



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 including your plan's Summary Plan Description, visit www.carpenterssw.org or call 1-800-293-1370. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-293-1370 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<p><u>Network Providers</u> per calendar year: \$0. <u>Out-of-Network Providers</u> per calendar year: \$500/individual; \$1,500/family.</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
Are there services covered before you meet your <u>deductible</u>?	<p>Yes. All services and supplies obtained from <u>Network Providers</u>, as well as second surgical opinions, ambulance services, emergency services received in an emergency room, and outpatient <u>prescription drugs</u> obtained from <u>Out-of-Network Providers</u> are covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.</p>
Are there other <u>deductibles</u> for specific services?	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<p>Medical Plan <u>Network Providers</u> per calendar year: \$2,500/individual; \$5,000/family. <u>Out-of-Network Provider</u>: No <u>out-of-pocket limit</u>. Outpatient <u>prescription drugs</u> from <u>Network Providers</u> per calendar year: \$1,000/individual; \$2,000/family.</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>
What is not included in the <u>out-of-pocket limit</u>?	<p>For the Medical <u>Plan</u>: <u>Premiums</u>, <u>balance billing</u> charges, health care this <u>plan</u> doesn't cover, vision <u>plan</u> expenses, outpatient retail/mail order drug expenses (which have a separate <u>out-of-pocket limit</u>), chiropractic treatment and <u>out-of-network deductibles</u>, <u>copayments</u> and <u>coinsurance</u> except an ER visit in cases of an <u>emergency</u>. The <u>prescription drug out-of-pocket limit</u> does not include <u>premiums</u>, <u>balance-billing</u> charges, medical costs, and health care this <u>plan</u> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. See www.anthem.com/ca or call Anthem at 1-877-359-9644 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
		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	Office visit: \$15 copay /visit. Online visit: No charge.	50% coinsurance .	None.
	Specialist visit	Office visit: \$30 copay /visit. Second opinion: No charge up to \$150. Online visit: No charge.	50% coinsurance . Second opinion: No charge up to \$150, deductible does not apply.	Preauthorization of surgical procedures exceeding \$1,500 is recommended. Assistant surgeon payable to 20% of the allowable charge for a primary surgeon.
	Preventive care/screening/immunization	No charge.	50% coinsurance .	Plan covers required preventive services and supplies described at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/ . Age and frequency guidelines apply to covered preventive care . 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 for.
If you have a test	Diagnostic test (x-ray, blood work)	\$30 copay /test.	50% coinsurance .	None.
	Imaging (CT/PET scans, MRIs)	\$30 copay /test.	50% coinsurance .	Preauthorization of imaging tests like CT, PET and MRI is recommended.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com or 1-800-987-7836.	Generic drugs	Retail Pharmacy for 30-day supply: \$10 <u>copayment</u> per prescription; Mail Order for 90-day supply: \$25 <u>copayment</u> per prescription. No charge for ACA preventive drugs (e.g. generic contraceptives).	\$60 <u>copayment</u> plus 20% <u>coinsurance</u> .	<ul style="list-style-type: none"> • <u>Out-of-Network deductible</u> does not apply. • Mail Order is required for maintenance medications after the second fill at a retail pharmacy to avoid non-payment of drugs. Maintenance drugs are those you take to treat an ongoing condition such as diabetes, arthritis or high blood pressure. • Some prescriptions are subject to <u>preauthorization</u> (to avoid non-payment) and quantity limits. • Certain over-the-counter (OTC) and <u>prescription drugs</u> are payable at no charge, with a prescription, in compliance with federal law. • If you purchase a brand drug when a generic drug is available you pay the brand drug <u>cost sharing</u> plus the difference in cost between the brand drug and generic drug. • If you fill a prescription at an Out-of-Network pharmacy, you will need to pay 100% for the drug at the time of purchase and file a claim with Express Scripts for reimbursement and Plan pays 80% of what it would have paid had you used a Network Retail pharmacy.
	Preferred brand drugs	Retail Pharmacy for 30-day supply: \$40 <u>copayment</u> per prescription; Mail Order for 90-day supply: \$100 <u>copayment</u> per prescription. No charge for brand name ACA preventive drugs if a generic is medically inappropriate.		
	Non-preferred brand drugs	Retail Pharmacy for 30-day supply: \$60 <u>copayment</u> per prescription; Mail Order for 90-day supply: \$150 <u>copayment</u> per prescription.		
	<u>Specialty drugs</u>	You pay a \$50 <u>copayment</u> per prescription for a 30-day supply and \$100 <u>copayment</u> per prescription for up to a 90-day supply.	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 <u>copay</u> /surgery.	50% <u>coinsurance</u> up to a maximum allowable charge of \$5,000 per operative session and \$3,500 for other outpatient department services/supplies.	<u>Preauthorization</u> of surgical procedures exceeding \$1,500 is recommended.
	Physician/surgeon fees	\$30 <u>copay</u> /surgery. <u>Deductible</u> does not apply.		<u>Preauthorization</u> of surgical procedures exceeding \$1,500 is recommended. Assistant surgeon payable to 20% of the allowable charge for a primary surgeon.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$250 <u>copayment</u> /visit.	For <u>emergency medical condition</u> : \$250 <u>copayment</u> /visit. <u>Deductible</u> does not apply. For non-emergency: \$250 <u>copayment</u> /visit plus 50% <u>coinsurance</u> .	Physician/provider's professional fees may be billed separately. <u>Copayment</u> waived if visit results in immediate admission to the hospital as an inpatient.
	Emergency medical transportation	\$100 <u>copayment</u> per trip.	\$100 <u>copayment</u> per trip. <u>Deductible</u> does not apply.	Professional air, sea or ground ambulance services payable to and from the nearest hospital where treatment can be given.
	Urgent care	\$100 <u>copay</u> /visit.	50% <u>coinsurance</u> .	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay</u> /admission.	50% <u>coinsurance</u> .	<u>Preauthorization</u> of a hospital admission for dental treatment is required to avoid non-payment, call Anthem at 1-800-274-7767.
	Physician/surgeon fees	\$30 <u>copay</u> /admission. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> .	<u>Preauthorization</u> of surgical procedures exceeding \$1,500 is recommended. Assistant surgeon payable to 20% of the allowable charge for a primary surgeon.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits and other outpatient services: \$15 <u>copay</u> /visit. Online visit: No charge.	50% <u>coinsurance</u> .	No coverage for treatment of eating disorders, so you must pay 100%, even in-network.
	Inpatient services	\$500 <u>copay</u> /admission.	50% <u>coinsurance</u> .	No coverage for treatment of eating disorders, so you must pay 100%, even in-network.
If you are pregnant	Office visits	No charge for office visits. <u>Deductible</u> does not apply.	Services for employee or spouse: 50% <u>coinsurance</u> .	<ul style="list-style-type: none"> <u>Cost sharing</u> does not apply for <u>preventive services</u>. Depending on the type of services, <u>coinsurance</u> may apply to <u>Out-of-Network</u> services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Prenatal care (other than ACA-required <u>preventive screenings</u>) is not covered for dependent children.
	Childbirth delivery professional services	For employee and spouse: \$30 <u>copay</u> /delivery. <u>Deductible</u> does not apply.	For employee and spouse: 50% <u>coinsurance</u> .	No coverage for delivery expenses for a dependent child, you must pay 100%, even in-network.

