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 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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
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 covered medical expenses. 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, 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.
Will you pay less if you use a network provider?	Not Applicable	This plan does not use a provider network. You can receive covered services from any provider.
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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to usual, customary and reasonable (UCR) amounts. Combined benefit for Naturopathic Therapy, Acupuncture and Massage Therapy limited to $1,000 per covered person per calendar year. Services of alternative providers are eligible only if they are covered expenses under the plan.
	Specialist visit		
	Preventive care/screening/ immunization	No charge if provider accepts Medicare assignment	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. Benefits for providers that do not accept Medicare assignment will be subject to UCR.
If you have a test	Diagnostic test (x-ray, blood work)	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Imaging (CT/PET scans, MRIs)		
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	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 (Tier 2)	30% coinsurance	
	Non-preferred brand drugs (Tier 3))	40% coinsurance	
	Specialty drugs (Tier 4)	Based on tier Level	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to UCR. Preauthorization required. Penalty of 50% reduction in benefits for non-compliance up to a maximum of $250.
	Physician/surgeon fees	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to UCR.
If you need immediate medical attention	Emergency room care	No charge if provider accepts Medicare assignment	Penalty of $200 applies except for accidental injury or direct admission to the hospital. Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Emergency medical transportation		
	Urgent care		

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to UCR. Preauthorization required. Penalty of 50% reduction in benefits for non-compliance up to a maximum of $250 for non-emergency treatment.
	Physician/surgeon fees	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to UCR.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Inpatient services	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to UCR. Preauthorization required. Penalty of 50% reduction in benefits for non-compliance up to a maximum of $250.
If you are pregnant	Office visits	No charge if provider accepts Medicare assignment	Benefits for member and spouse only. Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Childbirth/delivery professional services	No charge if provider accepts Medicare assignment	
	Childbirth/delivery facility services		
If you need help recovering or have other special health needs	Home health care	No charge if provider accepts Medicare assignment	Limited to 130 visits per year Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Rehabilitation services	No charge if provider accepts Medicare assignment	Outpatient visits limited to 40 per year Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Habilitation services	No charge if provider accepts Medicare assignment	Outpatient visits limited to 40 per year unless treatment of a mental disorder. Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Skilled nursing care	No charge if provider accepts Medicare assignment	Limited to 120 days. Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Durable medical equipment	No charge if provider accepts Medicare assignment	Preauthorization required for costs over $200. Benefits for providers that do not accept Medicare assignment will be subject to UCR.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
	Hospice services	No charge if provider accepts Medicare assignment		Benefits for providers that do not accept Medicare assignment will be subject to UCR.
If your child needs dental or eye care		PPO Provider	Non-PPO Provider	
	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-PPO 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 treatment of congenital birth defects or mental health conditions
- 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 $1,000 per person per year)
- Dental Care (Adult)
- Male sterilization
- 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)
- Spinal treatment (non-surgical)

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 1-800-331-6158.
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	$0
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Coinsurance	$10
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$70

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 coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
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 coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$0

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