North Atlantic States Carpenters Health Benefits Fund

Health Reimbursement Account Plan
Open Enrollment Materials April 2024 - March 2025

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OPEN ENROLLMENT FOR April 2024 – March 2025

Please complete all required forms and return to the Health Fund in the enclosed envelope by March 21, 2024

Dear Participant,

Enclosed is your open enrollment package for the health coverage plan year from April 1, 2024 through March 31, 2025. Your enrollment forms must be submitted to the Health Fund by **March 21, 2024.**

As previously communicated, the Health Fund will be offering Plan I & Plan II, you must make a new election at this time. Delta Dental coverage is now included in your medical election.

If the Health Fund does not receive a new election form, you will be automatically enrolled in Plan II. You will not be able to change this mandatory election until the next open enrollment period that begins April 2025.

THE ENCLOSED FORMS ARE REQUIRED TO BE SUBMITTED ON A YEARLY BASIS

- ***HRA Enrollment Form – Registers you to receive reimbursements for eligible out of pocket expenses incurred by you and your dependents. Must be on file with the Fund Office before reimbursements from your HRA can be processed. Absence of a form on file may result in the suspension of your HRA debit card.***
- ***Opt Out Election Form -This form allows you to Opt Out of the coverage through the Health Fund.***
- ***Health Insurance Application - MUST be completed, signed by the participant and returned to the Fund Office. If no form is received, you will be automatically enrolled in Plan II.***
- ***Coordination of Benefits Form – Informs the Health Fund of other medical insurance available to you and/ or your dependents. Example: If you and/or your dependents are also on your spouse's employer sponsored plan.***

The deadline for your open enrollment submittals is **March 21, 2024**. Any delay in the submittal of your new medical election may result in delayed processing and mailing of updated insurance cards.

Important: In order to maintain medical coverage, you must…

- Be a **UNION DUES** paying participant **in good standing.**
- Work within the last **4 CONSECUTIVE** months. **4 MONTHS** with no **EMPLOYER CONTIBUTIONS** will result in having your insurance **SUSPENDED.** In addition, your **HRA Account** will be **SUSPENDED.**

The Health Fund requires copies of ALL birth certificates, marriage certificates and social security cards for ALL members, spouses and dependents BEFORE coverage can begin. If you're unsure that your required documents are on file, please call your local Fund Office for assistance.

IMPORTANT: If you experience a qualifying event such as a birth, marriage or divorce, during the year you must notify the Funds office immediately to request proper paperwork. You will need to complete a new application to update existing records within **30 days** of the qualifying event or you will have to wait until the next open enrollment to seek a change in coverage.

Health care plans and premiums are stated on the enclosed rate sheet and premiums will be drawn from your Health Reimbursement Account monthly. Please note that the **Medical, Dental, Vision and Prescription coverage ID cards are all separate**.

THE ENCLOSED ENROLLMENT PACKAGE CONSISTS OF THE FOLLOWING:

- **Rate Sheet.** This form has this enrollment periods monthly medical/dental insurance premiums for PLAN I and PLAN II

- **Health Insurance Application.** This form must be completed and signed by the participant. On this form you will make your **NEW** insurance selection for the enrollment period April 2024- March 2025. Be sure to review the cost share comparison and benefits summary included in this mailing in considering your election. **(Form must be submitted)**

- **Opt Out Election Form.** This form allows you to Opt Out of the coverage through the Health Fund. **(Form must be submitted annually)**

- **HRA Enrollment form**. Required for you and your eligible dependents to submit for the reimbursement of eligible out of pocket expenses from your HRA. **(Form must be submitted annually)**

- **Coordination of Benefits Form** – Informs the Health Fund of other medical insurance available to you and/ or your dependents. Example: If you and/or your dependents are also on your spouse's employer sponsored plan.

- **HIPAA form.** This allows the Fund to disclose claim information, membership information, benefit information, and medical records that contain Protected Health Information for the participant, spouse and dependent children under the age of 19, if applicable, to those designated by the participant. **(Yearly submittal is encouraged)**

- **Summary of Benefit & Coverage (SBC) and Benefit Summaries for Plan I and Plan II.** What the plans cover and what you pay for certain covered services.

- Benefit and provider information on additional benefits included in Health Fund coverage.

If you have any questions regarding the new health plan option or your enrollment, please reach out to your local Fund Office listed below.

Buffalo Fund Office
1159 Maryvale Dr, Ste 20
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Email: bfo@carpentersfund.org

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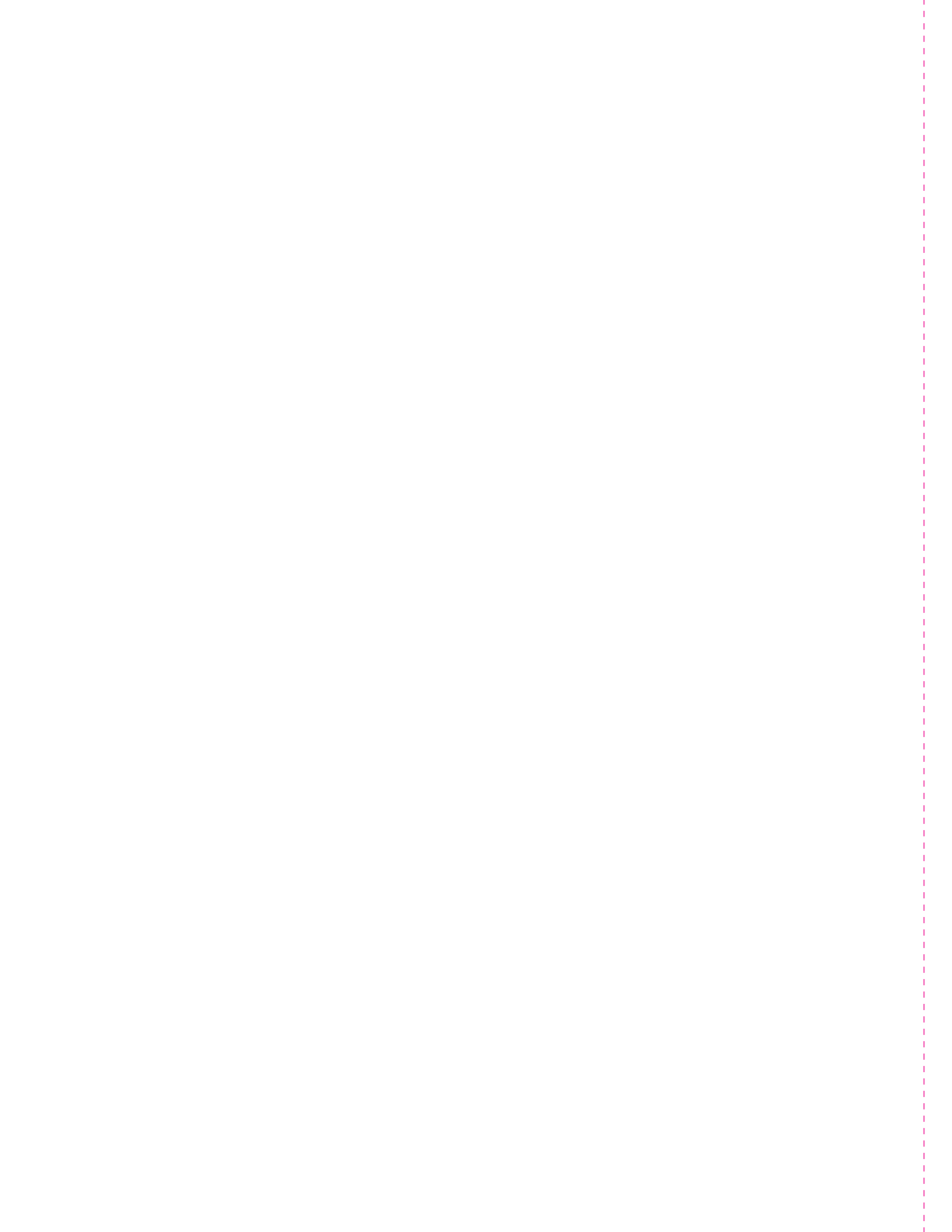
North Atlantic States Carpenters Health Benefits Fund

HRA Areas Health Care and Dental Coverage

April 1, 2024 through March 31, 2025

Health Coverage Options	Monthly Premium
Plan I	$1,071.00
Plan II	$1,030.00
Plan I - COBRA	$1,500.78
Plan II – COBRA	$1,439.79

Please review the enclosed benefit summaries for both PLAN I and PLAN II. The summaries show the copay, deductible and coinsurance percentage that each Plan will pay for various services. You should consider these out of pockets expenses when deciding which Plan you will be enrolling in for April 1, 2024.



North Atlantic States Carpenters Health Fund
Health Insurance Application

PLEASE PRINT CLEARLY IN BLUE / BLACK INK

OFFICE USE ONLY

Date Completed ______ Staff Rep Signature ______

1 Subscriber Plan Selection:
Please check applicable plan(s)

Independence Administrators (IA) plans

- ☐ Plan I
- ☐ Plan II

2 Reason for Enrollment/Change:
Subcriber, please indicate the reason for this enrollment change:

☐ **New Hire**	☐ **Marriage**	☐ **Add Dependent - Please indicate reason for adding dependent**
☐ **Open Enrollment**	☐ **Marital Status Change**	☐ **Newborn**
☐ **COBRA**	☐ **Re-Qualified**	☐ **Adoption**
☐ **Retirement**	☐ **Remove Dependent**	☐ **Medicare Eligible - Please indicate reason for Medicare Eligibility**
☐ **Loss of Coverage**	☐ **Update Address/ Ph #**	☐ **Disability**
☐ **Last Name Change**		☐ **Age 65+**

3 Subscriber Information
Please complete both sides of this application. The Subscribers signature is required in order to process this application

Subscriber's Last Name ______ Subscriber's First Name ______ Middle Initial ______

Mailing Address ______ Apt or Ste ______

City ______ State ______ Zip code ______ Gender: ☐ M ☐ F

Home Phone ______ Cell Phone ______

E-mail Address ______ Social Security Number ______

Date of Birth ______

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated

Divorced or Marital Date: ______

Medicare Number (If Applicable) ______ Part A Effective Date ______ Part B Effective Date ______

If Medicare eligible due to ESRD; Please check type of dialysis: ☐ Self Administered ☐ Faciliated

Date Started ______

4 Other Coverage Information
Please provide a copy of your "Certificate of Coverage" from your former Health Insurance Carrier or Employer

Have you, your spouse or any enrolled dependents had other insurance with in the last 63 days?

Health? ☐ Yes ☐ No Dental? ☐ Yes ☐ No

If answering YES, are you keeping the additional health and/or dental coverage?

Health? ☐ Yes ☐ No Dental? ☐ Yes ☐ No

Who did the other plan cover? ☐ Self ☐ Spouse ☐ Children

Other Insurance Carrier Name: ______

Other insurance name of policyholder: ______

Policy ID Number ______ Effective Date ______ Termination Date ______

5 Spouse / Dependent Information

Please provide all information for each person to be covered.

