




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 1-866-417-4240. 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 1-866-417-4240 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$300</b> person / <b>\$900</b> family. If 2 or more family members are in a common accident, only one <a href="#">deductible</a> will apply.	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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	<b>Yes.</b> Covered preventive care services provided by a Preferred Provider. Teladoc services.	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 services</a> 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> .
Are there other <a href="#">deductibles</a> for specific services?	<b>Yes.</b> <b>\$100/</b> preferred hospital and <b>\$300/</b> non-preferred hospital per admission. Dental: <b>\$25</b> person / <b>\$50</b> family	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Tier I Medical: <b>\$1,000</b> person. Tier II Medical: <b>\$2,000</b> person / <b>\$4,000</b> family (includes <a href="#">deductibles</a> and in network <a href="#">coinsurance</a> ) Prescription Drugs: <b>\$5,150</b> person / <b>\$10,300</b> 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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billed charges, <a href="#">deductibles</a> (Tier 1 only), <a href="#">Prescription Drugs</a> (Tier 1 only) <a href="#">durable medical equipment</a> (Tier 1 only), artificial limbs and implanted devices (Tier 1 only), and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	<b>Yes.</b> See <a href="http://www.premera.com/sharedadmin">www.premera.com/sharedadmin</a> or call (800) 810-BLUE (2583) for a list of <a href="#">network providers</a> (BlueCard PPO). For Teladoc visit <a href="http://www.teladoc.com/premera">www.teladoc.com/premera</a> or call (855) 332-4059.	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.
Do you need a <a href="#">referral</a> to	<b>No.</b>	You can see the <a href="#">specialist</a> you choose without a referral.

Important Questions	Answers	Why This Matters:
see a <a href="#">specialist</a> ?		

 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</a> office or clinic	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> of <a href="#">Allowed Amount</a>	<a href="#">Deductible</a> and <a href="#">coinsurance</a> waived for Teladoc visits. Chiropractic care limited to 25 visits annually. Nutritionist, 4 visit and only with diagnosis of pulmonary or cardiac disease. Massage and Acupuncturist limited to 10 visits per year. Diabetes Education limited to once per lifetime.  <a href="#">Preventive care</a> is defined in accordance with Federal Regulations. 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.	20% <a href="#">coinsurance</a> of <a href="#">Allowed Amount</a>	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> of <a href="#">Allowed Amount</a>	None.
	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="http://www.caremark.com">www.caremark.com</a> .	Generic drugs	Retail: 20% <a href="#">coinsurance</a> /prescription Mail: \$10 <a href="#">copay</a> /prescription.		Covers up to a 34-day supply for a retail prescription and up to a 90-day supply for a mail order prescription. For brand drugs, when a generic is available, the plan pays cost of generic equivalent. <a href="#">Specialty drugs</a> are limited to one fill (30-day supply) per month. New to market Specialty drugs will receive clinical review and require <a href="#">preauthorization</a> . No coverage for drugs available without physician's prescription (except insulin). Non-formulary drugs may not be covered without approval through the preauthorization process. To review preferred <a href="#">prescription drugs</a> ,
	Preferred brand drugs	Retail: 20% <a href="#">coinsurance</a> /prescription Mail: \$30 <a href="#">copay</a> /prescription		
	Non-preferred brand drugs	Retail: 30% <a href="#">coinsurance</a> /prescription Mail: \$50 <a href="#">copay</a> /prescription		
	<a href="#">Specialty drugs</a>	Same as generic/brand benefit		

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)	
				see the formulary at <a href="http://www.caremark.com">www.caremark.com</a> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> of <a href="#">Allowed Amount</a>	<u>Preauthorization</u> is required, the <u>Plan</u> may disallow charges if <u>preauthorization</u> is not obtained. Orthognathic surgery only covered for dependent children.
	Physician/surgeon fees			None.
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> of <a href="#">Allowed Amount</a>	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> of <a href="#">Allowed Amount</a>	Must show medical necessity. Transportation to nearest facility.
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> of <a href="#">Allowed Amount</a>	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)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> of <a href="#">Allowed Amount</a>	<u>Preauthorization</u> is required, the <u>Plan</u> may disallow charges if <u>preauthorization</u> is not obtained.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> of <a href="#">Allowed Amount</a>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> of <a href="#">Allowed Amount</a>	None.
	Inpatient services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> of <a href="#">Allowed Amount</a>	Care must be provided at an approved treatment facility. Inpatient stays require <u>preauthorization</u> , the <u>Plan</u> may disallow charges if <u>preauthorization</u> is not obtained.
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> of <a href="#">Allowed Amount</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services a <a href="#">coinsurance</a> may apply.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> of <a href="#">Allowed Amount</a>	No coverage for dependent child except for ACA preventive services.
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> of <a href="#">Allowed Amount</a>	Licensed birthing facility charges only to extent charges would have been incurred at hospital. No

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)	
				coverage for dependent child except for ACA preventive services.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> of <a href="#">Allowed Amount</a>	Physician certification required.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> of <a href="#">Allowed Amount</a>	To correct the effect of illness or injury. ECG-monitored exercise limited to 12 weeks.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> of <a href="#">Allowed Amount</a>	Coverage limited to the care rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and normal motor development. The <a href="#">Plan</a> also covers habilitative therapy services for autism spectrum and other disorders classified in the current International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) as mental disorders.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> of <a href="#">Allowed Amount</a>	Maximum of 70 days, provided hospitalized at least 5 days and admitted to <a href="#">skilled nursing care</a> within 14 days.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> of <a href="#">Allowed Amount</a>	None.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> of <a href="#">Allowed Amount</a>	Certified fewer than 6 months to live.
If your child needs dental or eye care	Children's eye exam	No charge		Once every year
	Children's glasses	No charge for children under age 19.		Once every 2 years
	Children's dental check-up	Costs in excess of the Dental Schedule (between \$35 and \$47)		The annual maximum of \$1,500 does not apply to dependent children under age 19.

#### 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](#).)**

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| <ul style="list-style-type: none"><li>• Bariatric surgery</li><li>• Benefits when Medicare is or could be primary (This exclusion applies if you are eligible to enroll in Medicare, but fail to do so.)</li></ul> | <ul style="list-style-type: none"><li>• Cosmetic Surgery (except to repair injury or congenital defect)</li><li>• Expenses resulting from work related conditions</li></ul> | <ul style="list-style-type: none"><li>• Infertility treatment</li><li>• Long-term care</li><li>• Routine foot care</li><li>• Weight Loss Programs</li><li>• Work related injury or illness</li></ul> |
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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

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| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Chiropractic Care</li><li>• Dental Care (Adult)</li></ul> | <ul style="list-style-type: none"><li>• Hearing Aids</li><li>• Non-emergency care when traveling outside the U.S.</li></ul> | <ul style="list-style-type: none"><li>• Private-Duty Nursing (if <u>medically necessary</u>)</li><li>• Routine Eye Care (Adult)</li></ul> |
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**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 1-866-417-4240.

**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 1-866-417-4240.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-417-4240.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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:

Cost Sharing	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,000
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,360</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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:

Cost Sharing	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,000
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,320</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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:

Cost Sharing	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$500
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$800</b>

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