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 carpenterbenefits.org. or call 312-787-9455, option 3. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary of Terms. You can view the Glossary of Terms at www.healthcare.gov/sbc-glossary/ or call 312-787-9455, option 3, to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	PPO: $300 per person/$900 per family; Non-PPO: $600 per person/$1,800 per 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, hearing benefits, and vision benefits 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?	Yes. $50 person/$100 family for dental coverage (Basic/Major Services only). There are no other specific deductibles.	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?	Medical PPO: $2,300/person, $6,900 family; Medical Non-PPO: $6,000/person, $18,000/family; Prescription drug: $2,000/person, $4,000/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?	Premiums, vision & dental expenses, balance-billing charges, select specialty medications and health care this plan doesn't cover. Prescription drug copayments, other than select specialty medications, count only toward the prescription drug out-of-pocket limit and not toward the major medical out-of-pocket limit.	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. For a list of network providers for medical & behavioral health services, see bcbsil.com or call 800-810-2583, for dental services, see deltadentalil.com or call Delta Dental at 800-323-1743, for prescription drugs, see express-scripts.com or call 800-939-2089, for vision services, see macrcvision.vspforme.com or call VSP at 800-877-7195, for hearing aid instruments, see epichearing.com or call Epic	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:
	Hearing at 866-956-5400, if you need a MRI, CT or PET Scan see absolutedx.com or call Absolute Solutions at 800-321-5040.	
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	20% coinsurance	40% coinsurance	No charge for services provided through the Health Center.
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered	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)	20% coinsurance	40% coinsurance	Diagnostic genetic testing up to an annual maximum benefit of $7,500.
	Imaging (CT/PET scans, MRIs)	**Absolute Solutions**: No charge. Deductible does not apply. **BCBS**: 20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carpenterbenefits.org.	Generic drugs	$5 copay retail, $12.50 copay mail order	You pay full cost and submit claim for reimbursement which is based on amount paid to PPO pharmacy	Covers lesser of 100 pills or a 30-day supply at retail or up to 90-day supply through mail order or Walgreens Smart90 program; must use mail order or Walgreens Smart90 for long-term medications after 3 fills at retail.
	Preferred brand drugs	20% coinsurance, $10 min/$100 max retail, $25 min/$250 max mail order	You pay full cost and submit claim for reimbursement which is based on amount paid to PPO pharmacy	
	Non-preferred brand drugs	35% coinsurance, $20 min retail, $50 min mail order	You pay full cost and submit claim for reimbursement which is based on amount paid to PPO pharmacy	
	Specialty drugs	20% coinsurance, $20 min/$100 max	Not covered	Preauthorization is required from the Plan's Specialty Pharmacy vendor or the expense is not covered. Select specialty

*For more information about limitations and exceptions, see the Summary Plan Description at www.carpenterbenefits.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)	
				medications are subject to cost sharing described in the Specialty Pharmacy Copay Assistance Program.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization required for certain procedures. Non-PPO surgi-centers not affiliated with a hospital are not covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	There is a $250 copayment per ER visit unless admitted to hospital within 72 hours or held in the emergency room observation unit for more than 24 hours.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required. Maximum 180 days/year, unless medically necessary.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Preauthorization required for certain services.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required for residential treatment & partial hospital programs. Maximum 180 days/year combined for hospital & residential, unless medically necessary. Custodial & group homes not covered.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	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	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have	Home health care	20% coinsurance	40% coinsurance	Home health and skilled nursing visits at home combined, limited to 120 visits per year.

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)	
other special health needs	Rehabilitation services	20% coinsurance	40% coinsurance	To restore an established function. Preauthorization required for inpatient therapy. Includes 50 visits for physical & speech therapy (combined), and 50 visits for occupational therapy.
	Habilitation services	20% coinsurance	40% coinsurance	For children through age 18 with developmental disabilities. Includes physical therapy, speech therapy, and occupational therapy.
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization required. Skilled nursing services provided in a facility are limited to a maximum of 120 days per convalescent period. For services provided in a home setting, see Home health care above.
	Durable medical equipment	20% coinsurance	40% coinsurance	Letter of Medical Necessity required for all DME purchases or rentals. Excludes vehicle and home modifications, exercise, and bathroom equipment.
	Hospice services	20% coinsurance	40% coinsurance	Coverage is limited to 180 days lifetime max/person.
If your child needs dental or eye care	Children's eye exam	No charge	You pay amount over $45	Coverage is limited to one exam/year.
	Children's glasses	Frames: no charge up to $200 retail or $220 for VSP frame brands; you pay 80% of balance over $200/$220 retail. Lenses: no charge for single vision, bifocal, trifocal lens.	Frames: You pay amount over $70. Lenses: You pay amount over $30-65 (depending on lens type).	Coverage is limited to one pair of glasses or contacts/year.
	Children's dental check-up	No charge	No charge	Check-ups limited to 2 visits/year/child. Deductible doesn't apply.

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, chiropractic, and naprapathy care for dependent children under the age of 12
- Cosmetic Surgery (unless medically necessary)
- Long Term Care
- Weight Loss Programs

*For more information about limitations and exceptions, see the Summary Plan Description at www.carpenterbenefits.org.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture, chiropractic, and naprapathy care (50 visits/year for employee, 30 visits/year for spouse and 15 visits/year dependents over age 12 (combined benefit) • Bariatric Surgery (for morbid obesity)	• Dental Care (Adult) ($2,500/person/year) • Hearing Aids (up to $5,000 every 5 years if age 19 or over, or every 3 years for dependent children through age 18) • Infertility Treatment ($60,000/employee & spouse combined/lifetime)	• Non-emergency care when traveling outside the U.S. Routine eye care (Adult) (one exam/year) • Private duty nursing (up to120 visits/calendar year; custodial care not covered) • Routine Foot Care

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, or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or www.cciio.cms.gov. For more information on your rights to continue coverage under the Plan, contact the plan at 312-787-9455, Option 3. 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 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 more information about your rights, this notice, or assistance, contact: Mid-America Carpenters Regional Council Health Fund, 12 East Erie Street, Chicago, Illinois 60611, 312-787-9455, Option 3, www.carpenterbenefits.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 312-787-9455, opción 3.

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

*For more information about limitations and exceptions, see the Summary Plan Description at www.carpenterbenefits.org.

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**
■ **Specialist coinsurance**	**20%**
■ **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	
Deductible	$300
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,360**

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 coinsurance**	**20%**
■ **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	
Deductible	$300
Copayments	$0
Coinsurance	$1,470
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,830**

Mia's Simple Fracture

in-network emergency room visit and follow up care

■ **The plan's overall deductible**	**$300**
■ **Specialist coinsurance**	**20%**
■ **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	
Deductible	$300
Copayments	$250
Coinsurance	$280
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$830**

If you are eligible, the Plan provides a Health Reimbursement Account ("HRA") Program that you can use to pay deductibles, copays and coinsurance amounts and other medical expenses that are not covered by the Plan or another source. You may file for reimbursement for some of these expenses, as permitted by the HRA Program.

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