Cement Masons and Plasterers Health and Welfare Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 4/1/16 – 3/31/17

Coverage for: Family | Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the plan's summary plan description at www.cementmasonstrust.com or by calling **206-441-7574 or 1-800-331-6158**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Medical - Preferred providers**: $300** person/**$600** family. Non- preferred providers: **$600** person/ **$1,200** family. Doesn't apply to ACA mandated preventive care services by a preferred provider and hospice care benefits.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	**Yes, $50** for the Traditional Dental Plan. 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.
Is there an out–of–pocket limit on my expenses?	**Yes.** For preferred medical providers **$3,300**/ person, **$6,600**/family per calendar year. No limit for non-preferred medical providers. For Tiers 1 & 2 prescription drugs: **$3,300**/person, **$6,600**/family, per calendar year. No limit for Tier 3.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, services provided by non-preferred medical providers, Tier 3 non-formulary brand prescription drugs, private duty nursing, penalties, dental, and vision.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	**No.**	The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	**Yes.** For a list of **preferred providers** see www.aetna.com/docfind and select Aetna Choice POS II (open access) network. For a list of **preferred vision providers** see www.nationalvision.com**.**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Questions: Call **206-441-7574 or 1-800-331-6158** or visit us at www.cementmasonstrust.com for more information, including a copy of your plan's summary plan description**.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call **206-441-7574 or 1-800-331-6158** to request a copy.

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Do I need a referral to see a specialist?	**No.**	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	**Yes.**	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	---none---
	Specialist visit	20% coinsurance	40% coinsurance	---none---
	Other practitioner office visit	20% coinsurance	40% coinsurance	Chiropractic visits limited to $25 per visit, maximum of 25 visits per year. Alternative care is limited to a maximum of $500 per person per year.
	Preventive care/screening/immunization	No charge	40% coinsurance	---none---
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	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.savrx.com**	Generic drugs	20% coinsurance	20% coinsurance	Retail is limited to a 34-day supply and Mail Order is limited to a 90-day supply. Specialty drugs are limited to a 30-day supply. Tier 1 and 2 (generics and preferred brand) are subject to a $3,300 per person/$6,600 per family annual out-of-pocket maximum.
	Preferred brand drugs	30% coinsurance	30% coinsurance	
	Non-preferred brand drugs	40% coinsurance	40% coinsurance	
	Specialty drugs	Based on Tier level	Based on Tier level	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Prior authorization required. Penalty of 50% reduction in benefits for non-compliance up to a maximum of $250.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	Penalty of $200 applies except for accidental injury or direct admission to the hospital.
	Emergency medical transportation	20% coinsurance	40% 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 plus penalty up to $500 or 50% of expense	Prior authorization required. Penalty of 50% reduction in benefits for non-compliance up to a maximum of $250 for non-emergency treatment.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	---none---

If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	---none---
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance plus penalty up to $500 or 50% of expense	Prior authorization required. Penalty of 50% reduction in benefits for non-compliance up to a maximum of $250.
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	---none---
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance plus penalty up to $500 or 50% of expense	Prior authorization required. Penalty of 50% reduction in benefits for non-compliance up to a maximum of $250.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	No coverage for a dependent child or child of dependent child.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Maximum of 130 visits per year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Outpatient visits limited to 40 per year.
	Habilitation services	20% coinsurance	40% coinsurance	Limited to neurodevelopmental therapy for children age 6 and younger limited to 12 visits per year. The age and visit limit does not apply to medically necessary treatment of a mental disorder.
	Skilled nursing care	20% coinsurance	40% coinsurance	Maximum of 120 days.
	Durable medical equipment	20% coinsurance	40% coinsurance	Prior authorization required for costs over $200.
	Hospice service	No charge	40% coinsurance	---none---
If your child needs dental or eye care	Eye exam	No charge	Charges in excess of $90 scheduled benefit	Limited to once every 12 months.
	Glasses	No charge	Charges in excess of scheduled benefit of $90 for single vision lens / $100 for fames	Limited to once every 12 months for lenses and once every 24 months for frames. Non-PPO charges are limited to scheduled amounts.
	Dental check-up	Diagnostic/preventive 0% to 30% depending on nature of services	Diagnostic/preventive 0% to 30% depending on nature of services	Annual maximum of $2,000.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your plan's summary plan description for other excluded services.)**

- Bariatric surgery
- Cosmetic surgery (except to correct function disorder)
- Hearing Aids
- Infertility treatment
- Habilitation services, except for certain neurodevelopmental therapy (limitations apply).
- Injury or Illness for which a third-party may be responsible.
- Long term care
- Pregnancy for a Dependent Child
- Routine foot care
- Services for which Medicare is or could be primary. **(This exclusion applies if you are eligible to enroll in Medicare, but fail to do so.)**
- Weight loss programs, except ACA mandated preventive care.
- Work related injury or illness

Other Covered Services **(This isn't a complete list. Check your plan's summary plan description for other covered services and your costs for these services.)**

- Acupuncture (Alternative care is limited to a maximum of $500 per person per year)
- Chiropractic care (Limited to 25 visits per year and $25 per visit)
- Dental Care (adult)
- Non-emergency care when traveling outside the United States, (care must be medically necessary and considered standard care in the U.S.)
- Private duty nursing
- Routine eye care (adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 206-441-7574 or 1-800-331-6158. You may also contact your state insurance department, 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.cementmasonstrust.com or by calling 206-441-7574 or 1-800-331-6158. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform for additional information.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al **206-441-7574 o 1-800-331-6158.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,690
- **Patient pays** $1,850

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Copays	$0
Coinsurance	$1,400
Limits or exclusions	$150
Total	**$1,850**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,030
- **Patient pays** $1,370

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$0
Coinsurance	$990
Limits or exclusions	$80
Total	**$1,370**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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