What this Plan Covers & What You Pay For Covered Services **Coverage for: Family** **Plan Type: Prescription, Dental and Vision**

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 the Fund office at (215) 561-2722. 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.dol.gov/ebsa/healthreform or call (215) 561-2722 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Prescription drugs, dental and vision.	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?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. Call (215) 561-2722 for a list of 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).
Do you need a referral to see a specialist?	No	You can see the specialist you chose you chose without a referral.

NOTE: THIS SUMMARY COVERS ONLY YOUR PRESCRIPTION, DENTAL AND VISION BENEFITS. YOU MIGHT RECEIVE A SEPARATE SUMMARY OF BENEFITS AND COVERAGE FROM YOUR EMPLOYER DESCRIBING YOUR MAJOR MEDICAL BENEFITS.

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	Not Covered	Not Covered	---none---
	Specialist visit	Not Covered	Not Covered	---none---
	Preventive care/screening/ immunization	Not Covered	Not Covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	Not Covered	Not Covered	---none---
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	---none---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available. Call (215) 561-2722.	Generic drugs	$6.75 copay/prescription for 30-day retail or 90-day mail order supply	Full price of prescription with reimbursement of average wholesale price less applicable copay.	Excluded: fertility drugs and all injectables (except for insulin).Some drugs may require prior authorization. If the necessary prior authorization is not obtained, the drug may not be covered.
	Brand drugs	$9.50 copay/prescription for 30-day retail or 90-day mail order supply	Full price of prescription with reimbursement of average wholesale price less applicable copay.	Excluded: fertility drugs and all injectables (except for insulin).Some drugs may require prior authorization. If the necessary prior authorization is not obtained, the drug may not be covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	---none---
	Physician/surgeon fees	Not Covered	Not Covered	---none---
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	---none---
	Emergency medical transportation	Not Covered	Not Covered	---none---
	Urgent care	Not Covered	Not Covered	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	---none---
	Physician/surgeon fees	Not Covered	Not Covered	---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	Not Covered	Not Covered	---none---
	Inpatient services	Not Covered	Not Covered	---none---
If you are pregnant	Office visits	Not Covered	Not Covered	---none---
	Childbirth/delivery professional services	Not Covered	Not Covered	---none---
	Childbirth/delivery facility services	Not Covered	Not Covered	---none---
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	---none---
	Rehabilitation services	Not Covered	Not Covered	---none---
	Habilitation services	Not Covered	Not Covered	---none---
	Skilled nursing care	Not Covered	Not Covered	---none---
	Durable medical equipment	Not Covered	Not Covered	---none---
	Hospice services	Not Covered	Not Covered	---none---
If you or your family needs dental or eye care	Eye exam	No charge	Reimbursed up to $25.	Coverage limited to one exam/calendar year.
	Glasses	Fitting fee for frames; Any frames whose wholesale cost is $24.00 or less; Regular size lenses (single or multifocal).	Lenses: reimbursed up to $24-$64 depending on type of lens. Frames: reimbursed up to $24.	Coverage limited to frames and lenses once every 2 calendar years. Contact lenses (cosmetic): $73 allowance. Alternative Program: lower costs with participating provider only.
	Dental check-up	• Preventative and endodontic services: no charge. • Supplemental services – 20% coinsurance. • Prosthetic, periodontic and orthodontic services: 50% coinsurance	Reimbursement based on total allowed charge for service. Provider may balance bill.	Orthodontia: $1,200 lifetime maximum benefit.

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.)

- Acupuncture
- Bariatric Surgery
- Chiropratric care
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Dental care
- Routine eye 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: U.S. Department of Labor, Employee Benefits Security Administration, 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or you may contact the Fund at (215) 561-2722. 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: U.S. Department of Labor, Employee Benefits Security Administration, 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or you may contact the Fund at (215) 561-2722.

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? **No**

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.

***Although coverage provided by the PFT Health and Welfare Fund does not meet the Minimum Value Standard, your employer-provided major medical coverage and the prescription drug coverage under this Fund, *taken together*, might meet the minimum value standard.**

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** **Not covered**
- **Hospital (facility)** **Not covered**
- **Prescription copayment** ***$6.75/$9.50***

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	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,700
The total Peg would pay is	**$12,730**

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** **Not covered**
- **Hospital (facility)** ***Not covered***
- **Prescription copayment** ***$6.75/$9.50***

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	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$3,100
The total Joe would pay is	**$3,400**

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

- **The plan's overall deductible** **$0**
- **Specialist** ***Not covered***
- **Hospital (facility)** **Not covered**
- **Prescription copayment** ***$6.75/$9.50***

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	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,900
The total Mia would pay is	**$1,900**

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