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**. 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** or call **1-800-552-0635** to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$200 individual / $400 family	Generally, you must pay all 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 and primary care 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 network 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?	No	
What is the out-of-pocket limit for this plan?	For network providers $4,000 individual / $8,000 family; $2,850 individual / $5,700 family for prescriptions; for non-network providers there is no out-of-pocket limit.	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?	Copayments for certain services, premiums, balance-billing charges, non-network coinsurance and copayments, and health care this plan doesn't cover.	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?	Yes. See **www.regence.com/go/OR/Preferred or call 1-888-367-2116** for a list of 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 a non-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 a non-network provider for some services (such as anesthesia and lab work). Check with your provider before you get services.
Do I need a referral to see a specialist?	No	You can see a specialist 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 copay and 10% coinsurance	$20 office visit copay and 20% coinsurance	None
	Specialist visit	$10 office visit copay and 10% coinsurance	$20 office visit copay and 20% coinsurance	None
	Preventive care/screening/ immunization	No charge	20% coinsurance. Subject to deductible.	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)	10% coinsurance/test	20% coinsurance/test	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance/test	20% coinsurance/test	None
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.Express-Scripts.com**	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

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% coinsurance	20% coinsurance	None
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	$50 copay and 10% coinsurance	$50 copay and 10% coinsurance	Copay waived if admitted to hospital
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	$10 office visit copay and 10% coinsurance	$20 office visit copay and 20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	$200 copay and 20% coinsurance	Precertification is required. If you don't get precertification, $50 is deducted from the room and board maximum allowable fee for each day, up to maximum of $250.
	Physician/surgeon fee	10% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/office visit and 10% coinsurance	$20 copay/office visit and 20% coinsurance	None
	Inpatient services	10% coinsurance	$200 copay and 20% coinsurance	Precertification is required. If you don't get precertification, $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 copay/office visit and 10% coinsurance	$20 copay/office visit and 20% coinsurance	Cost sharing does not apply to certain network preventive services. Depending on the type of services, coinsurance 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% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	$200 copay and 20% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at 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 need help recovering or have other special health needs	Home health care	Paid at 100%	Paid at 100%	30 visits/calendar year. Precertification required.
	Rehabilitation services	10% coinsurance	20% coinsurance	30 outpatient visits/calendar year for rehabilitation and habilitation services combined. 15 inpatient days/calendar year for rehabilitation and habilitation services combined.
	Habilitation services	10% coinsurance	20% coinsurance	30 outpatient visits/calendar year for rehabilitation and habilitation services combined
	Skilled nursing care	10% coinsurance	20% coinsurance	25 days/calendar year
	Durable medical equipment	10% coinsurance	20% coinsurance	Precertification required
	Hospice service	Paid at 100%	Paid at 100%	Precertification required
If your child needs dental or eye care	Children's eye exam	Services provided by Vision Service Plan. See www.vsp.com.	Services provided by Vision Service Plan. See www.vsp.com.	Benefits not available under the Eastern Washington, Idaho, Montana, Wyoming benefit package
	Children's glasses	Services provided by Vision Service Plan. See www.vsp.com.	Services provided by Vision Service Plan. See www.vsp.com.	Benefits not available under the Eastern Washington, Idaho, Montana, Wyoming benefit package
	Children's dental check-up	Services provided by Delta Dental. See www.deltadentalwa.com.	Services provided by Delta Dental. See www.deltadentalwa.com.	Services provided by Delta Dental. See www.deltadentalwa.com.

* For more information about limitations and exceptions, see the plan or policy document at 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	▪ Long-term Care	▪ Weight Loss Programs
▪ Experimental and Investigative Services	▪ Intentionally Self-Inflicted Injuries	▪ Routine Foot Care
▪ Infertility Treatment	▪ Private-Duty Nursing	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
▪ Allergy Testing	▪ Chiropractic Care	▪ Non-Emergency Care When Traveling Outside the U.S.
▪ Bariatric Surgery	▪ Hearing Aids	

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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance 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 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.

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

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

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

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

* For more information about limitations and exceptions, see the plan or policy document at www.ctww.org

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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$70
Coinsurance	$1,247
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,577**

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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$60
Coinsurance	$708
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,028**

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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$50
Coinsurance	$165
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$415**

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