Spouse Last Name | Spouse First Name | Middle Initial

☐ M ☐ F

Gender: | Date of Birth | Social Security Number

Medicare Number (If Applicable) | Part A Effective Date | Part B Effective Date

Dependent Last Name | Dependent First Name | Middle Initial

☐ M ☐ F | Yes or No

Gender: | Date of Birth | Social Security Number | Disabled?

Dependent Last Name | Dependent First Name | Middle Initial

☐ M ☐ F | Yes or No

Gender: | Date of Birth | Social Security Number | Disabled?

Dependent Last Name | Dependent First Name | Middle Initial

☐ M ☐ F | Yes or No

Gender: | Date of Birth | Social Security Number | Disabled?

Dependent Last Name | Dependent First Name | Middle Initial

☐ M ☐ F | Yes or No

Gender: | Date of Birth | Social Security Number | Disabled?

Dependent Last Name | Dependent First Name | Middle Initial

☐ M ☐ F | Yes or No

Gender: | Date of Birth | Social Security Number | Disabled?

Dependent Last Name | Dependent First Name | Middle Initial

☐ M ☐ F | Yes or No

Gender: | Date of Birth | Social Security Number | Disabled?

6 Release / Signature

Subscriber Signature Required. You must sign and date this form to be eligible for insurance:

Any person who knowingly and with intent to defraud any insurance company or other person files and application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty.

I have thoroughly read, understand and agree to comply with the terms of the Health Plan.

Subscriber Signature | Date

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OPT OUT APPLICATION

MUST BE COMPLETED AND RETURNED FOR NO COVERAGE

As communicated in a Summary Material Modification (SMM) in January 2024 participants of the Health Replacement Account (HRA) will be offered the option to "Opt Out" of the health insurance, dental and prescription coverage provided by the North Atlantic States Carpenters Health Benefits Fund. You will continue to be considered an Opt Out so long as you verify that your other medical/prescription coverage is a group health plan that meets the minimum value standard of the Affordable Care Act ("ACA") for yourself and each of your otherwise eligible dependents. **You may return to the health, dental and prescription coverage offered by the Health Fund if you experience a qualifying event, such as your other coverage being terminated. Once you're re-enrolled you will be placed into the Hours Based Health Coverage, you will pay a monthly premium from your HRA until you qualify under the Hours Based Plan.**

Please be advised that any NYS sponsored or government funded plans, such as Medicaid, are NOT acceptable and cannot be used to opt out of coverage through the North Atlantic States Carpenters Health Benefits Fund.

I, ________________________________ am electing to opt out of the medical/prescription coverage with the North Atlantic States Carpenters Health Benefits Fund. Last 4 digits of SS#________________.

STATEMENT OF OTHER MEDICAL COVERAGE

__________________________________ is insured by, ____
(*Subscriber of medical coverage*) (*Insurance company name on card*)

and receiving medical/prescription coverage from, ______________________________________ *(example-self, parent or spouse)*

Medical (Single)______ (Family)______ ***Vision (Single)______ (Family)______***

Dental (Single)______ (Family)______ ***Prescription (Single)______ (Family)______***

Is this an employer group health plan? ____

Effective Date:_________________________ Term date:__________________________________

Does this coverage meet the minimum value standards of the Affordable Care Act?__________

Is coverage with a plan purchased through a State Health Plan Marketplace?________________

Is coverage with a Medicaid plan?________________

If your plan coverage was purchased through a State Health Plan Marketplace or provided by Medicaid you will automatically be enrolled in the lowest level of medical/prescription coverage offered by the North Atlantic States Carpenters Health Benefits Fund. These plans are not group health plans as defined by the Affordable Care Act and therefore cannot be used to opt out of coverage through the North Atlantic States Carpenters Health Benefits Fund.

___ (check) He/She is enrolled in a family medical coverage or health insurance plan, which includes coverage for:

___________________________________ ___________________________________
Dependent name *Dependent name*

___________________________________ ___________________________________
Dependent name *Dependent name*

I have read the statements above and I attest to the following:

- As of the date indicated below, I am enrolled in a group health plan that meets the minimum value standard of the Affordable Care Act.
- I understand that I must notify the Fund immediately if and when I am no longer enrolled in a group health plan that meets the minimum value standard of the ACA.
- I agree to indemnify the Fund and its Trustees from any losses caused by any misstatements made herein.
- I understand if I return to coverage provided by the North Atlantic States Carpenters Health Benefits Fund, I will become eligible through the hours based program. I will pay for my health coverage through my HRA until I qualify for health coverage under the hours based plan requirements in place at that time.

____ ____________________

Member Signature Only Date

20092002v1

NORTH ATLANTIC STATES CARPENTERS HEALTH BENEFITS FUND
HRA Enrollment Form

Before you can begin receiving reimbursements from your HRA account, this form must be completed and on file with the Funds' Office.

If you have any changes to your marital status, spouse's coverage or any other coverage, or if you have to add or remove a dependent, a new form must be completed within 30 days of the event. Otherwise, you will have to wait to enroll your dependents at the next Open Enrollment. You will **NOT** receive reimbursements for any dependents not listed on this form and only up to age 26 years. In addition, **ALL** social security #'s and other coverage information **MUST** be completed below. The Funds 'office **MUST** have copies of the following documents on file for the members and all dependents: **Birth Certificates, Marriage Certificates, Social Security Cards and Divorce Documents**.

SECTION 1 – MEMBER INFORMATION (Please Print) **Email** ______________________

Name______________________________ SS#______________________

Address______________________________

City______________________ State______________ Zip________________

Telephone________________ Cell______________ Date of Birth_____/_____/_____

(Circle one) Married Single Divorced Marriage/Divorce Date: _____/_____/_____

SECTION 2 – SPOUSE'S INFORMATION (please print)

Name______________________________ SS#______________________

Date of Birth _____/_____/_____

SECTION 3- OTHER COVERAGE (please print)

Do you, your spouse or your dependent(s) have other insurance benefits? ____Y OR N (Circle one)

If yes, coverage is through: Self: ____________ Spouse: __________ Dependent: ______________

Name of the insurance company______________________________

Effective Date: _____/_____/_____ Term date: _____/_____/_____

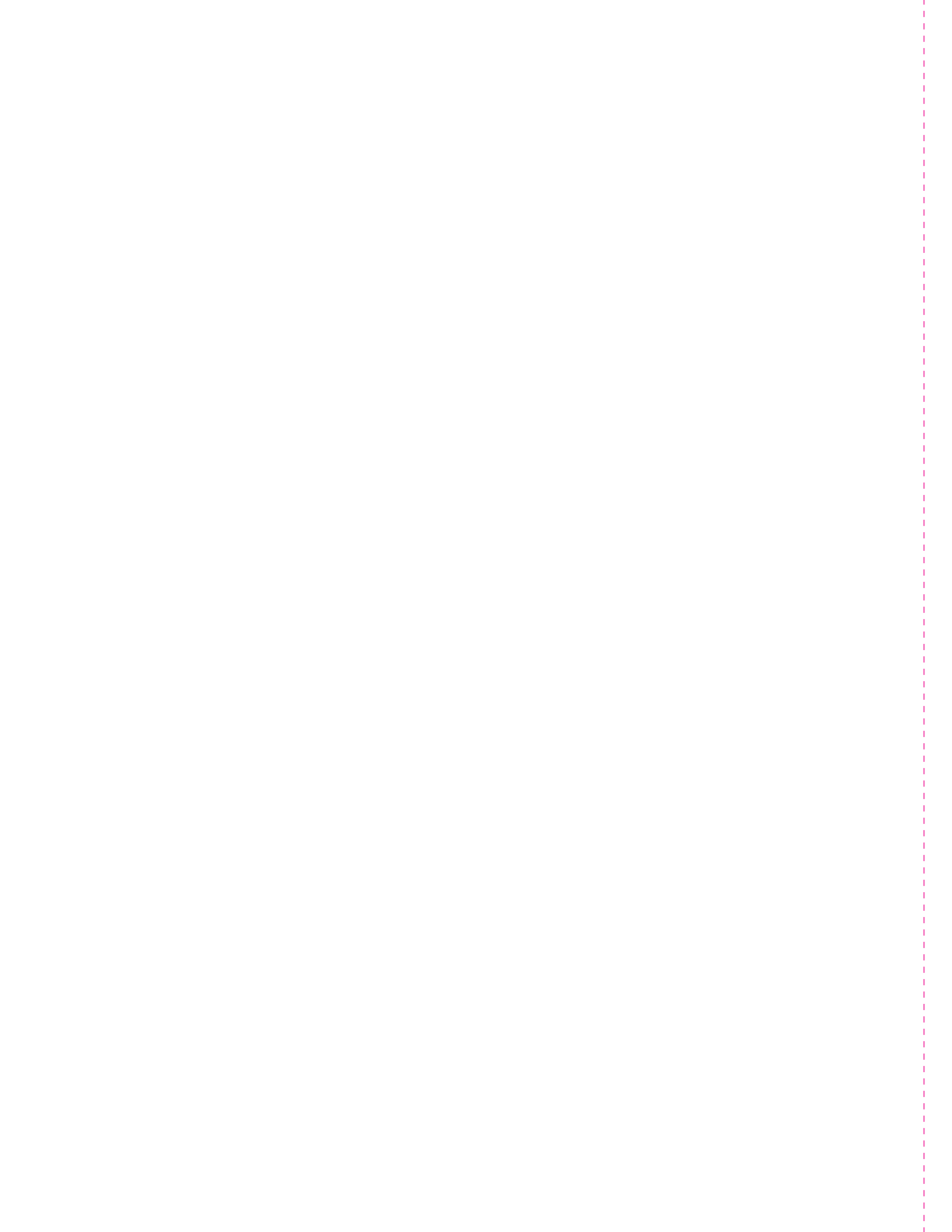
Medical - Single: _____ Two Person: _____ Family: ________ who does plan cover?:__________________
Dental - Single: _____ Two Person: _____ Family: ________ who does plan cover?:__________________
Optical - Single: _____ Two Person: _____ Family: ________ who does plan cover?:__________________

SECTION 4 – DEPENDENT CHILDREN INFORMATION (please print)

Name (include last name if different)	Date of Birth	Relationship to Member	Social Security Number

By signing below, I certify that the above information I have provided is true and correct.

Signature of Member ______________________________ **Date**_____/_____/_____



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COORDINATION OF BENEFITS PROVISION

Dear Participant,

Your health benefit plan includes a Coordination of Benefits clause that determines the primary source of payment when a member is covered by more than one health insurance policy. The terms of your health benefit plan require you to provide all of the information necessary to properly coordinate your benefits. Failure to provide this information may result in the denial of claims for you or your dependents.

The information you provide assists us in the prompt processing of claims. In addition, it may help us to:

* Reduce or lower your out-of-pocket expenses by utilizing all available insurances.
* Control legitimate medical costs to the Health Fund.
* Ensure contributions made to the Health Fund are utilized properly.

