




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 1.800.852.4877 or visit us at www.myCBS.org/health or email at hbscustomerservice@cbservices.org. 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.healthcare.gov/sbc-glossary/ or call 1.800.852.4877 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>Medical Only In-Network \$750 Individual / \$2,250 Family Medical Only Out-of-Network \$750 Individual / \$2,250 Family In-Network & Out-of-Network <u>deductibles</u> do not reduce each other.</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
<p>Are there services covered before you meet your <u>deductible</u>?</p>	<p>Yes. For <u>Preventive care</u> services, the In-Network <u>deductible</u> does not apply.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount, but a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>Yes. \$100 / Individual for <u>prescription drugs</u>. Applies to Retail & Mail. There are no other specific <u>deductibles</u>.</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.</p>
<p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p>	<p>Combined Medical & Prescription Drug In-Network \$3,500 Individual / \$7,000 Family Medical Out-of-Network \$4,500 Individual / \$9,000 Family In-Network & Out-of-Network <u>out-of-pocket limits</u> do not reduce each other.</p>	<p>The <u>out-of-pocket</u> limit is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>

This document is subject to change based on the Trust Plan effective January 1 through December 31. The actual amount of benefits, if any, is subject to all plan provisions at the time of service, including eligibility, plan limitations and exclusions. For more information about limitations and exceptions, see the plan or policy document at myCBS.org/health.

What is not included in the <u>out-of-pocket limit</u>?	Premiums, <u>balance-billed</u> charges, <u>deductible</u> , <u>copayment</u> , or <u>coinsurance</u> amounts paid on a covered persons behalf by a foundational or manufacturer sponsored patient, penalty for prescription retail refill allowances, penalty for mandatory generics, penalty for non-notification of hospital admission and other services requiring pre-certification, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the <u>out-of-pocket limits</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. Your network is Aetna Signature Administrators. See myCBS.org/ppo-aetna or call 1.800.852.4877 for a list of participating medical <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's office</u> or <u>clinic</u>	Primary care visit to treat an injury or illness	\$30 <u>Copayment</u> / visit; <u>deductible</u> does not apply	40% <u>Coinsurance</u> / visit	Virtual Care (via video or voice) <u>In-Network</u> only.
	<u>Specialist</u> visit	\$30 <u>Copayment</u> / visit; <u>deductible</u> does not apply	40% <u>Coinsurance</u> / visit	Virtual Care (via video or voice) <u>In-Network</u> only. <u>In-Network</u> Allergy injections \$10 <u>Copayment</u> / visit; <u>deductible</u> does not apply.
	<u>Preventive care/screening/immunization</u>	No Charge	40% <u>Coinsurance</u> / visit	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.

This document is subject to change based on the Trust Plan effective January 1 through December 31. The actual amount of benefits, if any, is subject to all plan provisions at the time of service, including eligibility, plan limitations and exclusions. For more information about limitations and exceptions, see the plan or policy document at myCBS.org/health.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab Work – No Charge; <u>deductible</u> does not apply Radiology – 20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Limited to services performed outside physician’s office. Payment may differ based on place of service.
	Imaging (CT/PET scans, MRIs)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Limited to services performed outside physician’s office. Payment may differ based on place of service. Precertification is required. A 25% penalty up to \$300 may apply. Penalty does not apply to <u>out-of-pocket limit</u> .
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myCBS.org/health Log in and click on My Prescription Drugs or call Express Scripts at 800-718-6601. More information about the Smart 90, Generics Member Pays The Difference, <u>Formulary</u> , Retail Refill Allowance and SaveonSP programs is available at: www.myCBS.org/Rx	Generic drugs	\$10 / prescription (retail); \$25 / prescription (mail or Smart90)	Same as In-Network +20% <u>coinsurance</u> penalty	\$100 <u>Deductible</u> must be met before copay applies. Covers up to 30-day supply at retail; 90-day supply mail order or Smart90 prescription. Retail maintenance prescriptions are limited to an initial fill and two refills. If you continue to use retail, outside of the Smart 90 program, you will pay the mail order <u>copayment</u> for a 30-day supply. You may fill a 90-day supply at Walgreens owned retail pharmacies through the Smart90 program. If a generic equivalent is available and a brand-name medication is dispensed for any reason, you will pay the difference in cost plus the brand <u>copayment</u> .
	Preferred brand drugs	\$30 / prescription (retail); \$75 / prescription (mail or Smart90)	Same as In-Network +20% <u>coinsurance</u> penalty	
	Non-preferred brand drugs	\$50 / prescription (retail); \$125 / prescription (mail or Smart90)	Same as In-Network +20% <u>coinsurance</u> penalty	
	<u>Specialty drugs</u>	Generic 10% up to a maximum of \$150 Preferred 20% up to a maximum of \$150 Non-Preferred 20% up to a maximum of \$250 Certain specialty pharmacy drugs are considered non-essential health benefits and <u>copayments</u> may be set to the maximum of above or any available manufacturer-funded copay assistance. For a complete list of non-essential specialty medications, see mycbs.org/health/SaveonSP		