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)	
	Childbirth delivery facility services	For employee and spouse: \$500 <u>copay</u> /delivery. <u>Deductible</u> does not apply.	For employee and spouse: 50% <u>coinsurance</u> .	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$30 <u>copay</u> /visit. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> .	<u>Plan</u> covers services that require the skill and training of a nurse. <u>Preauthorization</u> of home health care is recommended. No coverage for nurse's aide, custodial care or housekeeping services.
	<u>Rehabilitation services</u>	Inpatient <u>Rehabilitation Services</u> : \$500 <u>copay</u> /admission. <u>Deductible</u> does not apply. Outpatient <u>Rehabilitation Services</u> : \$15 <u>copay</u> /visit. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> .	Outpatient physical and occupational therapy maximum benefit is 20 sessions per calendar year. Speech therapy maximum benefit is 130 sessions per lifetime. <u>Preauthorization</u> of outpatient physical and speech therapy, and inpatient rehabilitation admission is recommended. Maximum benefit for inpatient rehabilitation admit is 30 days/calendar year.
	<u>Habilitation services</u>	\$15 <u>copay</u> /visit. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> .	Speech therapy maximum benefit is 130 sessions per lifetime.
	<u>Skilled nursing care</u>	\$500 <u>copay</u> /admission. <u>Deductible</u> does not apply.	\$500 <u>copay</u> /admission. <u>Deductible</u> does not apply.	Payable only if hospitalized for at least 5 consecutive days immediately before admission to a skilled nursing facility. <u>Preauthorization</u> of <u>skilled nursing facility</u> admission is recommended.
	<u>Durable medical equipment</u>	\$30 <u>copay</u> /item. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> .	<u>Preauthorization</u> of equipment is recommended. Rental is covered up to the purchase price.
	<u>Hospice services</u>	\$100 <u>copay</u> /admission. <u>Deductible</u> does not apply.	10% <u>coinsurance</u> .	Maximum benefit is 180 days/lifetime. <u>Preauthorization</u> of hospice is required to avoid non-payment, call Anthem at 1-800-274-7767.
	If your child needs dental or eye care	Children's eye exam	\$10 <u>copayment</u> /eye exam. <u>Deductible</u> does not apply.	You pay 100% and later submit your claim for reimbursement. You will be reimbursed up to \$40 per exam. You pay any amount over \$40 for an eye exam. <u>Deductible</u> does not apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Children's glasses	\$20 <u>copayment</u> for lenses only or lenses and a frame. <u>Deductible</u> does not apply.	You pay 100% and later submit your claim for reimbursement. You will be reimbursed up to \$65 for frame and \$40 for single vision lenses. <u>Deductible</u> does not apply.	<ul style="list-style-type: none"> See www.myuhcvision.com or call 1-800-638-3120 for network vision providers.
	Children's dental check-up	Not covered.	Not covered.	If you elect dental coverage, it will be available under a separate dental <u>plan</u> .

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
- Eating disorders
- Private-duty nursing
- Bariatric Surgery
- Infertility treatment
- Routine foot care
- Cosmetic surgery
- Long-term care
- Weight loss programs (except as required by health reform law)
- Dental care (Adult & Child)
- Non-emergency care when traveling outside the U.S.

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

- Chiropractic care (up to 24 visits/calendar year).
- Hearing aids (hearing test and hearing aids covered up to a maximum of \$1,000 per ear every 24 months)
- Routine eye care (Adult)

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 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: the Medical Plan Claims Administrator (Anthem) at 1-877-359-9644 or 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: Spanish (Español): Para obtener asistencia en Español, llame al 1-877-359-9644. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-359-9644. Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-359-9644. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijgo holne' 1-877-359-9644.

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 <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>copayment</u>	\$500
■ Other <u>copayment</u>	\$250

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
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In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Peg would pay is	\$720

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>copayment</u>	\$500
■ Other <u>copayment</u>	\$250

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
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In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,260
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,260

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>copayment</u>	\$500
■ Other <u>copayment</u>	\$250

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
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In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$720
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$720

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