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, visit laborfunds.org or call 314-644-4802. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary.com or call 314-644-4802, 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 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 services & immunizations, office visits, emergency room visits, in-network urgent care are covered before you meet your deductible.	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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	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 preauthorization for services, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.umr.com or call 1-877-232-3863 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$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; deductible does not apply.	50% 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.
If you have a test	Diagnostic test (x-ray, blood work)	LabCorp/Quest: No charge Outpatient lab: 20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	Free-Standing Facility: $25 copay; Hospital-System Owned Facility: 20% coinsurance	50% coinsurance	Preauthorization is required.
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: $10 min/$20 max 30-day supply, $20 min/$40 max 90-day	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
	Preferred brand drugs (Tier 2)	30% coinsurance, Restricted Retail & mail order: $20 min/$75 max 30-day supply, $40 min/$150 max 90-day	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at www.laborfunds.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs (Tier 3)	40% coinsurance, Restricted Retail & mail order: $30 min/$125 max 30-day supply, $60 min/$250 max 90-day	Not covered	www.saveonsp.com/carpdc.
	Specialty drugs (Tier 4)	Preferred: 35% coinsurance, $40 min/$150 max retail Non-preferred: 40% coinsurance, $40 min/$250 max	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization is required. If you participate in Orthopedic Health Support through a Center of Excellence, the network coinsurance may be reduced to 10%
	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 waived if admitted
	Emergency medical transportation	Ground: $150 copay; Air/Water: $1,000 copay; deductible does not apply	Ground: $150 copay; Air/Water: $1,000 copay; deductible does not apply	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	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit; deductible does not apply. 20% coinsurance for all other services	50% coinsurance	Preauthorization is required for inpatient, intensive outpatient, residential and partial hospital programs.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Inpatient services	20% coinsurance	50% coinsurance	
If you are pregnant	Office visits	$25 copay/office visit; deductible does not apply.	50% coinsurance	Specialist visit copay may apply depending on provider; cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests & 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	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Preauthorization is required. Limited to 100 days per year.
	Rehabilitation services	$25 copay/visit; deductible does not apply.	50% coinsurance	Specialist visit copay may apply depending on provider; preauthorization is required. Physical/occupational/speech therapy limited to 60 visits per year (not applicable to mental health). Chiropractic care $10 copay/visit, no deductible in-network; limited to 40 visits/year. Pulmonary and cardiac rehab 20% coinsurance in-network; limited to 60 visits each/year.
	Habilitation services	$25 copay/visit; deductible does not apply.	50% coinsurance	Specialist visit copay may apply depending on provider; preauthorization is required.
	Skilled nursing care	20% coinsurance	50% coinsurance	Preauthorization may be required. Limited to 100 days per year.
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization is required.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	$10 copay/visit	Greater of $10 copay/visit plus remaining balance after Plan pays $45	Limited to one/12 month period; deductible does not apply.
	Children's glasses	Frames: $25 copay. Plan pays max $220 on featured frame or max $200 non-featured frame. Lenses: $25 copay	Frames: $25 copay. Max $70 reimbursement Lenses: $25 copay. Max reimbursement varies by type of lens.	Frames limited to one/24 month period; lenses limited to one/12 month period. Your cost for out-of-network lenses varies by type. Deductible does not apply.

* For more information about limitations and exceptions, see the plan or policy document at www.laborfunds.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	**PPO Network:** No charge **Premier Network:** $50 deductible, then 25% coinsurance	$150 deductible, then 50% coinsurance	Limited to two visits/calendar year

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 for dependents
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Bariatric surgery (for morbid obesity)
- Chiropractic care (40 visits/year)
- Dental care (adults: $2,000/year)
- Hearing aids for members ($2,000/ear every 5 years)
- Routine eye care (one exam/12-month period)

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 866-444-ESBA (3272) or www.dol.gov/ebsa. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Mid-America Carpenters Regional Council Health Fund, 1419 Hampton Avenue, St. Louis, Missouri 63139, 314-644-4802, www.laborfunds.org or you may also contact the Department of Labor's Employee Benefits Security Administration at 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:

Spanish (Español): Para obtener asistencia en Español, llame al 314-644-4802.

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 copayments	**$25**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

Total Example Cost	**$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 copayments	**$50**
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	$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 copayments	**$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.

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