This document is subject to change based on the Trust Plan effective January 1 through December 31. The actual amount of benefits, if any, is subject to all plan provisions at the time of service, including eligibility, plan limitations and exclusions. For more information about limitations and exceptions, see the plan or policy document at myCBS.org/health.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center, hospital)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Limited to services performed outside physician's office. You may be billed amounts in excess of prevailing charges for <u>Out-of-Network Providers</u> . Precertification is required. A 25% penalty up to \$300 may apply. Penalty does not apply to <u>out-of-pocket limit</u> .
	Physician/surgeon fees	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u> – Facility fee	20% <u>Coinsurance</u> after \$250 <u>Copayment</u> ; <u>deductible</u> does not apply	20% <u>Coinsurance</u> after \$250 <u>Copayment</u> ; <u>deductible</u> does not apply	<u>Copayment</u> is waived if admitted.
	<u>Emergency room care</u> – Physician/surgeon fees	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	<u>Emergency room care</u> may include tests and services described elsewhere in the SBC (i.e. <u>Diagnostic tests</u> or <u>Imaging</u> .) You may be billed amounts in excess of prevailing charges for <u>Out-of-Network Providers</u> .
	<u>Emergency medical transportation</u>	20% <u>Coinsurance</u>		For transportation service charges exceeding \$5,000 by ground and/or air, payment will not exceed 150% of Medicare allowance for such incurred expenses. Charges include transportation and medical supplies used during transport.
	<u>Urgent care</u>	Primary Care – \$30 <u>Copayment</u> ; <u>deductible</u> does not apply Free Standing Clinic – 20% <u>Coinsurance</u> Emergency Room – 20% <u>Coinsurance</u> after \$250 <u>Copayment</u> ; <u>deductible</u> does not apply	Primary Care – 40% <u>Coinsurance</u> Free Standing Clinic – 40% <u>Coinsurance</u> Emergency Room – 20% <u>Coinsurance</u> after \$250 <u>Copayment</u> ; <u>deductible</u> does not apply	Payment may differ based on place of service. <u>Deductible</u> and <u>coinsurance</u> applies to <u>urgent care</u> services billed via the emergency room or outpatient clinic.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coinsurance</u> after \$250 <u>Copayment</u> ; <u>deductible</u> does not apply	40% <u>Coinsurance</u> after \$500 <u>Copayment</u> ; <u>deductible</u> does not apply	Precertification is required. A 25% penalty up to \$2,000 may apply. Penalty does not apply to <u>out-of-pocket limit</u> .

This document is subject to change based on the Trust Plan effective January 1 through December 31. The actual amount of benefits, if any, is subject to all plan provisions at the time of service, including eligibility, plan limitations and exclusions. For more information about limitations and exceptions, see the plan or policy document at myCBS.org/health.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None.
	Inpatient services	20% <u>Coinsurance</u> after \$250 <u>Copayment</u> ; <u>deductible</u> does not apply	40% <u>Coinsurance</u> after \$500 <u>Copayment</u> ; <u>deductible</u> does not apply	Precertification is required. A 25% penalty up to \$2,000 may apply. Penalty does not apply to <u>out-of-pocket limit</u> .
If you are pregnant	Office visits	\$30 <u>Copayment</u> / visit; <u>deductible</u> does not apply	40% <u>Coinsurance</u>	<u>Copayment</u> applies to initial prenatal visit only (per pregnancy). <u>Cost sharing</u> does not apply to <u>preventive services</u> .
	Childbirth/delivery professional services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	20% <u>Coinsurance</u> after \$250 <u>Copayment</u> ; <u>deductible</u> does not apply	40% <u>Coinsurance</u> after \$500 <u>Copayment</u> ; <u>deductible</u> does not apply	None.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Limited to 100 visits per year maximum.
	<u>Rehabilitation services</u>	20% <u>Coinsurance</u> / visit	40% <u>Coinsurance</u> / visit	Services for all State Licensed Practitioners, including Acupuncturist & Massage therapist visits, are limited to combined 12 visits per year.
	<u>Habilitation services</u>	Specialist – \$30 <u>Copayment</u> / visit; <u>deductible</u> does not apply Outpatient Facility – 20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Payment may differ based on place of service. Limited to a combined 20 visits per year for all <u>providers</u> , including, but not limited to, physical, occupational and speech therapy. Visit limits apply to <u>Habilitation services</u> only.
	<u>Skilled nursing care</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Limited to 120 day maximum for all confinements resulting from the same or a related illness or injury.
	<u>Durable medical equipment</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Check your <u>plan</u> document for limitations. <u>Orthotics</u> – Limited to \$500 lifetime

