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 1-800-331-6158. 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 1-800-331-6158 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$350** individual / **$700** family (Deductibles applied in October, November, December will also apply to the next calendar year's deductible.)	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.** Preventive care and primary care services provided by a Preferred Provider 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.
Are there other deductibles for specific services?	**Yes. $50** per person for dental services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$2,000** person for Preferred Providers. **$4,000** person for Non-Preferred Providers.	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, prescription drugs, penalties for failure to obtain preauthorization, skilled nursing care, copay, deductibles, and charges in excess of allowed amounts.	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.premera.com or call 800-810-BLUE (2583) 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. Participants will only be liable for the in-network cost share for non-network emergency services, non-network providers at in-network facilities, and non-network air ambulance 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	$25 copay/visit Deductible does not apply	20% coinsurance	All services must be medically necessary. Chiropractic limited to 20 visits per year. Acupuncture must be performed by an MD for pain management and anesthesia only. Outpatient therapy subject to copayment.
	Specialist visit	$25 copay/visit	20% coinsurance	
	Preventive care/screening/ immunization	Charges in excess of $200; No cost for dependents under age 12	Charges in excess of $200; No cost for dependents under age 12; Charges in excess of UCR	There is a $200 calendar year limit on routine physicals for participants age 12 and over. Immunizations, routine lab and x-ray and cancer screenings subject to a 20% coinsurance or 50% coinsurance for services performed by a Non-Preferred hospital. 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)	$25 copay	50% coinsurance for facility fees / 20% coinsurance for physician fees	Pap smears limited to 1 per year. Prostate Specific Antigen (PSA) for ages 50 & over limited to once every 5 years. Mammogram under age 50 covered 1 time every 2 years. Age 50 & over covered once every year.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	$15 copay/prescription for retail $30 copay/prescription for mail order Deductible does not apply.	100% coinsurance	Covers up to a 34-day supply (retail prescription); 35 – 90-day supply (mail order prescription). Covers up to a 90-day supply of maintenance drugs with mail order copay at retail Rx90 pharmacies. Brand drugs when a generic is available you pay the difference in cost between the generic and brand plus brand copay. If you fill your prescription at a non-Network Pharmacy you must pay full cost of prescription and file a claim for reimbursement with OptumRx.
	Preferred brand drugs	$25 copay/prescription for retail $50 copay/prescription for mail order Deductible does not apply.	100% coinsurance	
	Non-preferred brand drugs	$50 copay/prescription for retail	100% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
		$100 copay/prescription for mail order Deductible does not apply.		Contraceptive prescription drugs and devices are covered under the Plan's prescription drug benefit without a prior authorization requirement for all eligible participants and dependents. All contraceptive methods are subject to the prescription deductible and applicable coinsurance. Contraceptive procedures that are covered under the Medical Plan are subject to all standard plan benefits including deductible and coinsurance.
	Specialty drugs	Same as generic/brand benefit Deductible does not apply.	100% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	All services must be medically necessary.
	Physician/surgeon fees	$25 copay	20% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	50% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	To the nearest hospital equipped to furnish the necessary treatment.
	Urgent care	$25 copay/visit	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization required except when Medicare is prime and emergency admits of less than 24 hours. If preauthorization is not obtained, penalty of 50% not to exceed $500 applies.
	Physician/surgeon fees	$25 copay	20% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit	50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization required except when Medicare is prime, and emergency admits of less than 24 hours. If preauthorization is not obtained, penalty of 50%, not to exceed $500 applies.
If you are pregnant	Office visits	$25 copay/visit	20% coinsurance	No coverage for a dependent child or child of dependent child. Depending on the type of services, a copayment, or deductible may apply.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance for physician fees/50% coinsurance for facility	

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)	
			fees	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance for physician fees / 50% coinsurance for facility fees	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Treatment plan and letter of necessity required.
	Rehabilitation services	20% coinsurance	50% coinsurance	Preauthorization required for inpatient. If preauthorization is not obtained benefits are reduced by 50%, not to exceed $500.
	Habilitation services	Not Covered	Not Covered	Neurodevelopmental therapy available to dependent children age 6 and under, $2,000 maximum benefit.
	Skilled nursing care	50% coinsurance	50% coinsurance	Covered if within 14 days following a covered inpatient hospital stay of at least 3 days. Limited to 70 days.
	Durable medical equipment	20% coinsurance	20% coinsurance	Requires a prescription.
	Hospice services	No Charge Deductible does not apply.	No Charge Deductible does not apply.	Limited to $7,500 lifetime benefit
If your child needs dental or eye care	Children's eye exam	$25 copay/exam	Fees in excess of $40	Limited to one exam every 12 months
	Children's glasses	Fees in excess of $120 for frames and single vision lenses	Fees in excess of $40 for single vision lenses and fees in excess of $46 for frames	Lenses limited to once every 12 months. Frames are limited to once every 24 months.
	Children's dental check-up	20% or usual, customary and reasonable charges Deductible does not apply.	Not Covered	Participants age 12 and over subject to $2,000 calendar year maximum.

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.)

- Acupuncture
- Bariatric Surgery (unless medically necessary for morbid obesity)
- Cosmetic Surgery (except to correct function or disorder)
- Habilitation Services (except for treatment of neurodevelopmental disabilities in children age 6 and under)
- Infertility Treatment
- Long-term Care
- Massage Therapy
- Routine Foot Care
- Weight Loss Programs
- Work related injury or illness

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

- Chiropractic Care (limited to 20 visits per year)
- Hearing Aids (limited to $3,000 per ear every 36 months – eligible for Active (non-apprentice, Retiree, and Dependents. Deductible and Out-of-Pocket Maximum do not apply.)
- Dental Care (Adult)
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult – provided through VSP)

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 1-800-331-6158.

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 1-800-331-6158.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-331-6158.

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.nwrooferstrust.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	**$350**
Specialist *copay*	**$25**
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	$350
Copayments	$10
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,420**

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

The plan's overall deductible	**$350**
Specialist *copay*	**$25**
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	$350
Copayments	$700
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,170**

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

The plan's overall deductible	**$350**
Specialist *copay*	**$25**
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	$350
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$750**

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