Failure to provide the Fund Office with the correct insurance information causing the Fund to pay benefits in error on you or your dependents behalf will result in an Overpayment. You will then be required to reimburse the Fund in full and the Fund shall be entitled to recover such benefits. Any refusal by you or your dependents to reimburse the Fund for an overpaid amount will be considered a breach of the agreement between the Fund and you and the Fund reserves the right to cancel or rescind Fund coverage for any Participant or Dependent. The Fund also may recover any overpaid or advanced benefits by pursing legal action against the party to whom the benefits were paid.

In order to avoid any of these repercussions, we are asking that you complete all sections of the questionnaire enclosed as they apply to you and your dependents under your policy, sign and return it in the enclosed envelope within 14 days.

Failure to provide this information may result in the denial of claims for you or your dependents.

All pages must be returned.

If you have any questions please feel free to call your Fund Office and Health Department Representatives will be happy to assist you.

Thank you for your anticipated cooperation.

North Atlantic States Carpenters Health Benefits Fund

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COORDINATION OF BENEFITS

Please complete this form with OTHER Insurance Information (if applicable) other than the North Atlantic States Carpenters Health Benefits Fund.

Member's Name: ____ Local#: __________

Address: ____

Social Security #:______________________ Martial Status: ☐Single ☐ Married ☐ Divorced ☐Widow

Spouse's Name: ___________________ Date of Birth_____________ Spouse's SS#: __________________

Is Spouse Employed? ☐ Yes ☐ No Date of Employment: _______________

Name of Spouse's Employer: ____

Address of Spouse's Employer: ____

If Employed, Is Health Coverage Offered? ☐ Yes ☐ No Health Coverage is Paid by: ☐Employer ☐ Employee

Is Spouse or Dependents Insured? ☐Yes ☐No If yes, Please Provide **Other Health Insurance Info** (Including Medicaid) other than the North Atlantic States Carpenters Health Benefits Fund:

Name of Health Insurance Carrier: ____

Address of Health Insurance Carrier: ____

Insurance Tel #: ______________________ Your Policy #: ___________________ Group #: _____________

Name of Policy Holder: ____

Effective Date of Policy (**Required**): _______________ Termination Date (if applicable): ________________

Type of Policy: ☐ Single ☐ Family (List dependents, including spouse/member)

____

____

____

EXTENT OF COVERAGE: (Circle category(s) covered by **other** Medical insurance):

HOSPITAL OFFICE VISITS SURGERY X-RAY HEARING AIDS MAJOR MEDICAL

CHIROPRATIC PHYSICAL / OCCUPATIONAL / SPEECH THERAPY MENTAL HEALTH

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Does this Health Coverage also cover **Out-of-Network Medical**? ☐ Yes ☐ No

Name of OON Medical Carrier: ______________________________

Insurance Tel #: ______________ Your Policy #: ______________ Group #: ______________

Name of Policy Holder: ______________________________

Effective Date of Policy (**Required**): ______________ Termination Date (if applicable): ______________

Type of Policy: ☐ Single ☐ Family (List dependents, including spouse)

____

____

____

Are you or any member of your family enrolled in any **OTHER Dental Insurance Program**? ☐ Yes ☐ No
If, Yes (including Medicaid) please complete section below:

Name of Dental Carrier: ______________________________

Insurance Tel #: ______________ Your Policy #: ______________ Group #: ______________

Name of Policy Holder: ______________________________

Effective Date of Policy (**Required**): ______________ Termination Date (if applicable): ______________

Type of Policy: ☐ Single ☐ Family (List dependents, including spouse)

____

____

____

Are you or any member of your family enrolled in any **OTHER Vision Program**? ☐ Yes ☐ No
If, Yes (including Medicaid) please complete section below:

Name of Vision Carrier: ______________________________

Insurance Tel #: ______________ Your Policy #: ______________ Group #: ______________

Name of Policy Holder: ______________________________

Effective Date of Policy (**Required**): ______________ Termination Date (if applicable): ______________

Type of Policy: ☐ Single ☐ Family (List dependents, including spouse)

____

____

____

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Are you or any member of your family enrolled in any **OTHER** **Prescription Program**? ☐ Yes ☐ No
If, Yes (including Medicaid) please complete section below:

Name of Prescription Carrier: ____

Insurance Tel #: ____________________ Your Policy #: ____________________ Group #: _______________

Name of Policy Holder: ____

Effective Date of Policy (**Required**): __________________ Termination Date (if applicable): __________________

Type of Policy: ☐ Single ☐ Family (List dependents, including spouse)

____

____

____

If this coverage is provided for dependent child(ren) whose natural parents are divorced, separated or were never married, it is necessary to attach a copy of the court decree which identifies which parent is responsible for providing health coverage. If the court decree does not specify who is responsible, then it will be necessary to provide a copy of the custody agreement for the dependent child(ren). If you have previously provided the court decree to us, you do not have to provide it again.

Are you, your spouse, or any other dependents eligible for **Medicare**? ☐ Yes ☐ No

If Yes, (**submit a copy of your Medicare Card**) reason for Medicare coverage – check all that apply:

☐ Over age 65 ☐ Disabled Please indicate Medicare ID #: ________________________

Are you or your spouse enrolled in any **other** Health Savings Account (**HSA**), Health Reimbursements Accounts

(**HRA**) or Federal Savings Account (**FSA**)? ☐ Yes ☐ No If Yes, Which one? ________________________

I certify that all the information provided above is true and correct and I agree to notify the Fund in writing immediately if any of this information changes. I understand that the purpose of this information is to assure appropriate Coordination of Benefits of all plans. I also agree to indemnify the Fund and its Trustees from any losses caused by any misstatements made herein.

Member Signature: ____ Date: __________________

Spouse Signature: ____ Date: __________________

Home Phone: ___________________ Cell Phone: ___________________ Work Phone: ________________

Email Address: ____

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PROTECTED HEALTH INFORMATION OR ANY INFORMATION RELATED TO THE FUNDS

AUTHORIZATION TO RELEASE INFORMATION

Dear Participant:

The Fund is hereby authorized to use or disclose claim information, membership information, benefit information, and medical records that contain Protected Health Information concerning myself, my spouse and dependent children under the age of 18, if applicable, (hereinafter collectively referred to as the "Undersigned") in connection with Fund eligibility for benefits, enrollment, treatment, payment of medical expenses and administration of the Fund. The Health Fund Employees are authorized to make such use and disclosure.

The disclosure may be made to any provider of medical services to the Undersigned, to the Board of Trustees of the Fund, to any third-party claim's administrator retained by the Fund in connection with the payment of any claim and/or appeal concerning the health benefits of the Undersigned and to my eligible dependents.

This authorization expires as to the respective Undersigned individual when such individual is no longer a Participant of the Funds or on date selected: ________________ ***only complete if you have a specific date***
(mm/dd/yyyy)

The Undersigned understands that this authorization may be revoked by written notice to the Fund Office.

The Undersigned understands that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient, and may no longer be protected by the federal or state privacy rules.

Over to continue

The Undersigned understands that the Fund will not condition enrollment in the Fund, eligibility for benefits or payment of benefits upon the providing of this authorization by the Undersigned.

The Undersigned have the right to inspect or copy the Protected Health Information used or disclosed pursuant to this Authorization upon submission of a written request to the Fund.

The Undersigned hereby authorize the release of Protected Health Information and any other specific information related to the funds and members accounts.

Participant's Signature ____________________________________ Date _________________________

Print Name _______________________________ Last Four Digits of SSN XXX-XX-________________

Print Authorized Representative's Name _____________________________Date_________________________

Authorized Representative Signature___________________________________ Pin Number________________
(CREATE 4 DIGIT PIN)
optional

The Authorized Representative is the person you want to give permission to talk to North Atlantic States Carpenters Health Benefits Fund on your behalf. For example: balances in HRA, contributions and insurance information

DEPENDENT CHILDREN UNDER THE AGE OF 18 (If Applicable)

Name	Date of Birth	Social Security Number

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 04/01/2024 - 12/31/2024

North Atlantic States Carpenters Health Benefits Fund: Plan 1

Coverage for: Individual + Family | **Plan Type:** PPO

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 1-833-242-3330 or visit us at www.carpentersfund.org. For 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/sbc-glossary/** or call 1-833-242-3330 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300** person / **$600** 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 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. In-Network preventive care and any other services listed in SBC that indicate "Deductible waived."	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/.
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 In-Network providers **$2,000** person / **$4,000** family, for Out-of-Network providers **$3,200** person / **$6,400** family. In-Network pharmacy out-of-pocket limit for prescription drugs: **$3,600** person / **$7,200** 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?	Premiums, balance-billed charges, health care this plan doesn't cover, and preauthorization penalties.	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. See **https://provider.bcbs.com or call: 1-833-242-3330** for a list of **In-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.

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
		In-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	$15 copay per visit Deductible waived	25% coinsurance	---None---
	Specialist visit	$30 copay per visit Deductible waived	25% coinsurance	---None---
	Preventive care/screening/ immunization	No Charge Deductible waived	25% coinsurance	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. Age and frequency limitations apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	25% coinsurance	---None---
	Imaging (CT/PET scans, MRIs)	20% coinsurance	25% coinsurance	---None---
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	Retail: $8 copay per prescription Mail order: $16 copay per prescription	Not Covered	Deductible does not apply. Retail limit: 34-day supply. Mail order limit: 90-day supply. You pay copay plus difference in cost for brand name drugs where a generic is available. No charge for ACA-required preventive generic drugs (or a brand name preventive drug if the generic drug is not medically appropriate). Maintenance medication after 3 fills must use retail pick up (at CVS only) or mail order.
	Preferred brand drugs	30% coinsurance Retail: $25 minimum / $50 maximum Mail order: $63 minimum / $125 maximum	Not Covered	
	Non-preferred drugs	30% coinsurance Retail: $40 minimum / $80 maximum Mail order: $100 minimum / $200 maximum	Not Covered	
	Specialty drugs	30% coinsurance $150 minimum / $300 maximum	Not Covered	Deductible does not apply. Information about specialty drugs is available at www.accredo.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	25% coinsurance	Precertification is required for some outpatient surgeries. Coverage will be denied if precertification is not obtained when required.
	Physician/surgeon fees	20% coinsurance	25% coinsurance	
If you need immediate medical attention	Emergency room care	$100 copay per visit Deductible waived	$100 copay per visit Deductible waived	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Deductible applies first.
	Urgent care	$15 copay per visit Deductible waived/Specialist urgent care $30 copay per visit	25% coinsurance	In-Network deductible and coinsurance apply to services in addition to urgent care visit (e.g. lab work, X-rays).
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	25% coinsurance	Precertification is required. Coverage will be denied if precertification is not obtained when required.
	Physician/surgeon fees	20% coinsurance	25% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay per visit Deductible waived; Other outpatient: 20% coinsurance	25% coinsurance	---None---
	Inpatient services	20% coinsurance	25% coinsurance	Precertification is required. Coverage will be denied if precertification is not obtained when required.
If you are pregnant	Office visits	No Charge for prenatal care or postnatal care; deductible waived.	25% coinsurance	Cost-sharing does not apply for preventive services or prenatal 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	20% coinsurance	25% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	25% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	25% coinsurance	---None---
	Rehabilitation services	$30 copay per visit for physical & occupational therapy; deductible waived. 20% coinsurance for speech therapy.	25% coinsurance	---None---
	Habilitation services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	20% coinsurance	25% coinsurance	Precertification is required. Coverage will be denied if precertification is not obtained when required.
	Durable medical equipment	20% coinsurance	25% coinsurance	Precertification is required for some outpatient surgeries. Coverage will be denied if precertification is not obtained when required
	Hospice services	20% coinsurance	25% coinsurance	Precertification is required. Coverage will be denied if precertification is not obtained when required.
If your child needs dental or eye care	Children's eye exam	No Charge Deductible waived	Reimbursement of the allowed amount up to $50	Limited to one exam per 12 months. Vision benefits are administered by EyeMed.
	Children's glasses	No Charge Deductible waived	Reimbursement up to the allowed amount	Limited to two pairs per 12 months. Vision benefits are administered by EyeMed.
	Children's dental check-up	No Charge Deductible waived	No Charge up to allowed amount	Limited to two exams per year. Dental benefits are administered by Delta Dental.

