every calendar year (Classes P and S only)
	Children's glasses	$350 allowance, then 20% off any balance	Up to $350 allowance	$350 allowance applies once every 2 years (Classes P and S only)
	Children's dental check-up **– Delta Dental**	10% coinsurance	10% coinsurance	Limited to 2 check-ups per year, up to age 19, no maximum. Not subject to 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)

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 up to $500/year
- Chiropractic care 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 (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 (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 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 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: 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

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.

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	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$14,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$2,690
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,000**

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

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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	$250
Copayments	$740
Coinsurance	$330
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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	$250
Copayments	$150
Coinsurance	$510
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$910**

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.