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, contact **Carpenters Trusts: 1-800-552-0635** or **www.ctww.org**. For general definitions of common terms, such as allowed amount, balanced billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **www.ctww.org** or call **1-800-552-0635** to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$200 individual / $400 family	Generally, you must pay all 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. Preventive care and primary care services 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	
What is the out-of-pocket limit for this plan?	$2,300 individual / $4,600 family; $2,850 individual / $5,700 family for prescriptions	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	No	This plan treats providers the same in determining payment for the same services. Services may not be covered if you use a Medicare non-participating provider.
Do I need a referral to see a specialist?	No	You can see a specialist without permission from this plan.

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
		Medicare Participating Provider	Medicare Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	10% coinsurance	None
	Specialist visit	10% coinsurance	10% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge	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)	10% coinsurance/test	10% coinsurance/test	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance/test	10% coinsurance/test	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 (Tier 1)	$7 copay/prescription/30 days (retail) and $10 copay/ prescription (mail order)	Not covered	Covers up to a 90-day supply (retail and mail order prescription). Preauthorization required for specialty drugs.
	Preferred brand drugs (Tier 2)	$15 copay/prescription/30 days (retail) and $20 copay/ prescription (mail order)	Not covered	
	Non-preferred brand drugs (Tier 3)	$35 copay/prescription/30 days (retail) and $40 copay/ prescription (mail order)	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Medicare Participating Provider	Medicare Non-Participating Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	10% coinsurance	None
	Physician/surgeon fees	10% coinsurance	10% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	None
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	10% coinsurance	10% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	10% coinsurance	None
	Physician/surgeon fee	10% coinsurance	10% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	10% coinsurance	None
	Inpatient services	10% coinsurance	10% coinsurance	None
If you are pregnant	Office visits	10% coinsurance	10% coinsurance	Cost sharing does not apply to certain preventive 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). For participant and spouse only. Must use Medicare participating provider.
	Childbirth/delivery professional services	10% coinsurance	10% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	10% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Medicare Participating Provider	Medicare Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	Paid at 100%	Paid at 100%	30 visits/calendar year. Precertification required.
	Rehabilitation services	10% coinsurance	10% coinsurance	30 outpatient visits/calendar year for rehabilitation and habilitation services combined. 15 inpatient days/calendar year for rehabilitation and habilitation services combined.
	Habilitation services	10% coinsurance	10% coinsurance	30 outpatient visits/calendar year for rehabilitation and habilitation services combined. Must be Medicare covered services.
	Skilled nursing care	10% coinsurance	10% coinsurance	80 days/calendar year. Must be Medicare covered services.
	Durable medical equipment	10% coinsurance	10% coinsurance	Precertification required. Must be Medicare covered services.
	Hospice service	Paid at 100%	Paid at 100%	Precertification required. Must be Medicare covered services.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	None
	Glasses	Not covered	Not covered	None
	Dental check-up	Not covered	Not covered	None

Excluded Services and 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.)		
▪ Bariatric Surgery	▪ Hearing Aids	▪ Private-Duty Nursing
▪ Care When Traveling Outside of the U.S.	▪ Infertility Treatment	▪ Routine Eye Care
▪ Cosmetic Surgery	▪ Intentionally Self-Inflicted Injuries	▪ Routine Foot Care
▪ Dental Care	▪ Long-term Care	▪ Weight Loss Programs
▪ Experimental and Investigative Services	▪ Orthotics	

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

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For information about your rights, this notice, or assistance, contact the plan at: 1-800-552-0635. You may also contact the U.S. Department of Labor, Employee Benefits Security.

Does this Coverage Provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? 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 1-800-552-0635.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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 network pre-natal care and a hospital delivery)

■ **The plan's overall deductible**	$200
■ **Specialist copayment**	$10
■ **Hospital (facility) coinsurance**	10%
■ **Other coinsurance**	10%

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

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$70
Coinsurance	$1,247
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,577**

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

■ **The plan's overall deductible**	$200
■ **Specialist copayment**	$10
■ **Hospital (facility) coinsurance**	10%
■ **Other coinsurance**	10%

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$60
Coinsurance	$708
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,028**

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

■ **The plan's overall deductible**	$200
■ **Specialist copayment**	$10
■ **Hospital (facility) coinsurance**	10%
■ **Other coinsurance**	10%

This EXAMPLE event includes services like:
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$50
Coinsurance	$165
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$415**

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