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
- Gym memberships
- Long Term Care
- Private-duty nursing
- Weight loss programs (Except as required by ACA)

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

- Acupuncture
- Bariatric surgery
- Chiropractic care (20 visits per calendar year)
- Dental care (Adult) (Administered by Delta Dental)
- Hearing Aids (Limit of $1,500 per ear per year for individuals up to age 19, $1,500 per ear per 3 years for individuals over age 19. Administered by TRUHearing)
- Infertility Treatment
- Non-emergency care when traveling outside the U.S. (See www.bcbsglobalcore.com)
- Routine eye care (Adult) (Administered by EyeMed)
- Routine foot care (only for patients with systemic circulatory disease)

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 at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: 1-833-242-3330 or www.carpentersfund.org. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-864-4352 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-864-4352 (TTY: 711).

注意：如果您使用简体中文，您可以免费获得语言协助服务。请致电1-844-864-4352。

LƯU Ý: Nếu quý vị nói tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-844-864-4352.

ВНИМАНИЕ: Если вы говорите по-русски, вам предлагаются бесплатные услуги переводчика. Позвоните по телефону 1-844-864-4352.

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 1-844-864-4352.

알림: 한국어 통역서비스가 필요한 분은 1-844-864-4352로 전화하십시오. 통역서비스를 무료로 받으실 수 있습니다.

ATTENZIONE: se parla italiano, sono disponibili per lei servizi di assistenza linguistica gratuiti. Contatti il numero 1-844-864-4352.

انتباه: إذا كنت تتحدث العربية فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. اتصل على الرقم: 1-844-864-4352.

ATTENTION: Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le 1-844-864-4352.

HINWEIS: Wenn Sie Deutsch sprechen, steht Ihnen über Language Assistance Services ein Dolmetscher kostenlos zur Verfügung. Wählen Sie 1-844-864-4352.

ધ્યાન આપો : જો તમે ગુજરાતી બોલી શકતા હો, તો તમારા માટે ભાષા સહાય સેવાઓ, વિના મૂલ્યે, ઉપલબ્ધ છે. 1-844-864-4352 પર કૉલ કરો.

UWAGA: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-864-4352.

ATANSYON: Si ou pale kreyòl ayisyen, gen asistans ak lang disponib pou ou gratis. Rele 1-844-864-4352.

ចំណាំ៖ ប្រសិនបើអ្នកនិយាយភាសា មន-ខ្មែរ ប្រទេសខ្មែរ សេវាជំនួយភាសាដែលឥតគិតថ្លៃមានសម្រាប់អ្នក។ សូមទូរស័ព្ទមកលេខ 1-844-864-4352។

ATENÇÃO: se você fala português, serviços de assistência a idioma estão disponíveis gratuitamente para você. Ligue para 1-844-864-4352.

BAA !KON&N&ZIN: Din4 bizaad bee y1n7[ti'go, ata' hane' bee 1k1 i'iilyeed t'11 j77k'e bee n1 ah00t'i'. Koj8' hod77lnih 1-844-864-4352.

PAUNAWA: Kung nagsasalita ka ng Tagalog, makakakuha ka ng mga serbisyo ng tulong para sa wika nang walang bayad. Tumawag sa 1-844-864-4352.

注意：日本語をお話しになる場合は、言語支援サービスを無料でご利用いただけます。1-844-864-4352にお電話ください。

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک در زمینه زبان، به رایگان در اختیار شما می باشد. با شماره 1-844-864-4352تماس بگیرید.

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** $300
- **Primary Care Physician copayment** $15
- **Specialist copayment** $30
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:
Primary care physician office visits *prenatal care*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$10
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,030**

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

- **The plan's overall deductible** $300
- **Specialist copayment** $30
- **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	$120
Copayments	$510
Coinsurance	$650
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,280**

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

- **The plan's overall deductible** $300
- **Specialist copayment** $30
- **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	$300
Copayments	$350
Coinsurance	$150
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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

Nondiscrimination Notice and Notice of Availability of Auxiliary Aids and Services

Independence Administrators complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independence Administrators does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
Independence Administrators:

- Provides free aids and services to people with disabilities to communicate effectively with us and written information in other formats, such as large print
- Provides free language services to people whose primary language is not English and information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Independence Administrators 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 grievance with our Civil Rights Coordinator.

There are four ways to file a grievance directly with Independence Administrators:

- by mail: Independence Administrators,
  ATTN: Civil Rights Coordinator, 1900 Market Street, Philadelphia, PA 19103;
- by phone: 844-864-4352 (TTY 711);
- by fax: 215-761-0920; or
- by email: IACivilRightsCoordinator@ibxtpa.com.

If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also 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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Benefits at a Glance

LEVEL CARE HEALTH

PLAN I BENEFIT SUMMARY

013292 PLAN I

PLAN I

Please read the important information at the end of this Benefits at a Glance.

This summary shows the Coinsurance percentage the Plan pays for various services. All payments are based on the Plan's allowance for the services performed.

Benefit	IN NETWORK	OUT OF NETWORK[1]
BENEFIT PERIOD	Calendar year*	Calendar year*
DEDUCTIBLE (EMBEDDED)[2 3]		
• Individual	$300	$300
• Family	$600	$600
OUT OF POCKET MAXIMUM (EMBEDDED)[4 5]		
• Individual	$2,000	$3,200
• Family	$4,000	$6,400
LIFETIME MAXIMUM	Unlimited	Unlimited
PREVENTIVE SERVICES		
• Preventive Services	100%	75% after deductible
• Adult Immunizations	100%	75% after deductible
• Pediatric Immunizations	100%	75% after deductible
OUTPATIENT MEDICAL SERVICES		
• Primary Office Visit/Consultation	$15 copay	75% after deductible
• Specialist Office Visit/Consultation	$30 copay	75% after deductible
• Podiatry	$30 copay	75% after deductible

Benefit	IN NETWORK	OUT OF NETWORK[1]
URGENT CARE		
• Urgent Care	$15 copay / specialist $30	75% after deductible
RETAIL CLINIC (MINUTE CLINIC)	$15 copay	75% after deductible
TELEMEDICINE		
• Telemedicine	$15 copay / specialist $30	Not Covered
THERAPY/COUNSELING SERVICES		
• Physical Therapy	$30 copay	75% after deductible
• Occupational Therapy	$30 copay	75% after deductible
• Speech Therapy	80% after deductible	75% after deductible
• Cardiac Rehabilitation	80% after deductible	75% after deductible
• Pulmonary Therapy	$30 copay	75% after deductible
• Orthoptic/Pleoptic Therapy (Vision Therapy)	$30 copay	75% after deductible
EMERGENCY MEDICAL FACILITY		
• Emergency Medical [6]	$100 copay / 100%	$100 copay / 100%
• Non Emergency	$100 copay / 100%	$100 copay / 100%
AMBULANCE SERVICES		
• Emergency Ambulance	80% after deductible	80% after deductible
• Non-Emergency Ambulance	80% after deductible	80% after deductible
INPATIENT MEDICAL SERVICES		
• Inpatient Hospital Services	80% after deductible	75% after deductible
• Inpatient Professional Services	80% after deductible	75% after deductible
OUTPATIENT SURGICAL PROCEDURES		
• Outpatient Surgical Procedures	80% after deductible	75% after deductible
• Short Procedure Facility	80% after deductible	75% after deductible
DIAGNOSTIC TESTING OUTPATIENT		
• Diagnostic Medical	80% after deductible	75% after deductible
• Simple Radiology	80% after deductible	75% after deductible
• Advanced Radiology	80% after deductible	75% after deductible
• Lab and Pathology	80% after deductible	75% after deductible
MATERNITY CARE		
• Initial Prenatal Care Visit	100%	75% after deductible
• Subsequent Prenatal Care Visit	100%	75% after deductible
CRANIAL PROSTHESIS - WIG/HAIRPIECE 1 Items per year[7]	100%	100%

Benefit	IN NETWORK	OUT OF NETWORK[1]
CHIROPRACTIC SERVICES 20 Visits per year[7]	$30 copay	75% after deductible
ALLERGY TESTS	80% after deductible	75% after deductible
ALLERGY INJECTIONS	80% after deductible	75% after deductible
NUTRITIONAL COUNSELING	$15 copay / specialist $30	75% after deductible
DIALYSIS/HEMODIALYSIS	80% after deductible	75% after deductible
PRIVATE DUTY NURSING	Not Covered	Not Covered
SKILLED NURSING FACILITY	80% after deductible	75% after deductible
HOME HEALTH CARE	80% after deductible	75% after deductible
INPATIENT HOSPICE CARE	80% after deductible	75% after deductible
HOME INFUSION THERAPY	80% after deductible	75% after deductible
DURABLE MEDICAL EQUIPMENT	80% after deductible	75% after deductible
ORTHOTICS/PROSTHETICS DEVICES	80% after deductible	75% after deductible
OUTPATIENT MENTAL NERVOUS		
• Psychotherapy Office Visit/Consultation	$15 copay	75% after deductible
• Psychotherapy Visit	80% after deductible	75% after deductible
DIABETIC SERVICES		
• Diabetic Education	80% after deductible	75% after deductible
• Diabetic Equipment	80% after deductible	75% after deductible
• Diabetic Supplies	80% after deductible	75% after deductible

This summary represents only a partial listing of benefits and exclusions of the Group Health Plan described in this summary. Benefits and exclusions may be further defined by medical policy. As a result, this Group Health Plan may not cover all of your health care expenses. Read your member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the Group Health Plan. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibxtpa.com.

