Carpenters Health and Security Plan of Western Washington: Employee Coverage

Coverage Period: 4/1/2017 – 12/31/2017

Summary of Benefits and Coverage: What This Plan Covers and What It Costs **Coverage for:** Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the plan document at **www.ctww.org** or by calling **1-800-552-0635.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$200** person / **$400** family Does not apply to network preventive care or prescriptions	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. The **deductible** starts over on January 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$4,000** person / **$8,000** family for medical services. Includes deductible, coinsurance, and office visit and emergency copayments. **$2,850** person / **$5,700** family for prescriptions.	The **out-of-pocket limit** applies to network services only and is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. There is no out-of-pocket limit for non-network services.
What is not included in the out-of-pocket limit?	Premiums, non-network coinsurance and copayments, balance-billed charges, prescription copays, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.aetna.com or call 1-800-552-0635** for a list of participating providers.	If you use a network doctor or other network health care **provider,** this plan will pay some or all of the costs of covered services, except for health care this plan doesn't cover. Be aware, your network doctor or hospital may use a non-network **provider** for some services. Plans use the term network, **preferred,** or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.**

Questions: Call **1-800-552-0635** or visit us at **www.ctww.org.**
If you aren't clear about any of the underlined terms used in this form, see the Glossary in the plan booklet.
You can view the Glossary of Terms at **www.ctww.org** or call 1-800-552-0635 to request a copy.

Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 10% would be $100. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use preferred **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
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
	Other practitioner office visit	20% coinsurance for chiropractor	20% coinsurance for chiropractor	24 spinal manipulations annually
	Preventive care/screening/ immunization	Paid at 100%	Paid at 80%. Subject to deductible.	Use Preventive Health Benefit Schedule. See www.healthcare.gov/ preventive-care-benefits.
If you have a test	Diagnostic test (blood work, pathology)	10% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	None

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
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	$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); 31-90 day supply (mail order prescription)
	Preferred brand drugs	$15 copay/prescription (retail) and $30 copay/prescription (mail order)	Reimbursed at 100% of "average wholesale price" less appropriate copay	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Preauthorization required for specialty drugs.
	Non-preferred brand drugs	$30 copay/prescription (retail) and $60 copay/prescription (mail order)	Reimbursed at 100% of "average wholesale price" less appropriate copay	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Preauthorization required for specialty drugs.
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 services	$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 required
	Physician/surgeon fee	10% coinsurance	20% coinsurance	None

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	$10 office visit copay and 10% coinsurance	$20 office visit copay and 20% coinsurance	None
	Mental/behavioral health inpatient services	10% coinsurance	$200 copay and 20% coinsurance	Precertification required
	Substance use disorder outpatient services	10% coinsurance	20% coinsurance	None
	Substance use disorder inpatient services	10% coinsurance	$200 copay and 20% coinsurance	Precertification required
If you are pregnant	Prenatal and postnatal care	10% coinsurance	20% coinsurance	For the participant or spouse only
	Delivery and all inpatient services	10% coinsurance	$200 copay and 20% coinsurance	For the participant or spouse only. Baby has separate charges.
If you need help recovering or have other special health needs	Home health care	Paid at 100%	Paid at 100%	Maximum 30 visits per calendar year. Precertification required.
	Rehabilitation services	10% coinsurance	20% coinsurance	Maximum 30 outpatient visits per calendar year for rehabilitation and habilitation services combined. Maximum 15 inpatient days per calendar year for rehabilitation and habilitation services combined.
	Habilitation services	10% coinsurance	20% coinsurance	Maximum 30 outpatient visits per calendar year for rehabilitation and habilitation services combined
	Skilled nursing care	10% coinsurance	20% coinsurance	Maximum 25 days per calendar year
	Durable medical equipment	10% coinsurance	20% coinsurance	Precertification required
	Hospice service	Paid at 100%	Paid at 100%	Precertification required

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If your child needs dental or eye care	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
	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
	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.

Excluded Services and Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan document for other excluded services.)

- Cosmetic surgery
- Experimental and investigative services
- Infertility treatment
- Intentionally self-inflicted injuries
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)

- Allergy testing
- Ambulance
- Bariatric surgery
- Hearing aids
- Non-emergency care when traveling outside of the U.S.
- Orthotics

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium,** which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at: 1-800-552-0635. You may also contact your state insurance department, 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.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value.) **This health coverage does meet the minimum value standard for the benefits it provides.**

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance.** For questions about your rights, this notice, or assistance, you can contact the plan at: 1-800-552-0635. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-552-0635.

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

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,420
- **Patient pays** $1,120

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$400
Copays	$30
Coinsurance	$690
Limits or exclusions	$0
Total	**$1,120**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,880
- **Patient pays** $520

Sample care costs:

Prescriptions	$2,900
Medical equipment and supplies	$1,300
Office visits and procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$200
Copays	$90
Coinsurance	$230
Limits or exclusions	$0
Total	**$520**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from network **providers.** If the patient had received care from non-network **providers,** costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles, copayments,** and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

× **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

× **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium,** the more you'll pay in out-of-pocket costs, such as **copayments, deductibles,** and **coinsurance.** You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.