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 deductible?	Network Providers per calendar year: $0. Out-of-Network Providers per calendar year: $500/individual; $1,500/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. All services and supplies obtained from Network Providers, as well as ambulance services, emergency services received in an emergency room, and outpatient prescription drugs obtained from Out-of-Network Providers 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.
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?	Medical Plan Network Providers per calendar year: $2,500/individual; $5,000/family. Out-of-Network Provider: No out-of-pocket limit. Outpatient prescription drugs from Network Providers per calendar year: $1,000/individual; $2,000/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?	For the Medical Plan: Premiums, balance billing charges, health care this plan doesn't cover, vision plan expenses, outpatient retail/mail order drug expenses (which have a separate out-of-pocket limit), chiropractic treatment and out-of-network deductibles, copayments and coinsurance except Emergency Services, certain non-emergency service provided by a Non-PPO provider at a PPO facility, and/or air ambulance service (as covered under the federal No Surprises Act). The prescription drug out-of-pocket limit does not include premiums, balance-billing charges, medical costs, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.MyIBXTPAbenefits.com or call Independence Administrators (IA) at 1-800-810-BLUE 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. Online visit: No charge.	50% coinsurance.	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 copayment per prescription; Mail Order for 90-day supply: $25 copayment per prescription. No charge for ACA preventive drugs (e.g. generic contraceptives).	$60 copayment plus 20% coinsurance.	• Out-of-Network deductible 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 preauthorization (to avoid non-payment) and quantity limits. • Certain over-the-counter (OTC) and prescription drugs 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 cost sharing 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. • 90-day supplies of maintenance drugs can be obtained from any Smart90 retail pharmacy.
	Preferred brand drugs	Retail Pharmacy for 30-day supply: $40 copayment per prescription; Mail Order for 90-day supply: $100 copayment 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 copayment per prescription; Mail Order for 90-day supply: $150 copayment per prescription.		
	Specialty drugs	You pay a $50 copayment per prescription for a 30-day supply and $100 copayment per prescription for up to a 90-day supply.	Not covered.	• Out-of-Network deductible does not apply. Specialty drugs require preauthorization (to avoid non-payment) by calling Accredo Specialty Pharmacy at 1-800-803-2523. • The SaveOnSP Specialty Drug List is available at 1-800-683-1074. Your cost sharing for these "non-essential" specialty drugs, as well as any amount paid by the drug manufacturer through its copay assistance program, do not count toward your out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/surgery.	50% coinsurance up to a maximum allowable charge of $5,000 per operative session and $3,500 for other	Preauthorization of surgical procedures exceeding $1,500 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)	
	Physician/ surgeon fees	$30 copay/surgery. Deductible does not apply.	outpatient department services/supplies.	Preauthorization of surgical procedures exceeding $1,500 is recommended. Assistant surgeon payable to 20% of the allowable charge for a primary surgeon.
If you need immediate medical attention	Emergency room care	$250 copayment/visit.	For emergency services: $250 copayment/visit. Deductible does not apply. For non-emergency services: $250 copayment/visit plus 50% coinsurance.	Physician/provider's professional fees may be billed separately. Copayment waived if visit results in immediate admission to the hospital as an inpatient.
	Emergency medical transportation	$100 copayment per trip.	$100 copayment per trip. Deductible does not apply.	• Professional air, sea or ground ambulance services payable to and from the nearest hospital where treatment can be given. • You will not be Balance Billed for covered air ambulance services. • Services from an Emergency Medical Technician (EMT) are covered at the Plan's regular benefits level for ambulance services for a medical emergency, even if you are not transported to a hospital, provided you reasonably believe that a medical emergency existed.
	Urgent care	$50 copay/visit.	50% coinsurance.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/admission.	50% coinsurance.	Preauthorization of a hospital admission for dental treatment is required to avoid non-payment.
	Physician/ surgeon fees	$30 copay/admission. Deductible does not apply.	50% coinsurance.	Preauthorization 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 copay/visit. Online visit: No charge.	50% coinsurance.	None.
	Inpatient services	$500 copay/admission.	50% coinsurance.	None.

