

 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, contact Carpenters Trusts: 1-800-552-0635 or [www.ctww.org](http://www.ctww.org). For general definitions of common terms, such as [allowed amount](#), [balanced billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at [www.ctww.org](http://www.ctww.org) or call 1-800-552-0635 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <a href="#">deductible</a> ?	\$200 individual / \$400 family	Generally, you must pay all the costs from <a href="#">providers</a> 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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	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 network <a href="#">preventive services</a> without <a href="#">cost-sharing</a> 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> .
Are there other <a href="#">deductibles</a> for specific services?	No	
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$4,000 individual / \$8,000 family; \$2,850 individual / \$5,700 family for prescriptions; for <a href="#">non-network providers</a> there is no <a href="#">out-of-pocket limit</a> .	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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> for certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, <a href="#">non-network coinsurance</a> and <a href="#">copayments</a> , and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.regence.com/go/OR/Preferred">www.regence.com/go/OR/Preferred</a> or call 1-888-367-2116 for a list of <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 a <a href="#">non-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use a <a href="#">non-network provider</a> for some services (such as anesthesia and lab work). Check with your <a href="#">provider</a> before you get services.
Do I need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see a <a href="#">specialist</a> without permission from this plan.



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)	Non-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	\$10 office visit <a href="#">copay</a> and 10% <a href="#">coinsurance</a>	\$20 office visit <a href="#">copay</a> and 20% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$10 office visit <a href="#">copay</a> and 10% <a href="#">coinsurance</a>	\$20 office visit <a href="#">copay</a> and 20% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	20% <a href="#">coinsurance</a> . Subject to deductible.	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 preventive. 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)	10% <a href="#">coinsurance</a> /test	20% <a href="#">coinsurance</a> /test	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a> /test	20% <a href="#">coinsurance</a> /test	None
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.Express-Scripts.com">www.Express-Scripts.com</a>	Generic drugs (Tier 1)	\$7 copay/prescription (retail) and \$14 copay/prescription (mail order)	Reimbursed at 100% of "average wholesale price" less appropriate copay	Covers up to a 30-day supply (retail prescription); up to a 90-day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	\$15 copay/prescription (retail) and \$30 copay/prescription (mail order)	Reimbursed at 100% of "average wholesale price" less appropriate copay	
	Non-preferred brand drugs (Tier 3)	\$30 copay/prescription (retail) and \$60 copay/prescription (mail order)	Reimbursed at 100% of "average wholesale price" less appropriate copay	
	Specialty drugs (Tier 4)	\$7/\$15/\$30 copay (retail only)	Not covered	Tiers 1, 2 and 3 copays apply. Preauthorization required.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.ctww.org](http://www.ctww.org)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$50 <a href="#">copay</a> and 10% <a href="#">coinsurance</a>	\$50 <a href="#">copay</a> and 10% <a href="#">coinsurance</a>	Copay waived if admitted to hospital
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$10 office visit <a href="#">copay</a> and 10% <a href="#">coinsurance</a>	\$20 office visit <a href="#">copay</a> and 20% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	\$200 <a href="#">copay</a> and 20% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required. If you don't get <a href="#">precertification</a> , \$50 is deducted from the room and board maximum allowable fee for each day, up to maximum of \$250.
	Physician/surgeon fee	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <a href="#">copay</a> /office visit and 10% <a href="#">coinsurance</a>	\$20 <a href="#">copay</a> /office visit and 20% <a href="#">coinsurance</a>	None
	Inpatient services	10% <a href="#">coinsurance</a>	\$200 <a href="#">copay</a> and 20% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required. If you don't get <a href="#">precertification</a> , \$50 is deducted from the room and board maximum allowable fee for each day, up to maximum of \$250.
If you are pregnant	Office visits	\$10 <a href="#">copay</a> /office visit and 10% <a href="#">coinsurance</a>	\$20 <a href="#">copay</a> /office visit and 20% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain network <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). For participant and spouse only.
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	\$200 <a href="#">copay</a> and 20% <a href="#">coinsurance</a>	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Paid at 100%	Paid at 100%	30 visits/calendar year. <a href="#">Precertification</a> required.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	30 outpatient visits/calendar year for rehabilitation and habilitation services combined. 15 inpatient days/calendar year for rehabilitation and habilitation services combined.
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	30 outpatient visits/calendar year for rehabilitation and habilitation services combined
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	25 days/calendar year
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Precertification</a> required
	<a href="#">Hospice service</a>	Paid at 100%	Paid at 100%	<a href="#">Precertification</a> required
If your child needs dental or eye care	Children's eye exam	Services provided by Vision Service Plan. See <a href="http://www.vsp.com">www.vsp.com</a> .	Services provided by Vision Service Plan. See <a href="http://www.vsp.com">www.vsp.com</a> .	Benefits not available under the Eastern Washington, Idaho, Montana, Wyoming benefit package
	Children's glasses	Services provided by Vision Service Plan. See <a href="http://www.vsp.com">www.vsp.com</a> .	Services provided by Vision Service Plan. See <a href="http://www.vsp.com">www.vsp.com</a> .	Benefits not available under the Eastern Washington, Idaho, Montana, Wyoming benefit package
	Children's dental check-up	Services provided by Delta Dental. See <a href="http://www.deltadentalwa.com">www.deltadentalwa.com</a> .	Services provided by Delta Dental. See <a href="http://www.deltadentalwa.com">www.deltadentalwa.com</a> .	Services provided by Delta Dental. See <a href="http://www.deltadentalwa.com">www.deltadentalwa.com</a> .

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.ctww.org](http://www.ctww.org)

## Excluded Services and 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](#).)

- Cosmetic Surgery
- Experimental and Investigative Services
- Infertility Treatment
- Long-term Care
- Intentionally Self-Inflicted Injuries
- Private-Duty Nursing
- Weight Loss Programs
- Routine Foot Care

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Allergy Testing
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Non-Emergency Care When Traveling Outside the U.S.

**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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](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 information about your rights, this notice, or assistance, contact the plan at: 1-800-552-0635. You may also contact the U.S. Department of Labor, Employee Benefits Security.

**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 1-800-552-0635.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-552-0635.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-552-0635.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-552-0635.

————— [To see examples of how this \[plan\]\(#\) might cover costs for a sample medical situation, see the next page.](#) —————

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**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 network pre-natal care and a hospital delivery)

- The [plan's overall deductible](#) \$200
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$70
<a href="#">Coinsurance</a>	\$1,247
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,577</b>

**Managing Joe's Type 2 Diabetes**  
(a year of routine network care of a well-controlled condition)

- The [plan's overall deductible](#) \$200
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

- [Primary care physician](#) 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>	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$60
<a href="#">Coinsurance</a>	\$708
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,028</b>

**Mia's Simple Fracture**  
(network emergency room visit and follow up care)

- The [plan's overall deductible](#) \$200
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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>	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$50
<a href="#">Coinsurance</a>	\$165
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$415</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services