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, go online at www.umr.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $300/individual or $900/family For out-of-network providers: $2,000/individual or $6,000/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 or until the total amount of deductible expenses paid by all family members meets theoverall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations, office visits, emergency room visits, in-network urgent care facility visits.	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: $2,800/individual or $8,400/family For out-of-network providers: $90,000/individual or Unlimited/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?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plandoesn't cover.	Even though you pay these expenses, they don't count towardthe out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.umr.com or call 1-877-232-3863 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). 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	$25 copay/visit Deductible does not apply	50% coinsurance	None
	Specialist visit	$50 copay/visit Deductible does not apply	50% coinsurance	None
	Preventive care/ screening/ immunization	No charge/visit* No charge/screening* No charge/immunizations* *Deductible does not apply	50% coinsurance/visit 50% coinsurance/ screening 50% coinsurance/immunizations	None None None You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay.
If you have a test	Diagnostic test (x-ray, blood work)	LabCorp/Quest: No copay Outpatient lab: Deductible & 20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	Free-Standing Facility: $25 copay; Hospital-System Owned Facility: Deductible & 20% coinsurance	50% coinsurance	Preauthorization is 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)	
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 (Tier 1)	10% coinsurance (Restricted Retail & mail order)	Not covered	Preauthorization may be required for some drugs. Minimum and maximum copayments apply for all Tiers. Carpenters Pharmacy Center can fill most prescriptions with little to no out-of-pocket cost. You must enroll in the SaveonSP program to be reimbursed by the Specialty drugs manufacturer at no cost to you. The SaveonSP drug list and copayment amounts are available at www.saveonsp.com/carpdc.
	Preferred brand drugs (Tier 2)	30% coinsurance (Restricted Retail & mail order)	Not covered	
	Non-preferred brand drugs (Tier 3)	40% coinsurance (Restricted Retail & mail order)	Not covered	
	Specialty drugs (Tier 4)	Premiums, balance-billing charges over usual and customary allowable amounts, SaveonSP specialty drug copayments, and health care this plan doesn't cover	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	OHS participation: 10% coinsurance, see Limitations/ Exceptions 20% coinsurance	50% coinsurance	If you participate in Orthopedic Health Support through a center of excellence, coinsurance may be reduced to 10%. Otherwise, 20%. Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Preauthorization is required.
If you need immediate medical attention	Emergency room care	$250 copay/visit then 20% coinsurance Deductible does not apply	$250 copay/visit, then 20% coinsurance. Deductible does not apply	Per visit copay is waived if admitted
	Emergency medical transportation	Ground: $150 copay Air or Water: $1,000 copay	Ground: $150 copay Air or Water: $1,000 copay	None
	Urgent care	$75 copay/visit Deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Preauthorization is 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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/All other providers office visits* 20% coinsurance/all other services* *Deductible does not apply	50% coinsurance/office visit 50% coinsurance/all other services	Preauthorization is required for Inpatient, Intensive Outpatient, Residential and Partial Hospital programs.
	Inpatient services	20% coinsurance	50% coinsurance	
If you are pregnant	Office visits	$25 copay /visit Deductible does not apply	50% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	

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 need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Preauthorization is required. Coverage is limited to 100 days annual max.
	Rehabilitation services	Coverage varies based on place of service	50% coinsurance/PCP visit 50% coinsurance/ Specialistvisit	Preauthorization is required. Occupational Therapy, Physical Therapy, Speech Therapy: 60 visits - $25 copay.Cognitive Therapy, Pulmonary Rehabilitation: 60 visits - 20% coinsurance. Chiropractic Care: 40 visits - $10copay. Cardiac Rehabilitation: 60 visits - 20% coinsurance. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	$25 copay/PCP visit* $50 copay/ Specialist visit* *Deductible does not apply	50% coinsurance/PCP visit 50% coinsurance/ Specialistvisit	Preauthorization is required. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for PT, ST & OT.
	Skilled nursing care (facility)	20% coinsurance	50% coinsurance	Coverage is limited to 100 days annual max. Preauthorization may be required.
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization is required.
	Hospice services	20% coinsurance/inpatient & outpatient services	50% coinsurance/inpatient & outpatient services	Preauthorization is 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)	
If your child needs dental or eye care	Children's eye exam	$10 copay /visit	Not covered	Coverage limited to one exam/year.
	Children's glasses	$25 copay for lenses and/or frames	Not covered	Coverage limited to one pair of glasses/2 years.
	Children's dental check-up	No charge for preventive care	Deductible, then 50% coinsurance	Dental deductible for out-of-network preventive services is $150

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Hearing aids, dependents only
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside theU.S.
- Private-duty nursing
- Routine Foot Care
- Weight loss programs

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

- Bariatric Surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids, members only
- Routine eye care (Adult)

Carpenters Wellness Centers offer Preventive & Acute Care services, Chiropractic, Counseling, Lab, X-ray and other services, provided to participants and dependents covered under the Plan at no charge.

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: Department of Labor's 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: UMR Customer service at 1-800-826-9781. 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. Additionally, a consumer assistance program can help you file your appeal. Contact: Missouri Division of Insurance at (573) 751-4126.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-826-9781.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-826-9781.

Chinese (中文): 如果需要中文的帮助， 请拨打这个号码1-800-826-9781.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-826-9781.

----------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 copayment	$25
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care 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	$25
Coinsurance	$2,475
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,800**

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	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$200
Coinsurance	$1,020
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,520**

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

The plan's overall deductible	$300
Specialist copayment	$50
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	$400
Coinsurance	$420
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,120**

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