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 your Plan Booklet/Summary Plan Description and Summary Material Modifications, visit www.cementmasonstrust.com or call 1-800-331-6158. 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.healthcare.gov/sbc-glossary or call 1-800-331-6158 to request a copy.

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.	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. Preventive care services by a preferred provider and certain hospice 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?	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.
What is the out-of-pocket limit for this plan?	$3,300 person / $6,600 family for preferred providers per calendar year. No limit for non-preferred 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 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, balance-billed charges, health care this plan doesn't cover, services provided by non-preferred providers, Tier 3 non-formulary brand prescription drugs, private duty nursing, penalties, dental, and	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Important Questions	Answers	Why This Matters:
	vision.	
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind and select "Aetna Choice® POS II (Open Access)" for a list of network providers. See www.nationalvision.com For a list of vision 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
		Preferred Provider (You will pay the least)	Non-Preferred 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	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No Charge Deductible does not apply	40% coinsurance	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	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.savrx.com.	Generic drugs (Tier 1)	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 person/$6,600 family annual out-of-pocket limit.
	Preferred brand drugs (Tier 2)	30% coinsurance	30% coinsurance	
	Non-preferred brand drugs (Tier 3)	40% coinsurance	40% coinsurance	
	Specialty drugs (Tier 4)	Based on Tier level	Based on Tier level	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization 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	Emergency room care	20% coinsurance	20% coinsurance	Penalty of $200 applies except for accidental

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
medical attention				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	Preauthorization required. Penalty of 50% reduction in benefits for non-compliance up to a maximum of $250 for non-emergency treatment.
	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	None
	Inpatient services	20% coinsurance	40% coinsurance plus penalty up to $500 or 50% of expense	Preauthorization required. Penalty of 50% reduction in benefits for non-compliance up to a maximum of $250.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	No coverage for a dependent child or child of dependent child.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility 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 unless medically necessary treatment of a mental disorder.
	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	Preauthorization required for costs over $200. Limited to $2,000 per covered person per calendar year.
	Hospice services	No Charge Deductible does not	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
		apply		
If your child needs dental or eye care	Children's eye exam	No Charge	Charges in excess of $90 scheduled benefit	Limited to once every 12 months.
	Children's glasses	No Charge	Charges in excess of scheduled benefit of $90 for single vision lens / $100 for frames	Limited to once every 12 months for lenses and once every 24 months for frames. Non-preferred provider charges are limited to scheduled amounts.
	Children's 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 Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery (except for 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
- 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (Alternative care is limited to a maximum of $500 per person per year)
- Chiropractic Care (Limited to 25 visits/year and $25/visit)
- Dental Care (Adult)
- Non-emergency care when traveling outside the U.S. (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: 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 1-866-444-3272 or www.dol.gov/ebsa/healthreform and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x 61565 or www.cciio.cms.gov. 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 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or contact the Administration Office at 1-206-441-7574 or 1-800-331-6158.
Additionally, a consumer assistance program can help you file your appeal. Contact Washington Consumer Assistant Program at 1-800-562-6900 or www.insurance.wa.gov.

Does this plan 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 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 1-800-331-6158.

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	$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	
Deductibles	$300
Copayments	$0
Coinsurance	$2,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,960

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,160

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$700

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