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to www.ibxtpa.com or call the phone number that is listed on the back of your identification card.

*A calendar year benefit period begins on the first day of the calendar year and ends on the last day of the calendar year. The deductible and out-of-pocket maximum amount starts at $0 at the beginning of each calendar year.

[1]It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the actual charge of the provider.
[2]The in- and out-of-network deductibles cross-apply.
[3]Each member contributes towards his or her own deductible. The deductible is considered met when he or she reaches the individual deductible or the family deductible is met.

[4]Out of pocket includes medical only.
[5]Each member contributes towards his or her own out-of-pocket maximum. The out-of-pocket maximum is considered met when he or she reaches the individual out-of-pocket maximum or the family out-of-pocket maximum is met.

[6]Copay waived if admitted.
[7]Service limits combined across tiers.

Services that require precertification

Level Care North Atlantic precertification list effective January 1, 2023

This applies to elective, nonemergency services. Some services or supplies in this list may not be covered by your benefits plan. Please check your benefit plan documents.

Inpatient services

- Acute rehabilitation admissions
- Elective surgical and nonsurgical inpatient admissions
- Elective inpatient hospital-to-hospital transfers
- Inpatient hospice admissions
- Long term acute care (LTAC) facility admissions
- Skilled nursing facility admissions

Procedures

- Carticel (ACI), osteochondral allograft, and autograft transplantations
- Cochlear implant surgery
- Obesity surgery

Reconstructive procedures and potentially cosmetic procedures

- Blepharoplasty/blepharoptosis repair
- Bone graft, genioplasty, and mentoplasty
- Breast: reconstruction, reduction, augmentation, mammoplasty, mastopexy, insertion and removal of breast implants
- Canthopexy/canthoplasty
- Cervicoplasty
- Chemical peels
- Dermabrasion
- Excision of subcutaneous skin and/or subcutaneous tissue
- Gender reassignment surgery
- Genetically and bioengineered skin substitutes for wound care
- Hair transplants
- Injectable dermal fillers
- Keloid removal
- Lipectomy, liposuction, or any other excess fat removal procedure
- Otoplasty
- Rhinoplasty
- Rhytidectomy
- Scar revision
- Skin closures including:
  - Skin grafts
  - Skin flaps
  - Tissue grafts
- Surgery for varicose veins, including perforators and sclerotherapy

Day rehabilitation programs

Elective (nonemergency) ground, air, and sea ambulance transportation inpatient, including hospital-to-hospital transfers (excluding ground transportation, if the transfer to the receiving facility is related to services not offered at the transferring facility)

Outpatient private-duty nursing

Interventional pain management services

- Epidural injection procedures and diagnostic selective nerve root blocks
- Paravertebral facet injection/nerve block/neurolysis
- Regional sympathetic nerve block
- Sacroiliac joint injections
- Implanted spinal cord stimulators

Home-care services

- Enteral feeding therapy (tube feeding)
- Home health care
- Home infusion therapy
- Hospice

Prosthetics/orthoses

- Custom ankle-foot orthoses
- Custom knee-ankle-foot orthoses
- Custom knee braces
- Custom limb prosthetics including accessories/components
- Repair of replacement of all prosthetics/orthoses that require precertification

Independence
Independence Administrators

Durable medical equipment (DME)

- Bone growth stimulators
- Bone-anchored (osseointegrated) hearing aids
- Continuous positive airway pressure (CPAP) device and bi-level (Bi-PAP) devices
- Dynamic adjustable and static progressive stretching devices (excludes CPMs)
- Electric, power, and motorized wheelchairs, including custom accessories
- Manual wheelchairs with the exception of those that are rented
- Negative pressure wound therapy
- Neuromuscular stimulators
- Pressure-reducing support surfaces, including:
  - Air-fluidized bed
  - Non-powered advanced pressure-reducing mattress
  - Powered air flotation bed (low air loss therapy)
  - Powered pressure-reducing mattress
- Push rim activated power assist devices
- Repair or replacement of all DME items that require precertification
- Speech-generating devices

Medical foods

Hyperbaric oxygen therapy

Proton beam therapy

Sleep studies (facility-based)

Transplants

- All transplant procedures, with the exception of corneal transplants

Mental health/serious mental illness/ substance abuse[1]

- Mental health and serious mental illness treatment (inpatient/partial hospitalization programs/intensive outpatient programs)
- Repetitive transcranial magnetic stimulation (rTMS)
- Substance abuse treatment (inpatient/partial hospitalization programs/intensive outpatient programs)

Autism spectrum disorders

- Applied behavioral analysis

1 Precertification review for this service is provided by Magellan Healthcare, Inc., an independent company.

North Atlantic States Carpenters Health Benefits Fund: Plan 2

Coverage for: Individual + Family | **Plan Type:** PPO

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 1-833-242-3330 or visit us at www.carpentersfund.org. For 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/sbc-glossary/** or call 1-833-242-3330 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500** person / **$1,000** 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 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. In-Network preventive care and any other services listed in SBC that indicate "Deductible waived."	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/.
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 In-Network providers **$3,200** person / **$6,400** family, for Out-of-Network providers **$4,300** person / **$8,600** family. In-Network pharmacy out-of-pocket limit for prescriptions drugs: **$3,600** person / **$7,200** 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?	Premiums, balance-billed charges, deductible carryover, health care this plan doesn't cover, and preauthorization penalties.	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. See **https://provider.bcbs.com or call: 1-833-242-3330** for a list of **In-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.

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: In-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	$20 copay per visit Deductible waived	40% coinsurance	---None---
	Specialist visit	$40 copay per visit Deductible waived	40% coinsurance	---None---
	Preventive care/screening/ immunization	No Charge Deductible waived	40% coinsurance	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. Age and frequency limitations apply.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	40% coinsurance	---None---
	Imaging (CT/PET scans, MRIs)	30% coinsurance	40% coinsurance	---None---
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	Retail: $8 copay per prescription Mail order: $16 copay per prescription	Not Covered	Deductible does not apply. Retail limit: 34-day supply. Mail order limit: 90-day supply. You pay copay plus difference in cost for brand name drugs where a generic is available. No charge for ACA-required preventive generic drugs (or a brand name preventive drug if the generic drug is not medically appropriate). Maintenance medication after 3 fills must use retail pick up (at CVS only) or mail order.
	Preferred brand drugs	30% coinsurance Retail: $25 minimum / $50 maximum Mail order: $63 minimum / $125 maximum	Not Covered	
	Non-preferred drugs	30% coinsurance Retail: $40 minimum / $80 maximum Mail order: $100 minimum / $200 maximum	Not Covered	
	Specialty drugs	30% coinsurance $150 minimum / $300 maximum	Not Covered	Deductible does not apply. Information about specialty drugs is available at www.accredo.com
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	40% coinsurance	Precertification is required. Coverage will be denied if precertification is not obtained when required.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay In-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 immediate medical attention	Emergency room care	$100 copay per visit Deductible waived	$100 copay per visit Deductible waived	Copay waived if admitted or for observation stay.
	Emergency medical transportation	30% coinsurance	30% coinsurance	In-Network deductible applies first.
	Urgent care	$20 copay per visit Deductible waived /Specialist Urgent Care $40 copay per visit	40% coinsurance	In-Network deductible and coinsurance apply to services in addition to urgent care visit (e.g. lab work, X-rays).
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance	Precertification is required. Coverage will be denied if precertification is not obtained when required.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay per visit Deductible waived Other outpatient: 20% coinsurance	40% coinsurance	---None---
	Inpatient services	30% coinsurance	40% coinsurance	Precertification is required. Coverage will be denied if precertification is not obtained when required.
If you are pregnant	Office visits	No Charge for prenatal care or postnatal care; deductible waived.	40% coinsurance	Cost-sharing does not apply for preventive services or prenatal 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	30% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	Precertification is required. Coverage will be denied if precertification is not obtained when required
	Rehabilitation services	$40 copay per visit for physical & occupational therapy; deductible waived 30% coinsurance for speech therapy	40% coinsurance	Deductible applies first except for In-Network physical or occupational therapy visits.
	Habilitation services			
	Skilled nursing care	30% coinsurance	40% coinsurance	Precertification is required. Coverage will be denied if precertification is not obtained when required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	30% coinsurance	40% coinsurance	Precertification is required. Coverage will be denied if precertification is not obtained when required.
	Hospice services	30% coinsurance	40% coinsurance	Precertification is required. Coverage will be denied if precertification is not obtained when required.
If your child needs dental or eye care	Children's eye exam	No Charge Deductible waived	Reimbursement of the allowed amount up to $50	Limited to one exam per 12 months. Vision benefits are administered by EyeMed.
	Children's glasses	No Charge Deductible waived	Reimbursement up to the allowed amount	Limited to two pairs per 12 months. Vision benefits are administered by EyeMed.
	Children's dental check-up	No Charge Deductible waived	No charge up to allowed amount	Limited to two exams per year. Dental benefits are administered by Delta Dental.

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
- Gym memberships
- Long Term Care
- Private-duty nursing
- Weight loss programs (Except as required by ACA)

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

- Acupuncture
- Bariatric surgery
- Chiropractic care (20 visits per calendar year)
- Dental care (Adult) (Administered by Delta Dental)
- Hearing Aids (Limit of $1,500 per ear per year for individuals up to age 19, $1,500 per ear per 3 years for individuals over age 19. Administered by TRUHearing)
- Infertility Treatment
- Non-emergency care when traveling outside the U.S. (See www.bcbsglobalcore.com)
- Routine eye care (Adult) (Administered by EyeMed)
- Routine foot care (only for patients with systemic circulatory disease)

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 at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: 1-833-242-3330 or www.carpentersfund.org. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-864-4352 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-864-4352 (TTY: 711).

注意：如果您使用简体中文，您可以免费获得语言协助服务。请致电1-844-864-4352。

LƯU Ý: Nếu quý vị nói tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-844-864-4352.

ВНИМАНИЕ: Если вы говорите по-русски, вам предлагаются бесплатные услуги переводчика. Позвоните по телефону 1-844-864-4352.

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 1-844-864-4352.

알림: 한국어 통역서비스가 필요한 분은 1-844-864-4352로 전화하십시오. 통역서비스를 무료로 받으실 수 있습니다.

ATTENZIONE: se parla italiano, sono disponibili per lei servizi di assistenza linguistica gratuiti. Contatti il numero 1-844-864-4352.

انتباه: إذا كنت تتحدث العربية فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. اتصل على الرقم: 1-844-864-4352.

ATTENTION: Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le 1-844-864-4352.

HINWEIS: Wenn Sie Deutsch sprechen, steht Ihnen über Language Assistance Services ein Dolmetscher kostenlos zur Verfügung. Wählen Sie 1-844-864-4352.

ધ્યાન આપો : જો તમે ગુજરાતી બોલી શકતા હો, તો તમારા માટે ભાષા સહાય સેવાઓ, વિના મૂલ્યે, ઉપલબ્ધ છે. 1-844-864-4352 પર કૉલ કરો.