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 are pregnant	Office visits	No charge for office visits. Deductible does not apply.	For employee or spouse: 50% coinsurance.	• Cost sharing does not apply for preventive services. • Depending on the type of services, coinsurance may apply to Out-of-Network services. • Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). • Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children.
	Childbirth delivery professional services	For employee and spouse: $30 copay/delivery. Deductible does not apply.	For employee and spouse: 50% coinsurance.	No coverage for delivery expenses for a dependent child, you must pay 100%, even in-network.
	Childbirth delivery facility services	For employee and spouse: $500 copay/delivery. Deductible does not apply.	For employee and spouse: 50% coinsurance.	
If you need help recovering or have other special health needs	Home health care	$30 copay/visit. Deductible does not apply.	50% coinsurance.	Plan covers services that require the skill and training of a nurse. Preauthorization of home health care is recommended. No coverage for nurse's aide, custodial care or housekeeping services.
	Rehabilitation services	Inpatient Rehabilitation Services: $500 copay/admission. Deductible does not apply. Outpatient Rehabilitation Services: $15 copay/visit. Deductible does not apply.	50% coinsurance.	Outpatient physical and occupational therapy maximum benefit is 20 sessions per calendar year. Speech therapy maximum benefit is 130 sessions per lifetime. If additional sessions are needed beyond 20 visits (or 130 lifetime visits for speech therapy), preauthorization is required to avoid nonpayment. Preauthorization of outpatient physical and speech therapy, and inpatient rehabilitation admission is recommended. Maximum benefit for inpatient rehabilitation admit is 30 days/calendar year. Visit limits will not apply to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice.
	Habilitation services	$15 copay/visit. Deductible does not apply.	50% coinsurance.	Speech therapy maximum benefit is 130 sessions per lifetime. If additional sessions are needed beyond 130 lifetime visits, preauthorization is required to avoid nonpayment. Visit limits will not apply to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice.

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)	
	Skilled nursing care	$500 copay/admission. Deductible does not apply.	$500 copay/admission. Deductible does not apply.	Payable only if hospitalized for at least 5 consecutive days immediately before admission to a skilled nursing facility. Preauthorization of skilled nursing facility admission is recommended.
	Durable medical equipment	$30 copay/item. Deductible does not apply.	50% coinsurance.	Preauthorization of equipment is recommended. Rental is covered up to the purchase price.
	Hospice services	$100 copay/admission. Deductible does not apply.	10% coinsurance.	Maximum benefit is 180 days/lifetime. Preauthorization of hospice is required to avoid non-payment, call IA at 1-888-234-2393. Day limits will not apply to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice.
If your child needs dental or eye care	Children's eye exam	$10 copayment/eye exam. Deductible 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. Deductible does not apply.	• Vision coverage is available under a separate plan. An eye exam is covered every 12 months. • Frames are payable every 24 months. • See www.myuhcvision.com or call 1-800-638-3120 for network vision providers.
	Children's glasses	$20 copayment for lenses only or lenses and a frame. Deductible 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. Deductible does not apply.	
	Children's dental check-up	Please refer to your comparison of dental benefits for specific plan information.		• Your dental coverage is available under separate dental plans through United Healthcare. • See www.myuhcdental.com or call 1-800-638-3120 for network dental providers

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

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 Dental care (adult & child) available through United Healthcare
- Routine Eye care (adult & child) available through United Healthcare

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 (Independence Administrators) at 1-833-242-3330 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 1-833-242-3330. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-242-3330. Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-242-3330. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-242-3330.

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** **$0**
- **Specialist copayment** **$30**
- **Hospital (facility) copayment** **$500**
- **Other copayment** **$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**

In this example, Peg would pay:

Cost sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
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 plan's overall deductible** **$0**
- **Specialist copayment** **$30**
- **Hospital (facility) copayment** **$500**
- **Other copayment** **$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**

In this example, Joe would pay:

Cost sharing	
Deductibles	$0
Copayments	$1,260
Coinsurance	$0
What isn't covered	
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 plan's overall deductible** **$0**
- **Specialist copayment** **$30**
- **Hospital (facility) copayment** **$500**
- **Other copayment** **$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**

In this example, Mia would pay:

Cost sharing	
Deductibles	$0
Copayments	*$720
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$720**

* Copays in the fracture example include a $250 emergency room copay and various copays for other services. The $500 hospital copay has not been applied.

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