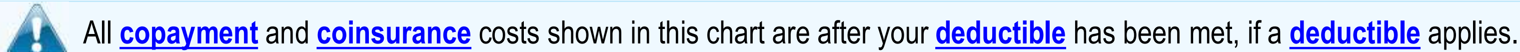
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to obtain a copy of the complete terms of coverage, please call KTF Compliance at 844-KTF-FUND. 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 www.ktftrustfund.com or call 1-844-KTF-FUND to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 for network providers $1,800 person/$4,800 family for out-of-network providers	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, all PPO services, Emergency, Urgent Care, and Preventive.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment 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/https://www.healthcare.gov/coverage/preventive-care-benefits/.
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?	For network providers $1,500 individual / $3,000 family; for out-of-network providers $2,700 individual / $5,200 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.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't 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. This plan uses MagnaCare as the primary PPO Network. See www.ktftrustfund.com for network providers.	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.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019) (DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)


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	$30 copay/visit	Deductible + 30% coinsurance	Visits in excess of 6 to one provider must be preauthorized. Failure to preauthorize will result in denied benefits.
	Specialist visit	$30 copay/visit	Deductible + 30% coinsurance	Visits in excess of 6 to one provider must be preauthorized. Failure to preauthorize will result in denied benefits.
	Preventive care/screening/ immunization	No charge	Deductible + 30% coinsurance	Excess visits not covered.
If you have a test	Diagnostic test (x-ray, blood work)	$30 copay/test <$2,500 or $100 copay/test >$2,500	Deductible + 30% coinsurance	Subject to preauthorization if costs exceed $2,500. Failure to preauthorize benefits will result in denied benefits.
	Imaging (CT/PET scans, MRIs)	$30 copay/test <$2,500 or $100 copay/test >$2,500	Deductible + 30% coinsurance	Subject to preauthorization if costs exceed $2,500. Copay applies to all tests combined on a daily basis for same provider. Failure to preauthorize benefits will result in denied benefits.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ktftrustfund.com	Generic drugs	$15 copay/prescription (retail day) $20 copay/prescription (mail order)	Not Covered	Covers up to a 31-day supply (retail); 31–93-day supply (mail order). Mandatory generic and mail order rules apply. Failure to use generic or mail order will result in penalties.
	Preferred Brand drugs	$25 copay/prescription (retail) $50 copay/prescription (mail order)	Not Covered	Covers up to a 31-day supply (retail); 31–93-day supply (mail order). Mandatory generic and mail order rules apply. Failure to use generic or mail order will result in penalties.
	Non-Preferred Brand drugs	$60 copay/prescription (retail) $120 copay/prescription (mail order)	Not Covered	Covers up to a 31-day supply (retail); 31–93-day supply (mail order). Mandatory generic and mail order rules apply. Failure to use generic or mail order will result in penalties.
	Specialty drugs	20% per 31-day supply up to Rx OOP	Not Covered	Subject to preauthorization and must be ordered through **the Specialty Pharmacy**.