UWAGA: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-864-4352.

ATANSYON: Si ou pale kreyòl ayisyen, gen asistans ak lang disponib pou ou gratis. Rele 1-844-864-4352.

ចំណាំ៖ ប្រសិនបើអ្នកនិយាយភាសា មន-ខ្មែរ ប្រទេសខ្មែរ សេវាជំនួយភាសាដែលឥតគិតថ្លៃមានសម្រាប់អ្នក។ សូមទូរស័ព្ទមកលេខ 1-844-864-4352។

ATENÇÃO: se você fala português, serviços de assistência a idioma estão disponíveis gratuitamente para você. Ligue para 1-844-864-4352.

BAA !KON&N&ZIN: Din4 bizaad bee y1n7[ti'go, ata' hane' bee 1k1 i'iilyeed t'11 j77k'e bee n1 ah00t'i'. Koj8' hod77lnih 1-844-864-4352.

PAUNAWA: Kung nagsasalita ka ng Tagalog, makakakuha ka ng mga serbisyo ng tulong para sa wika nang walang bayad. Tumawag sa 1-844-864-4352.

注意：日本語をお話しになる場合は、言語支援サービスを無料でご利用いただけます。1-844-864-4352にお電話ください。

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک در زمینه زبان، به رایگان در اختیار شما می باشد. با شماره 1-844-864-4352تماس بگیرید.

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** **$500**
- **Primary Care Physician copayment** **$20**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

This EXAMPLE event includes services like:
Primary care physician office visits *prenatal care*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$3,230**

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	$120
Copayments	$570
Coinsurance	$650
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,340**

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	$500
Copayments	$430
Coinsurance	$170
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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

Nondiscrimination Notice and Notice of Availability of Auxiliary Aids and Services

Independence Administrators complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independence Administrators does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
Independence Administrators:

- Provides free aids and services to people with disabilities to communicate effectively with us and written information in other formats, such as large print
- Provides free language services to people whose primary language is not English and information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Independence Administrators 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 grievance with our Civil Rights Coordinator.

There are four ways to file a grievance directly with Independence Administrators:

- by mail: Independence Administrators,
  ATTN: Civil Rights Coordinator, 1900 Market Street, Philadelphia, PA 19103;
- by phone: 844-864-4352 (TTY 711);
- by fax: 215-761-0920; or
- by email: IACivilRightsCoordinator@ibxtpa.com.

If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also 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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Benefits at a Glance

LEVEL CARE HEALTH

PLAN II BENEFIT SUMMARY

013292 PLAN II

PLAN II

Please read the important information at the end of this Benefits at a Glance.

This summary shows the Coinsurance percentage the Plan pays for various services. All payments are based on the Plan's allowance for the services performed.

Benefit	IN NETWORK	OUT OF NETWORK[1]
BENEFIT PERIOD	Calendar year*	Calendar year*
DEDUCTIBLE (EMBEDDED)[2 3]		
• Individual	$500	$500
• Family	$1,000	$1,000
OUT OF POCKET MAXIMUM (EMBEDDED)[4 5]		
• Individual	$3,200	$4,300
• Family	$6,400	$8,600
LIFETIME MAXIMUM	Unlimited	Unlimited
PREVENTIVE SERVICES		
• Preventive Services	100%	60% after deductible
• Adult Immunizations	100%	60% after deductible
• Pediatric Immunizations	100%	60% after deductible
OUTPATIENT MEDICAL SERVICES		
• Primary Office Visit/Consultation	$20 copay	60% after deductible
• Specialist Office Visit/Consultation	$40 copay	60% after deductible
• Podiatry	$40 copay	60% after deductible

Benefit	IN NETWORK	OUT OF NETWORK[1]
URGENT CARE		
• Urgent Care	$20 copay / specialist $40	60% after deductible
RETAIL CLINIC (MINUTE CLINIC)	$20 copay	60% after deductible
TELEMEDICINE		
• Telemedicine	$20 / specialist $40	Not Covered
THERAPY/COUNSELING SERVICES		
• Physical Therapy	$40 copay	60% after deductible
• Occupational Therapy	$40 copay	60% after deductible
• Speech Therapy	70% after deductible	60% after deductible
• Cardiac Rehabilitation	70% after deductible	60% after deductible
• Pulmonary Therapy	$40 copay	60% after deductible
• Orthoptic/Pleoptic Therapy (Vision Therapy)	$40 copay	60% after deductible
EMERGENCY MEDICAL FACILITY		
• Emergency Medical[6]	$100 copay / 100%	$100 copay / 100%
• Non Emergency	$100 copay / 100%	$100 copay / 100%
AMBULANCE SERVICES		
• Emergency Ambulance	70% after deductible	70% after deductible
• Non-Emergency Ambulance	70% after deductible	70% after deductible
INPATIENT MEDICAL SERVICES		
• Inpatient Hospital Services	70% after deductible	60% after deductible
• Inpatient Professional Services	70% after deductible	60% after deductible
OUTPATIENT SURGICAL PROCEDURES		
• Outpatient Surgical Procedures	70% after deductible	60% after deductible
• Short Procedure Facility	70% after deductible	60% after deductible
DIAGNOSTIC TESTING OUTPATIENT		
• Diagnostic Medical	70% after deductible	60% after deductible
• Simple Radiology	70% after deductible	60% after deductible
• Advanced Radiology	70% after deductible	60% after deductible
• Lab and Pathology	70% after deductible	60% after deductible
MATERNITY CARE		
• Initial Prenatal Care Visit	100%	60% after deductible
• Subsequent Prenatal Care Visit	100%	60% after deductible
CRANIAL PROSTHESIS - WIG/HAIRPIECE 1 Items per year[7]	100%	100%

Benefit	IN NETWORK	OUT OF NETWORK[1]
CHIROPRACTIC SERVICES 20 Visits per year[7]	$40 copay	60% after deductible
ALLERGY TESTS	70% after deductible	60% after deductible
ALLERGY INJECTIONS	70% after deductible	60% after deductible
NUTRITIONAL COUNSELING	$20 copay / specialist $40	60% after deductible
DIALYSIS/HEMODIALYSIS	70% after deductible	60% after deductible
PRIVATE DUTY NURSING	Not Covered	Not Covered
SKILLED NURSING FACILITY	70% after deductible	60% after deductible
HOME HEALTH CARE	70% after deductible	60% after deductible
INPATIENT HOSPICE CARE	70% after deductible	60% after deductible
HOME INFUSION THERAPY	70% after deductible	60% after deductible
DURABLE MEDICAL EQUIPMENT	70% after deductible	60% after deductible
ORTHOTICS/PROSTHETICS DEVICES	70% after deductible	60% after deductible
OUTPATIENT MENTAL NERVOUS		
• Psychotherapy Office Visit/Consultation	$20 copay	60% after deductible
• Psychotherapy Visit	70% after deductible	60% after deductible
DIABETIC SERVICES		
• Diabetic Education	70% after deductible	60% after deductible
• Diabetic Equipment	70% after deductible	60% after deductible
• Diabetic Supplies	70% after deductible	60% after deductible

This summary represents only a partial listing of benefits and exclusions of the Group Health Plan described in this summary. Benefits and exclusions may be further defined by medical policy. As a result, this Group Health Plan may not cover all of your health care expenses. Read your member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the Group Health Plan. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibxtpa.com.

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to www.ibxtpa.com or call the phone number that is listed on the back of your identification card.

*A calendar year benefit period begins on the first day of the calendar year and ends on the last day of the calendar year. The deductible and out-of-pocket maximum amount starts at $0 at the beginning of each calendar year.

[1]It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the actual charge of the provider.

[2]The in- and out-of-network deductibles cross-apply.

[3]Each member contributes towards his or her own deductible. The deductible is considered met when he or she reaches the individual deductible or the family deductible is met.

[4]Out of pocket includes medical only.

[5]Each member contributes towards his or her own out-of-pocket maximum. The out-of-pocket maximum is considered met when he or she reaches the individual out-of-pocket maximum or the family out-of-pocket maximum is met.

[6]Copay waived if admitted.

[7]Service limits combined across tiers.

Services that require precertification

Level Care North Atlantic precertification list effective January 1, 2023

This applies to elective, nonemergency services. Some services or supplies in this list may not be covered by your benefits plan. Please check your benefit plan documents.

Inpatient services

- Acute rehabilitation admissions
- Elective surgical and nonsurgical inpatient admissions
- Elective inpatient hospital-to-hospital transfers
- Inpatient hospice admissions
- Long term acute care (LTAC) facility admissions
- Skilled nursing facility admissions

Procedures

- Carticel (ACI), osteochondral allograft, and autograft transplantations
- Cochlear implant surgery
- Obesity surgery

Reconstructive procedures and potentially cosmetic procedures

- Blepharoplasty/blepharoptosis repair
- Bone graft, genioplasty, and mentoplasty
- Breast: reconstruction, reduction, augmentation, mammoplasty, mastopexy, insertion and removal of breast implants
- Canthopexy/canthoplasty
- Cervicoplasty
- Chemical peels
- Dermabrasion
- Excision of subcutaneous skin and/or subcutaneous tissue
- Gender reassignment surgery
- Genetically and bioengineered skin substitutes for wound care
- Hair transplants
- Injectable dermal fillers
- Keloid removal
- Lipectomy, liposuction, or any other excess fat removal procedure
- Otoplasty
- Rhinoplasty
- Rhytidectomy
- Scar revision
- Skin closures including:
  - Skin grafts
  - Skin flaps
  - Tissue grafts
- Surgery for varicose veins, including perforators and sclerotherapy

Day rehabilitation programs

Elective (nonemergency) ground, air, and sea ambulance transportation inpatient, including hospital-to-hospital transfers (excluding ground transportation, if the transfer to the receiving facility is related to services not offered at the transferring facility)

Outpatient private-duty nursing

Interventional pain management services

- Epidural injection procedures and diagnostic selective nerve root blocks
- Paravertebral facet injection/nerve block/neurolysis
- Regional sympathetic nerve block
- Sacroiliac joint injections
- Implanted spinal cord stimulators

Home-care services

- Enteral feeding therapy (tube feeding)
- Home health care
- Home infusion therapy
- Hospice

Prosthetics/orthoses

- Custom ankle-foot orthoses
- Custom knee-ankle-foot orthoses
- Custom knee braces
- Custom limb prosthetics including accessories/components
- Repair of replacement of all prosthetics/orthoses that require precertification

Independence

Independence Administrators

Durable medical equipment (DME)

- Bone growth stimulators
- Bone-anchored (osseointegrated) hearing aids
- Continuous positive airway pressure (CPAP) device and bi-level (Bi-PAP) devices
- Dynamic adjustable and static progressive stretching devices (excludes CPMs)
- Electric, power, and motorized wheelchairs, including custom accessories
- Manual wheelchairs with the exception of those that are rented
- Negative pressure wound therapy
- Neuromuscular stimulators
- Pressure-reducing support surfaces, including:
  - Air-fluidized bed
  - Non-powered advanced pressure-reducing mattress
  - Powered air flotation bed (low air loss therapy)
  - Powered pressure-reducing mattress
- Push rim activated power assist devices
- Repair or replacement of all DME items that require precertification
- Speech-generating devices

