**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, call 1-844-811-6789. 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.dol.gov/ebsa/healthreform or call 1-844-811-6789 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$300** per Individual/**$900** per family. | Generally, you must pay all of the costs from provider 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.** Emergency care, in-network Urgent care, prescription drugs; plus in-network office visits and preventive care from network providers 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 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.** | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Medical: **$1,500** per Individual / $**4,500** per family.<br>Prescription Drugs: **$1,500** per Individual / **$4,500** per family. | 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 does not cover and penalties for failure to obtain preauthorization for services. | 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.aetna.com/docfind and select Aetna Choice® POS II (Open Access) networkhttp://www.premera.com/ 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 an out-of-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 an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **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 |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-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 | $30 copay/visit deductible does not apply; | 30% coinsurance | Chiropractic limited to 20 visits per calendar year. Massage therapy limited to 12 visits per calendar year. Massage therapy is not subject to deductible and covered up to $80 per visit subject to copay and coinsurance. |
| | Specialist visit | | | |
| | Preventive care/screening/ immunization | No Charge Deductible does not apply. | 30% coinsurance | 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) | 20% coinsurance | 30% coinsurance | Diagnostic services provided by an out-of-network provider at an in-network facility will be covered as though in-network. |
| | Imaging (CT/PET scans, MRIs) | | | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at caremark.com | Generic drugs | $5 copay/prescription, deductible does not apply: (retail and mail order) | $5 copay/prescription and 30% coinsurance (retail) deductible does not apply | Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics. |
| | Preferred brand drugs | Greater of $5 or 20% of the negotiated charge, not to exceed $80 /prescription, deductible does not apply. (retail and mail order) | Copay of the greater $5 or 20% of the negotiated charge, not to exceed $80 and 30% coinsurance of negotiated charges /prescription, deductible does not apply (retail) | |
| | Non-preferred brand drugs | Greater of $5 or 35% of the negotiated charge, not to exceed $140 /prescription, deductible does not apply (retail and mail order) | Copay of the greater $5 or 35% of the negotiated charge, not to exceed $140 and 30% coinsurance of the negotiated charges/prescription(retail ), deductible does not apply | |



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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Specialty drugs | 30% coinsurance | Not covered | 30-day supply maximum. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 30% coinsurance | None |
| | Physician/surgeon fees | 20% coinsurance | 30% coinsurance | None. |
| **If you need immediate medical attention** | Emergency room care | $100 copay/visit deductible does not apply | $100 copay/visit deductible does not apply | No coverage for non-emergency use. Emergency services provided in response to an emergent condition will be covered the same at in-network or out-of-network facilities. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | No coverage for non-emergency transport. |
| | Urgent care | $50 copay/visit deductible does not apply | $50 copay/visit | No coverage for non-urgent use. Emergency services provided at an out-of-network Urgent Care facility will be covered as though in-network. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $200 copay/stay | $200 copay/stay | Penalty of $400 for failure to obtain preauthorization for out-of-network care. |
| | Physician/surgeon fees | 20% coinsurance | 30% coinsurance | None. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office & other outpatient services: $30 copay/visit deductible does not apply | Office & other outpatient services: 30% coinsurance | None. |
| | Inpatient services | 20% coinsurance after $200 copay/stay | 30% coinsurance | Penalty of $400 for failure to obtain preauthorization for out-of-network care. None. |
| **If you are pregnant** | Office visits | No charge for preventive services. $30 copay/visit deductible does not apply. | 30% coinsurance | Cost-sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply. |
| | Childbirth/delivery professional services | 20% coinsurance | 30% coinsurance | . Penalty of $400 for failure to obtain preauthorization may apply to out-of-network care when in excess of maximum stay requirements for maternity services. |
| | Childbirth/delivery facility services | 20% coinsurance after $200 copay/stay | 30% coinsurance | |
| **If you need help recovering or have** | Home health care | 20% coinsurance | 30% coinsurance | Penalty of $400 for failure to obtain preauthorization for out-of-network care. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **other special health needs** | Rehabilitation services | $30 copay/visit<br>deductible does not apply | 30% coinsurance | 30 visits/calendar year for Physical, Occupational & Speech Therapy combined. |
| | Habilitation services | $30 copay/visit<br>deductible does not apply | 30% coinsurance | Visit limit does not apply to medically necessary treatment of a mental health condition. |
| | Skilled nursing care | 20% coinsurance after<br>$200 copay/stay | 30% coinsurance | 60 days/calendar year. Penalty of $400 for failure to obtain preauthorization for out-of-network care. |
| | Durable medical equipment | 20% coinsurance | 30% coinsurance | Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. |
| | Hospice services | 20% coinsurance | 30% coinsurance | Penalty of $400 for failure to obtain preauthorization for out-of-network care. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | Costs in excess of $102 | 1 routine eye exam/12 months. Vision coverage provided through Vision Service Plan (www.vsp.com). |
| | Children's glasses | No charge | Costs in excess of $108 for frames, $39 for single vision, $62 bifocal lenses, $80 trifocal lenses | $200 maximum/12 months. Vision coverage provided through Vision Service Plan (www.vsp.com). |
| | Children's dental check-up | Not covered | Not covered | None – Covered under Active Dental Plan only |

## 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
- Dental care (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Over the counter Foot Orthotics and orthotics for dependents and retired employees
- Private-duty nursing
- Routine foot care
- Weight loss programs - Except for required preventive services
- Work related injuries or illnesses

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

- Acupuncture
- Chiropractic Care (20 visits/calendar year)
- Foot orthotics for Active Employees only, limited to $200 per calendar year
- Infertility treatment – Limited to the diagnosis & treatment of underlying medical condition
- Massage
- Routine eye care (Adult) – see www.vsp.com

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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 x61565 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 on how 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Trust Administration Office at 1-844-811-6789.

**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 1-844-811-6789.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-811-6789.

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



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

## 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 *copayment*** | **$30** |
| **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)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $70 |
| Coinsurance | $500 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$930** |

### 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 *copayment*** | **$30** |
| **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)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $400 |
| Coinsurance | $700 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,420** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$300** |
| **Specialist *copayment*** | **$30** |
| **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)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $300 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$900** |

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