




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](http://www.dol.gov/ebsa/healthreform) or call 1-844-811-6789 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<b>\$300</b> per Individual/ <b>\$900</b> per family.	Generally, you must pay all of the costs from <a href="#">provider</a> up to the <a href="#">deductible</a> amount before this plan 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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	<b>Yes.</b> 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 <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 plan covers certain <a href="#">preventive</a> services without cost sharing 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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	<b>No.</b>	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<u>Medical</u> : <b>\$1,500</b> per Individual / <b>\$4,500</b> per family. <u>Prescription Drugs</u> : <b>\$1,500</b> per Individual / <b>\$4,500</b> per family.	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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<u>Premiums</u> , <u>balance-billed</u> charges, health care this plan does not cover and penalties for failure to obtain <u>preauthorization</u> for services.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	<b>Yes.</b> See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> and select Aetna Choice® POS II (Open Access) network <a href="http://www.premera.com/">http://www.premera.com/</a> 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 an <a href="#">out-of-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 an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	<b>No.</b>	You can see the <a href="#">specialist</a> 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 <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	No <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply;	30% <a href="#">coinsurance</a>	Chiropractic limited to 20 visits per calendar year. Massage therapy limited to 12 visits per calendar year. Massage therapy is not subject to <a href="#">deductible</a> and covered up to \$80 per visit.  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.
	<a href="#">Specialist</a> visit			
	<a href="#">Preventive care/screening/immunization</a>	No Charge <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a>	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	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 <a href="#">prescription drug coverage</a> is available at <a href="#">caremark.com</a>	Generic drugs	\$5 <a href="#">copay</a> /prescription, <a href="#">deductible</a> does not apply: (retail and mail order)	\$5 <a href="#">copay</a> /prescription and 30% <a href="#">coinsurance</a> (retail) <a href="#">deductible</a> 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, <a href="#">deductible</a> does not apply. (retail and mail order)	Copay of the greater \$5 or 20% of the negotiated charge, not to exceed \$80 and 30% <a href="#">coinsurance</a> of negotiated charges /prescription, <a href="#">deductible</a> does not apply (retail)	
	Non-preferred brand drugs	Greater of \$5 or 35% of the negotiated charge, not to exceed \$140 /prescription, <a href="#">deductible</a> does not apply (retail and mail order)	Copay of the greater \$5 or 35% of the negotiated charge, not to exceed \$140 and 30% <a href="#">coinsurance</a> of the negotiated charges/prescription(retail), <a href="#">deductible</a> does not apply	

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\* 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)	
	<a href="#">Specialty drugs</a>	30% <a href="#">coinsurance</a>	Not covered	30-day supply maximum.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply	\$100 <a href="#">copay</a> /visit <a href="#">deductible</a> 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.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	No coverage for non-emergency transport.
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply	\$50 <a href="#">copay</a> /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 <a href="#">copay</a> /stay	\$200 <a href="#">copay</a> /stay	Penalty of \$400 for failure to obtain <a href="#">preauthorization</a> for out-of-network care.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: No <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply	Office & other outpatient services: 30% <a href="#">coinsurance</a>	None.
	Inpatient services	20% <a href="#">coinsurance</a> after \$200 <a href="#">copay</a> /stay	30% <a href="#">coinsurance</a>	Penalty of \$400 for failure to obtain <a href="#">preauthorization</a> for out-of-network care. None.
If you are pregnant	Office visits	No charge for preventive services. No <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply.	30% <a href="#">coinsurance</a>	<a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Penalty of \$400 for failure to obtain <a href="#">preauthorization</a> may apply to out-of-network care when in excess of maximum stay requirements for maternity services.
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> after \$200 <a href="#">copay</a> /stay	30% <a href="#">coinsurance</a>	
If you need help recovering or have	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Penalty of \$400 for failure to obtain <a href="#">preauthorization</a> for out-of-network care.

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\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.nwinsulationtrust.com](http://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)	
<b>other special health needs</b>	<a href="#">Rehabilitation services</a>	No <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	30 visits/calendar year for Physical, Occupational & Speech Therapy combined. Visit limit does not apply to medically necessary treatment of a mental health condition.
	<a href="#">Habilitation services</a>	No <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> after \$200 <a href="#">copay</a> /stay	30% <a href="#">coinsurance</a>	60 days/calendar year. Penalty of \$400 for failure to obtain <a href="#">preauthorization</a> for out-of-network care.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Limited to 1 <a href="#">durable medical equipment</a> for same/similar purpose. Excludes repairs for misuse/abuse.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Penalty of \$400 for failure to obtain <a href="#">preauthorization</a> for out-of-network care.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Costs in excess of \$102	1 routine eye exam/12 months. Vision coverage provided through Vision Service Plan ( <a href="http://www.vsp.com">www.vsp.com</a> ).
	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 ( <a href="http://www.vsp.com">www.vsp.com</a> ).
	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](http://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](http://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](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 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](http://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.*

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](#) \$0
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$1000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,560</b>

### 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](#) \$0
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,120</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$300
- [Specialist copayment](#) \$0
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$700</b>

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