Medical foods

Hyperbaric oxygen therapy

Proton beam therapy

Sleep studies (facility-based)

Transplants

- All transplant procedures, with the exception of corneal transplants

Mental health/serious mental illness/ substance abuse[1]

- Mental health and serious mental illness treatment (inpatient/partial hospitalization programs/intensive outpatient programs)
- Repetitive transcranial magnetic stimulation (rTMS)
- Substance abuse treatment (inpatient/partial hospitalization programs/intensive outpatient programs)

Autism spectrum disorders

- Applied behavioral analysis

1 Precertification review for this service is provided by Magellan Healthcare, Inc., an independent company.

PLAN I & II PRESCRIPTION BENEFIT SUMMARY

www.express-scripts.com

CURRENT PLAN		
Type	Retail	Home Delivery
GENERIC	$5 copay 30 day supply	$10 copay 90 day supply
FORMULARY	20% coinsurance	20% coinsurance
NON-FORMULARY	20% coinsurance	20% coinsurance

NEW PLAN		
Type	Retail	Home Delivery
GENERIC	$8 copay 30 day supply	$16 copay 90 day supply
FORMULARY	30% coinsurance $25 Min $50 Max	30% coinsurance $63 Min $125 Max
NON-FORMULARY	30% coinsurance $40 Min $80 Max	30% coinsurance $100 Min $200 Max

CURRENT PLAN		
Specialty		
Type	Retail	Home Delivery
SPECIALTY	20% coinsurance	20% coinsurance

NEW PLAN		
Specialty		
Type	Retail	Home Delivery
SPECIALTY	30% coinsurance $150 Min $300 Max	30% coinsurance $150 Min $300 Max

CURRENT PLAN		
Cost Sharing		
Type	Individual	Family
OUT OF POCKET MAXIMUM	$5,000	$10,000
DEDUCTIBLE	NONE	NONE

NEW PLAN		
Cost Sharing		
Type	Individual	Family
OUT OF POCKET MAXIMUM	$3,600	$7,200
DEDUCTIBLE	NONE	NONE

Prescription Coinsurance Minimums and Maximums
Prescription Coinsurance is the percentage a Participant pays for a covered prescription. Under this plan the coinsurance will be at least the minimum stated above, but will not exceed the maximum stated above.

Coinsurance Minimum Example – a formulary brand drug costs $40, the 30% coinsurance is $12, because the Plan has a minimum coinsurance the Participant pays $25, the Plan pays the $15balance of the cost of the formulary brand drug.

Coinsurance Maximum Example – a formulary brand drug costs $1200, the 30% coinsurance is $360, because the plan has a maximum coinsurance the Participant will pay $50in coinsurance, the Health Fund will pay the $1,150 balance for the formulary brand drug.

DELTA DENTAL®

Delta Dental PPO Plus Premier™ for North Atlantic States Carpenters

You've brought your smile to the right place!

North Atlantic States Carpenters has partnered with Delta Dental for your family's oral health needs

DELTA DENTAL

Delta Dental PPO℠ *Plus Premier*

Visit **deltadentalma.com** for detailed benefit information

2023 Coverage Summary for North Atlantic States Carpenters Health Benefit Fund Group #007525

Deductible: None

Calendar Year Maximum: $2,500 per person.

Category / Procedure	Qualifications	Co-insurance In Network	Co-insurance Out of Network*
Diagnostic		100%	100%
Comprehensive Evaluation	Once every 60 months.		
Periodic Oral Evaluation	Twice per calendar year.		
Panoramic or Full Mouth X-rays	Once every 60 months.		
Bitewing X-rays	Twice per calendar year.		
Single Tooth X-rays	As needed.		
Preventive		100%	100%
Teeth Cleaning	Twice per calendar year.		
Fluoride Treatments	Twice per calendar year for members under age 19.		
Space Maintainers	Required due to the premature loss of teeth. For members under age 14 and not for the replacement of primary or permanent anterior teeth.		
Sealants	Unrestored permanent molars, every 4 years per tooth for members through age 15. Sealants also covered for members age 16 up to age 19 with a recent cavity and are at risk for decay.		
Restorative		80%	80%
Silver Fillings	Once every 24 months per surface per tooth.		
White Fillings (Front Teeth)	Once every 24 months per surface per tooth.		
Inlays and White Fillings (Back Teeth)	Covered only for single surfaces. Once every 24 months per surface, per tooth, multi-surfaces will be processed as a silver filling and the patient is responsible for the difference between the silver filling and the Delta Dental negotiated fee for white fillings.		
Protective Restorations	Once per tooth.		
Stainless Steel Crowns	Once every 24 months per tooth (on primary teeth only).		
Oral Surgery		80%	80%
Extractions	Once per tooth.		
General Anesthesia	General Anesthesia and IV sedation allowed with covered surgical impacted teeth only (up to one hour).		
Periodontics (on natural teeth only)		80%	80%
Periodontal Surgery	One surgical procedure per quadrant in 36 months. Only two quadrants allowed per date of service.		
Scaling and Root Planing	Once in 24 months, per quadrant. No more than 2 quadrants per date of service.		
Periodontal Cleaning	Four per calendar year following active periodontal treatment (scaling and root planing or osseous surgery). Not to be combined with preventive cleanings.	100%	100%
Bone Grafts/GTR	No more than 2 teeth per quadrant per 36 months on natural teeth.		
Endodontics		80%	80%
Root Canal Treatment	Once per tooth.		
Root Canal Retreatment	Once per tooth after 24 months have elapsed from initial treatment		
Vital Pulpotomy	Limited to deciduous teeth.		
Prosthetic Maintenance		80%	80%
Bridge or Denture Repair	Once per bridge/denture per 12 months, after 24 months of initial insertion.		
Crown or Onlay Repair	Once per tooth per 12 months after 24 months of initial placement		
Rebase or Reline of Dentures	Once per denture within 36 months.		
Recement of Crowns & Onlays, Bridges	Once per crown, onlay or bridge.		
Emergency Dental Care		80%	80%
Palliative Treatment	Three occurrences in 12 months.		
Prosthodontics		50%	50%
Dentures	Once within 60 months (age 16 and older).		
Fixed Bridges	Once within 60 months (age 16 and older).		
Implants	Once per 60 months per implant. (Pre-estimate recommended).		
Bone Grafts	Once per 60 months, covered when placement is at an extraction or implant site.		
Implant Abutments	Once per implant only when surgical implant is benefitted,		
Major Restorative		50%	50%
Crowns or Onlay	When teeth cannot be restored with regular fillings due to fracture or decay. Once within 60 months per tooth (age 12 and older).		
Cast Posts/Buildups	Once per tooth per 60 months only benefitted to retain a crown.		

Orthodontics: Covered at 100% of Maximum Plan Allowance charges to any age. $2,000 separate LIFETIME maximum. Orthodontic treatment must be administered/supervised by a licensed dentist. Mail order orthodontic kits are not covered under this plan.

Dependent Eligibility Eligible dependents covered up to the end of the month in which they turn age 26.

*Non-participating dentists may balance bill. Subscribers are responsible for the difference between the non-participating maximum plan allowance and the full fee charged by the dentist.

DELTA DENTAL®

Delta Dental PPO Plus Premier

You have the flexibility to select providers in the Delta Dental PPO network or the Delta Dental Premier network.

Delta Dental PPO™
This is a smaller network of dentists who offer dental care at a deeply discounted rate, allowing you to maximize the value of your plan.

Delta Dental Premier®
This provides a larger network of dentists who offer care at discounted rates, but you will have a higher out-of-pocket cost for services not covered in full.

You can also see a dentist outside of our contracted network – however, you will likely pay more.

Confirm your dentists network

You can confirm if your current dentist is in the PPO or Premier network by visiting www.deltadentalma.com and clicking on “Find a Dentist” (make sure to select your plan name, Delta Dental PPO Plus Premier) or by calling 800-872-0500.

Member discounts

As a member of Delta Dental, you can take advantage of discounts on Sonic toothbrushes and replacement Heads.

Discounts are available for hearing tests, diagnostics and hearing aids through Amplifon.

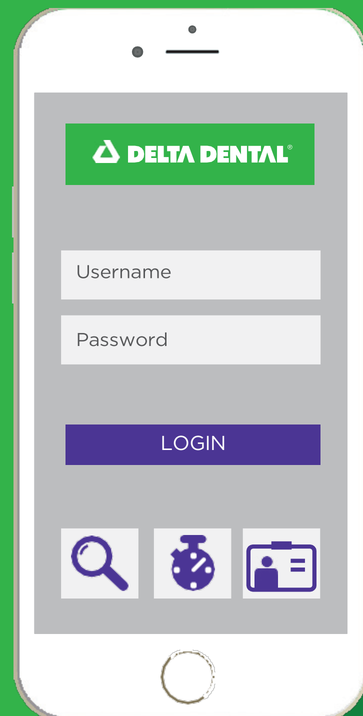
Details and discounts are available at deltadentalma.com.

Use our app to access your dental plan anytime, anywhere.

Download our Delta Dental mobile app and get instant access to:

- Mobile ID card
- Dentist search
- Cost estimator
- Claims and coverage information

Stay on track with your oral health routine by using our built-in toothbrush timer.



Pre-treatment estimate

Ask your dentist to submit a pre-treatment estimate to Delta Dental for any procedure that exceeds $300. This will help you estimate any out-of-pocket expenses you may incur and will confirm that the services are covered under your dental coverage.

Orthodontic benefits

If you or your dependent's orthodontic treatment began before you were covered under this dental plan, a monthly fee will be paid for the remaining orthodontic visits until either the treatment is completed or the lifetime benefit maximum is exhausted, whichever comes first.

Multi-stage procedures

Some procedures, such as crowns dentures, and root canals, require more than one visit to the dentist. To get coverage for a multi-stage procedure, you must be enrolled in this Delta Dental plan on the date that the procedure is completed.

DELTA DENTAL®

Talk to a dentist online with virtual visits

Delivered by TeleDentistry.com

Delta Dental of Massachusetts members can now schedule a virtual visit with a dentist 24/7 using their smartphone, tablet or computer

Virtual visits are available to Delta Dental of Massachusetts members for urgent dental problems through their existing Delta Dental coverage. A virtual visit is an effective way to receive care and avoid the emergency room.

You can schedule a virtual visit when you:

- Are having a dental emergency or an urgent dental concern.
- Need access to a dentist after hours and your dentist isn't available.
- Need to consult with a dentist while traveling.

TeleDentistry.com dentists diagnose the problem and provide treatment options. You will be referred to a Delta Dental dentist for follow-up care.