This document is subject to change based on the Trust Plan effective January 1 through December 31. The actual amount of benefits, if any, is subject to all plan provisions at the time of service, including eligibility, plan limitations and exclusions. For more information about limitations and exceptions, see the plan or policy document at myCBS.org/health.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Limited to 180 day per year maximum.
If your child needs dental or eye care	Children's eye exam	No charge.	40% <u>Coinsurance</u>	Covered up to age 5.
	Children's glasses	Not covered.		Unless covered by your vision <u>plan</u> .
	Children's dental check-up	Covered under dental plan.		Please refer to your policy or plan document for benefit details.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Contraceptives • Cosmetic surgery • Dental care (Adult) • Eye exam over age 5 	<ul style="list-style-type: none"> • Hearing aids and related charges • Infertility treatment (except initial diagnosis) • Long-term care • Private-duty nursing 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care • Sterilization or Abortion • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> • Bariatric surgery • Chiropractic care (payable per medical necessity as <u>specialist MD</u>). • <u>Habilitation services</u> (payable per medical necessity). • Non-emergency care when traveling outside the U.S. (only when on assignment by ER). • Services provided by State Licensed Practitioners within the scope of license not specifically covered under any other provisions of the medical <u>plan</u>, including Acupuncture, Massage Therapy, and Nutritional Counseling – Limited to 12 combined visits per year for all services. 		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. Church plans are not covered by the Federal COBRA continuation coverage rules. For more information on your rights to continue coverage, contact the plan at 1.800.852.4877. You may also contact your state insurance department. 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 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 the plan at 1.800.852.4877. A list of states with Consumer Assistance Programs is available at cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

This document is subject to change based on the Trust Plan effective January 1 through December 31. The actual amount of benefits, if any, is subject to all plan provisions at the time of service, including eligibility, plan limitations and exclusions. For more information about limitations and exceptions, see the plan or policy document at myCBS.org/health.

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 1.800.852.4877.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1.800.852.4877.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1.800.852.4877.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1.800.852.4877.

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

This document is subject to change based on the Trust Plan effective January 1 through December 31. The actual amount of benefits, if any, is subject to all plan provisions at the time of service, including eligibility, plan limitations and exclusions. For more information about limitations and exceptions, see the plan or policy document at myCBS.org/health.

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 \$750
- Specialist copayment \$ 30
- Hospital (facility) copayment \$250
- 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	\$13,218
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$ 135
Copayments	\$ 860
Coinsurance	\$ 33
<i>What isn't covered</i>	
Limits or exclusions	\$ 60
The total Peg would pay is	\$1,087

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

- The plan's overall deductible \$750
- Specialist copayment \$ 30
- Hospital (facility) copayment \$250
- 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	\$7,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$ 850
Copayments	\$1,000
Coinsurance	\$ 346
<i>What isn't covered</i>	
Limits or exclusions	\$ 55
The total Joe would pay is	\$2,251

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

- The plan's overall deductible \$750
- Specialist copayment \$ 30
- Hospital (facility) copayment \$250
- Other coinsurance 20%

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic tests (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,925
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$ 750
Copayments	\$ 210
Coinsurance	\$ 283
<i>What isn't covered</i>	
Limits or exclusions	\$ 0
The total Mia would pay is	\$1,243

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

This document is subject to change based on the Trust Plan effective January 1 through December 31. The actual amount of benefits, if any, is subject to all plan provisions at the time of service, including eligibility, plan limitations and exclusions. For more information about limitations and exceptions, see the plan or policy document at myCBS.org/health.