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)	
				Failure to preauthorize benefits will result in denied benefits.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Deductible + 30% coinsurance	Surgical procedures expected to cost more than $2,500 must be preauthorized. Failure to preauthorize benefits will result in denied benefits. Assistant surgeon charges limited to 25% of primary surgeon.
	Physician/surgeon fees	$100 copay/surgery	Deductible + $250 copay following 30% coinsurance	Surgical procedures expected to cost more than $2,500 must be preauthorized. Failure to preauthorize benefits will result in denied benefits. Assistant surgeon charges limited to 25% of primary surgeon.
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Deductible waived. Non-emergencies paid at 50%.
	Emergency medical transportation	No charge (ambulance) $250 copay (air ambulance)	No charge up to *allowed amount* (ambulance) $250 copay + excess charges (air ambulance)	Deductible waived
	Urgent care	$30 copay/visit	Deductible + 30% coinsurance	While traveling, you may preauthorize urgent care in lieu of an Emergency Room to have the visit covered the same as a PPO benefit.
If you have a hospital stay	Facility fee (e.g., hospital room)	$50 copay/day up to $250 per confinement	$500 per confinement + 30% coinsurance	Subject to preauthorization. Failure to preauthorize benefits will result in denied benefits. Assistant surgeon charges limited to 25% of primary surgeon.
	Physician/surgeon fees	$100 copay/surgery	Deductible + $250 copay following 30% coinsurance	Subject to preauthorization. Failure to preauthorize benefits will result in denied benefits. Assistant surgeon charges limited to 25% of primary surgeon.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit	Deductible + 30% coinsurance	Visits in excess of 6 must be preauthorized. Failure to preauthorize benefits will result in denied benefits.
	Inpatient services	$50 copay/day up to $250 per confinement	$500 per confinement + 30% coinsurance	Subject to preauthorization. Failure to preauthorize benefits will result in denied benefits.
If you are pregnant	Office visits	No Charge	Deductible + 30% coinsurance	Covered under Well Woman Care as set out by HHS guidelines.
	Childbirth/delivery professional services	No Charge	$500 per confinement + 30% coinsurance	Hospital and surgical copays are waived for members enrolled in Healthy Beginnings Program. **Normal hospital and surgical copays apply for members not enrolled in the Healthy Beginnings program.**
	Childbirth/delivery facility services	No Charge	$500 per confinement + 30% coinsurance	Hospital and surgical copays are waived for members enrolled in Healthy Beginnings Program. **Normal hospital and surgical copays apply for members not enrolled in the Healthy Beginnings program.**
If you need help recovering or have other special health needs	Home health care	$30 copay/visit	Deductible + 30% coinsurance	Subject to preauthorization. Failure to preauthorize benefits will result in denied benefits. Limited to 200 visits per calendar year and 4 hours equals one visit.
	Rehabilitation services	$30 copay/visit	Deductible + 30% coinsurance	Maximum of 40 visits. Applies to cardiac rehab. Visits in excess of 6 must be preauthorized. Failure to preauthorize benefits will result in denied benefits.
	Habilitation services	$30 copay/visit	Deductible + 30% coinsurance	Applies to outpatient services. Visits in excess of 6 must be preauthorized. Failure to preauthorize benefits will result in denied benefits.
	Skilled nursing care	$50 copay/day up to $250 per confinement	$500 per confinement + 30% coinsurance	Limited to maximum of 100 days. Second hospital copay does not apply if transferred directly from the hospital to a Skilled Nursing Facility following an illness or injury.

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	30% coinsurance	Deductible waived, DME that costs over $500 must be preauthorized. Failure to preauthorize benefits will result in denied benefits.
	Hospice services	No Charge	Deductible + 30% coinsurance	Limited to 210 days per spell of illness/injury
If your child needs dental or eye care	Children's eye exam	$30 copay/visit	$30 copay/visit	Deductible waived, one exam/annually
	Children's glasses	50% coinsurance	50% coinsurance	Deductible waived, maximum benefit of $300.
	Children's dental check-up	Not Covered	Not Covered	Not Covered: Separate dental plan is provided

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
- Educational Services/Care
- Long Term Care
- Non-Emergency care while traveling outside of the U.S.
- Nursing Home or Custodial Care
- Private-duty nursing
- Routine foot care for non-diabetics
- Treatment for learning disabilities
- Half-way houses and residential camps

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

- Acupuncture
- Bariatric Surgery
- Chiropractic
- Hearing Aids
- Infertility Treatment
- Routine eye care
- Weight Loss Program

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. 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, contact 844-KTF-FUND.

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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 845-338-5422.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 845-338-5422.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 845-338-5422.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 845-338-5422.]

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** **$0**
- **Specialist *[cost sharing]*** **$30**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **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	$33
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$93**

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 *[cost sharing]*** **$30**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **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	$330
Coinsurance	$
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$385**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **$30**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **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	$240
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$240**

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