The TeleDentistry.com dentist will email you consultation notes and direct you to follow up with your provider. If you have not established care with a Delta Dental network dentist, TeleDentistry.com will provide you with a list of local Delta Dental network dentists for follow-up care.

This service supplements Delta Dental's current plan coverage and should be used after business hours, holidays and weekends, or when your regular dentist is unavailable.

TeleDentistry.com services are only available to current Delta Dental of Massachusetts members. A TeleDentistry.com consultation counts as a problem-focused exam under your dental plan.

IT'S EASY TO SCHEDULE A VIRTUAL VISIT

Delta Dental has partnered with TeleDentistry.com to provide virtual visits.

Here's how it works:

Step 1 – Go online to teledentistry.com/ddma.

Step 2 – Complete a brief registration and health questionnaire.

Step 3 – You'll be connected with a TeleDentistry.com dentist to begin your visit.

TeleDentistry.com is backed by the power of Preventistry™, Delta Dental of Massachusetts' groundbreaking and unique approach to transforming the oral health care system. Preventistry combines clinical innovation, actionable data and digital engagement to provide a higher level of care and improve the health of our members.

Contact us with any questions.

Email us at customer.care@deltadentalma.com

Customer Service Call 800-872-0500
Monday – Friday 8:00 a.m. – 8:00 p.m.

A 24-hour automated voice response is also available after hours and on weekends.

deltadentalma.com

Need translation services? We offer a foreign language translation service through AT&T Language Line to assist with non-English speaking members in 140 languages.

eye Med

North Atlantic States Carpenters Routine

40% OFF

additional complete pair of prescription eyeglasses

20% OFF

non-covered items, including non-prescription sunglasses

Find an eye doctor

(Select Network)

- 866.299.1358
- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads Up

You may have additional benefits. Log into **eyemed.com/member** to see all plans included with your benefits.

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$0 copay	Up to $57
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up - Standard	$0 copay	Up to $25
Fit and Follow-up - Premium	$0 copay; 10% off retail price less $40 allowance	Up to $25
FRAME		
Frame	$0 copay; 20% off balance over $100 allowance	Up to $100
LENSES		
Single Vision	$0 copay	Up to $47
Bifocal	$0 copay	Up to $79
Trifocal	$0 copay	Up to $100
Lenticular	$0 copay	Up to $100
Progressive - Standard	$0 copay	Up to $73
Progressive - Premium	$50 - 135 copay	Up to $77
LENS OPTIONS		
Anti Reflective Coating - Standard	$35 copay	Up to $23
Anti Reflective Coating - Premium Tier 1 - 3	$48 - 60 copay	Up to $23
Polycarbonate - Standard	$0 copay	Up to $22
Scratch Coating - Standard Plastic	$0 copay	Up to $10
Tint - Solid and Gradient	$0 copay	Up to $10
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $100 allowance	Up to $100
Contacts - Disposable	$0 copay; 100% of balance over $100 allowance	Up to $100
Contacts - Medically Necessary	$0 copay	Up to $300
OTHER		
Hearing Care from Amplifon Network	Up to 64% off hearing aids; call 1.877.203.0675	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered
FREQUENCY	**ALLOWED FREQUENCY - ADULTS**	**ALLOWED FREQUENCY - KIDS**
Exam	Once every 2 plan years	Once every plan year
Lenses	Once every 2 plan years	Once every plan year
Frame	Once every 2 plan years	Once every plan year
Contact Lenses	Once every 2 plan years	Once every plan year

(Plan allows the member to receive either contacts or frame and lens services.)

(Note: This plan can be used for a routine pair of glasses OR contacts OR a pair of safety glasses. Safety glasses should be for the subscriber only. A member with a multi-focal prescription may opt for two complete pairs of single vision glasses. For the second pair of single vision lenses, use group ID 1035131 for Legacy New England members or group ID 1035132 for Legacy New England Pensioners; OR use group ID 1035135 for Legacy Empire members or group ID 1035136 for Legacy Empire Pensioners.)

Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Member receives a 20% discount on items not covered by the plan at In-Network locations. Discount does not apply to Provider's professional services or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see the online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products. The Plan reserves the right to make changes to the products on each tier and to the member out-of-pocket costs. Fixed tier pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Services and amounts listed above are subject to change at any time. Discounts are not insured benefits.

HOW TO: mobilize your vision plan

EYEMED MEMBERS APP

Our member app was the first of its kind. But innovation – like your life – never stops. The EyeMed Members App is packed with ahead-of-the-game resources wherever you are. Before, during and after your eye appointment.

Get the latest EyeMed Members App:

1. **DOWNLOAD** – Search "EyeMed Members" in your App store, iTunes or Google Play.
2. **OPEN** – You can use some features right away; others unlock once you register.
3. **REGISTER** – You'll need your member ID or the last four digits of your social security number.
4. **LOG IN** – If you've already registered on eyemed.com, you can log onto the app the same way.

	Ready when you download	Unlocked when you register
Find nearby network providers	●	
On-the-fly appointment scheduling	●	
Turn by turn directions and map	●	
Eye exam and contact lens reminders		●
Electronic ID card for office visits		●
Save vision prescriptions*		●
Benefit plan details		●
Answers to common questions	●	
Special offers and discounts		●
Direct line to EyeMed support	●	

SEE THE GOOD STUFF

Register on eyemed.com or grab the member app (App Store or Google Play) now.

** Take a picture of your prescription and store it in your app. No need to type in the numbers.*

NORTH ATLANTIC STATES CARPENTERS
— HEALTH BENEFITS FUND —

TruHearing®

1-877-760-7681 | TTY: 711
www.truhearing.com/carpenters

Get Back the Joy of Hearing

Better hearing helps you stay connected to the ones you love. That's why the North Atlantic States Carpenters Health Benefits Fund partners with TruHearing to provide you a comprehensive hearing care solution.

The TruHearing program includes:

Personalized Care

Guidance and assistance from a TruHearing Hearing Consultant

Professional exam from one of 7,000 nationwide licensed providers

One year of follow-up visits for fitting and adjustments to ensure you're completely satisfied with your hearing aids

Next-Generation Sound

The latest chips and algorithms combine to make speech clearer, even in the most challenging environments

Advanced sensors automatically adjust to the noise around you for better clarity and natural sound

New models include sound enhancement technology that makes your own voice less noticeable and more natural sounding

Devices for Your Lifestyle

The latest models come with Bluetooth® so you can stream audio like Siri®, music, and phone calls right to your ears

A wide variety of rechargeable models that keep a charge for an entire day[1]

Options to match your lifestyle including virtually indetectable devices

Think you might have hearing loss?

Try our free, fast online screening

Visit:
Truhearing.com/carpenters-hs

Accessible from your tablet, computer, or smartphone

Call TruHearing to learn more and schedule an appointment. Mention you are a member of the North Atlantic States Carpenters Health Benefits Fund

Hours:
8am–8pm, Monday–Friday

1-877-760-7681
TTY: 711

Benefit Details

The North Atlantic States Carpenters Health Benefits Fund provides a free Hearing exam and $1500 per ear allowance (max $3000) every three years.

(Price per aid)

Hearing Aid Tier	Average Retail Price	Fund Price	Fund Allowance	You Pay
Value	~~$1,600~~	$499	$499	**$0**
Basic	~~$1,950~~	$699	$699	**$0**
Standard	~~$2,200~~	$999	$999	**$0**
Advanced	~~$2,750~~	$1,399	$1,399	**$0**
Premium	~~$3,100~~	$1,799	$1,500	**$299**

How to take advantage of your hearing benefit

1. Call TruHearing
2. Schedule a hearing exam
3. Order your hearing aid
4. Return for fitting and programming

Call TruHearing to learn more and schedule an appointment

1-877-760-7681 | TTY: 711

Hours: 8am–8pm, Monday–Friday

This program also includes:

+ Risk-free 60-day trial period
+ one year of follow-up visits
+ 80 free batteries per non-rechargeable hearing aid
+ Full 3-year manufacturer warranty
+ One-time loss and damage replacement (deductible applies)

[1] Rechargeable features may not be available in all models and styles.

All content ©2022 TruHearing, Inc. All Rights Reserved. TruHearing is a registered trademark of TruHearing, Inc. All other trademarks, product names, and company names are the property of their respective owners. Three follow-up visits must be used within one year after the date of initial purchase. Free battery offer is not applicable to the purchase of rechargeable hearing aid models. Three-year warranty includes repairs and one-time loss and damage replacement. Hearing aid repairs and replacements are subject to provider and manufacturer fees. For questions regarding fees, contact a TruHearing hearing consultant. <220212_NAC_C_F_5T_0222>

Available 24/7
800-648-9557
info@kgreer.com

Website: my.kgalifeservices.com
Company code: carpenters

EMPLOYEE ASSISTANCE AND WORK-LIFE PROGRAM

A free, confidential program for employees and adult household members. Here's how we can help:

EMOTIONAL HEALTH

Counseling, Consultations & Referrals

- Alcohol & Drug Concerns
- Anxiety
- Chronic Illness
- Depression
- Eating Disorders
- Family & Relationship Concerns
- Gambling
- Meditation
- Mindfulness
- Partner Violence
- Smoking Cessation
- Sleep Issues
- Stress Management

Up to eight (8) counseling sessions

PARENTING

Childcare Consultation & Referrals

- Back-up Care
- Before/After School
- Childcare Centers
- Family Day Care
- Nannies & In-home Care
- Summer Camps

Information & Support

- Adolescence
- Adoption
- Child Development
- College Planning
- New Parents and Pregnancy
- Special Needs

ELDERCARE

Consultation & Referrals

- Assisted Living Facilities
- Caregiver Support
- Community Services
- Home Health Care
- Hospice
- Medicare/Medicaid
- Nursing Homes
- Respite Care
- Social Security
- Transportation

LEGAL

Consultation & Referrals

- Bankruptcy
- Child Custody & Support
- Consumer Issues
- Elder Law
- Estate Planning
- Immigration
- Landlord Tenant Disputes
- Real Estate Concerns
- Restraining Orders
- Separation & Divorce
- Wills & Trusts

*See back for legal disclaimer

FINANCIAL

Consultation & Referrals

- Budgeting
- Credit Problems
- Debt Management
- Financial Wellbeing
- Home buying Information
- Insurance Planning
- Retirement Planning
- Tax Resources

WORK

Consultation & Referrals

- Career Exploration
- Job Performance Concerns
- Job Search Strategies
- Resume Review
- Time Management
- Work-life Integration
- Work Stress

CONVENIENCE SERVICES

Information & Referrals

- Community Education Classes
- Fitness Programs & Trainers
- Home Cleaning
- Home Repair Services
- Moving Services
- Organizer Services
- Pet Care
- Relocation Information
- Yoga Classes

NUTRITION

Consultation & Information:

- Child Friendly Meals
- Diabetes
- Food Allergies
- Gastrointestinal Problems
- Healthy Eating
- High Blood Pressure
- High Cholesterol
- Lactation
- Weight Management

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