




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](http://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](http://www.healthcare.gov/sbc-glossary) or call 1-800-331-6158 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p>Medical - <u>Preferred providers</u>: \$300 person/\$600 family. <u>Non-preferred providers</u>: \$600 person/ \$1,200 family.</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. <a href="#">Preventive care</a> services by a <u>preferred provider</u> and certain <u>hospice services</u> are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without cost sharing and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>Yes, \$50 for the Traditional Dental Plan.                      There are no other specific <a href="#">deductibles</a>.</p>	<p>You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p>\$3,300 person / \$6,600 family for <u>preferred providers</u> per calendar year. No limit for <u>non-preferred providers</u>.                      For Tiers 1 &amp; 2 <u>prescription drugs</u>: \$3,300 person/ \$6,600 family, per calendar year. No limit for Tier 3.</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p><a href="#">Premiums</a>, <u>balance-billed</u> charges, health care this <a href="#">plan</a> doesn't cover, services provided by <u>non-preferred providers</u>, Tier 3 non-formulary brand <u>prescription drugs</u>, private duty nursing, penalties, dental, and</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

Important Questions	Answers	Why This Matters:
	vision.	
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> and select "Aetna Choice® POS II (Open Access)" for a list of <a href="#">network providers</a> . See <a href="http://www.nationalvision.com">www.nationalvision.com</a> For a list of vision <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Combined benefit for Naturopathic Therapy, Acupuncture and Massage Therapy limited to \$1,000 per covered person per calendar year.
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.savrx.com">www.savrx.com</a> .	Generic drugs (Tier 1)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	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 <a href="#">out-of-pocket limit</a> .
	Preferred brand drugs (Tier 2)	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Non-preferred brand drugs (Tier 3)	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Specialty drugs</a> (Tier 4)	Based on Tier level	Based on Tier level	
If you have outpatient	Facility fee (e.g., ambulatory)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required. Penalty of 50%

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)	
surgery	surgery center)			reduction in benefits for non-compliance up to a maximum of \$250.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Penalty of \$200 applies except for accidental injury or direct admission to the hospital.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> plus penalty up to \$500 or 50% of expense	<a href="#">Preauthorization</a> required. Penalty of 50% reduction in benefits for non-compliance up to a maximum of \$250 for non-emergency treatment.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> plus penalty up to \$500 or 50% of expense	<a href="#">Preauthorization</a> required. Penalty of 50% reduction in benefits for non-compliance up to a maximum of \$250.
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	No coverage for a dependent child or child of dependent child.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Maximum of 130 visits per year.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Outpatient visits limited to 40 per year unless treatment of a mental disorder.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Outpatient visits limited to 40 per year unless treatment of a mental disorder.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Maximum of 120 days.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required for costs over \$200.
	<a href="#">Hospice services</a>	No Charge <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	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)	
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. <u>Non-preferred provider</u> 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](#).)**

<ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Cosmetic Surgery (except for correct function disorder)</li> <li>• Hearing Aids</li> <li>• Infertility Treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Habilitation Services, except for treatment of congenital birth defects or mental health conditions</li> <li>• Injury or Illness for which a third-party may be responsible</li> <li>• Long Term Care</li> <li>• Routine Foot Care</li> </ul>	<ul style="list-style-type: none"> <li>• 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.)</li> <li>• Weight Loss Programs, except ACA mandated preventive care</li> <li>• Work related injury or illness</li> </ul>
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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

<ul style="list-style-type: none"> <li>• Acupuncture (Alternative care is limited to a maximum of \$1,000 per person per year)</li> <li>• Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Male sterilization</li> <li>• Non-emergency care when traveling outside the U.S. (care must be medically necessary and considered standard care in the U.S.)</li> </ul>	<ul style="list-style-type: none"> <li>• Private Duty Nursing</li> <li>• Routine Eye Care (Adult)</li> <li>• Spinal treatment (non-surgical)</li> </ul>
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**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](http://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](http://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](http://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](http://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](http://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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$0
Coinsurance	\$2,600
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,960</b>

**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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

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

**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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

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