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?	$250 per person / $500 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. Teladoc and Preventive care services 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: $4,800 per person / $9,600 per family. Prescription drugs: $1,500 per person / $3,000 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-billing charges, out-of-network (Non-PPO) coinsurance charges, health care this plan doesn't cover, expenses in excess of usual, customary and reasonable (UCR), penalties for failure to follow preauthorization requirements, non-formulary prescription drugs, vision and dental benefits.	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/sharedadmin or call 800-810-BLUE (2583) for a list of network providers. For Teladoc see Teladoc.com/Premera or 1-855-332-4059.	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

Important Questions	Answers	Why This Matters:
		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	$30 copay/visit + 20% coinsurance	$30 copay/visit plus 40% coinsurance of the Allowed Charge	All services must be medically necessary. Copay and deductible waived for Teladoc visits. Massage therapy and acupuncture to a combined limit of the lesser of 15 visits for each benefit or $1,000 per calendar year.
	Specialist visit			
	Preventive care/screening/ immunization	No charge	$30 copay + 40% coinsurance of the Allowed Charge	Preventive benefits are HHS and CDC recommendations. Preventative services provided outside these recommendations are subject to applicable copays and 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 of the Allowed Charge	40% coinsurance of the Allowed Charge	Covered under the inpatient hospital benefit if done inpatient or as a prerequisite to surgery.
	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.express-scripts.com	Generic drugs	Retail: $10 copay/prescription Mail: $10 copay/prescription	Member pays out-of-pocket and must submit to Express Scripts for reimbursement. In-network copays apply	Copay waived for generic FDA approved contraceptives. Covers up to a 30-day supply for a retail prescription and up to a 90-day supply for a mail order prescription. Maintenance medications must be purchased through the Smart90 program or through mail order to receive a 90-day supply of a maintenance
	Preferred brand drugs	Retail: $20 copay/prescription Mail: $20 copay/prescription		

* For more information about limitations and exceptions, see the plan or policy document at www.psbenefitstrust.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)	
	Non-preferred brand drugs	Retail: 50% coinsurance Mail: 50% coinsurance		medication. Specialty medications must be purchased through Accredo Specialty Pharmacy. Rx annual out-of-pocket maximum is $1,500 per person/$3,000 per family for Formulary drugs. There is no out-of-pocket limit for non-formulary drugs.
	Specialty drugs	Same as generic/brand benefit		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance of the Allowed Charge	40% coinsurance of the Allowed Charge	None
	Physician/surgeon fees	20% coinsurance of the Allowed Charge	40% coinsurance of the Allowed Charge	None
If you need immediate medical attention	Emergency room care	$250 copay/visit	$250 copay/visit	Copay waived if admitted within 24 hours.
	Emergency medical transportation	40% coinsurance of the Allowed Charge	40% coinsurance of the Allowed Charge	None
	Urgent care	$30 copay/visit + 20% coinsurance	$30 copay/visit plus 40% coinsurance of the Allowed Charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance of the Allowed Charge	40% coinsurance of the Allowed Charge	Preauthorization is required. If preauthorization is not obtained, the reimbursement rate will be 50%.
	Physician/surgeon fees	20% coinsurance of the Allowed Charge	40% coinsurance of the Allowed Charge	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit + 20% coinsurance	$30 copay/visit plus 40% coinsurance of the Allowed Charge	None
	Inpatient services	20% coinsurance of the Allowed Charge	40% coinsurance of the Allowed Charge	Preauthorization and completion of inpatient program is required. If preauthorization or the treatment program is not completed, the reimbursement rate will be 50%.
If you are pregnant	Office visits	$30 copay/visit + 20% coinsurance deductible does not apply	$30 copay/visit plus 40% coinsurance of the Allowed Charge	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance or copay may apply.
	Childbirth/delivery professional services	20% coinsurance of the Allowed Charge	$30 copay/visit plus 40% coinsurance of the	Ultrasound payable as a diagnostic test. Office visits are generally included in global fee for

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)	
			Allowed Charge	delivery. Maternity benefits for a pregnant dependent child are limited to preventive prenatal and post-natal treatment and treatment of a complication of pregnancy. No coverage for the child of a dependent child.
	Childbirth/delivery facility services	20% coinsurance of the Allowed Charge	40% coinsurance of the Allowed Charge	No coverage for a dependent child or child of dependent child.
If you need help recovering or have other special health needs	Home health care	20% coinsurance of the Allowed Charge	40% coinsurance of the Allowed Charge	None
	Rehabilitation services	20% coinsurance of the Allowed Charge for speech therapy.	40% coinsurance of the Allowed Charge	Referral from treating physician required.
	Habilitation services	$30 copay/visit + 20% coinsurance	40% coinsurance of the Allowed Charge	Habilitative services limited to neurodevelopment treatment of a mental health condition or congenital birth defect.
	Skilled nursing care	20% coinsurance of the Allowed Charge	40% coinsurance of the Allowed Charge	Maximum of 90 days.
	Durable medical equipment	20% coinsurance of the Allowed Charge	40% coinsurance of the Allowed Charge	Rental or purchase of medically necessary equipment. Cost of rental covered up to purchase price.
	Hospice services	20% coinsurance of the Allowed Charge	40% coinsurance of the Allowed Charge	Limited to 30 days inpatient/6 months outpatient.
If your child needs dental or eye care	Children's eye exam	If separate vision plan: costs in excess of $60. $30 copay for preferred/40% coinsurance of Allowed Charge for non-preferred provider		Benefit limited to once every 12 months. Benefit applicable to children up to age 18.
	Children's glasses	Only if provided in the collective bargaining agreement. Lens: Costs in excess of $60 single vision $120 bifocal / $135 trifocal Frames: Costs in excess of $100		Frame benefit limited to once every 24 months. Lens benefit limited to once every 12 months. Benefit applicable to children up to age 18.
	Children's dental check-up	up to 30% of Allowed Charge	Preferred provider coinsurance amount plus any amount in excess of Allowed Charge	Only if provided in the collective bargaining agreement. Benefit applicable to children up to age 18. Older children and adults subject to annual maximum of $2,000/non-preferred provider or $2,500/preferred provider.

Excluded Services & Other Covered Services:

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

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Benefits when Medicare is or could be primary. (This exclusion applies if you are eligible to enroll in Medicare, but fail to do so.) • Cosmetic Surgery (except to correct function disorder)	• Expenses resulting from work related conditions • Hearing Aids • Infertility treatment • Injury or Illness for which a third-party may be responsible	• Long-term care • Pregnancy for a dependent child • Private duty nursing • Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric Surgery • Chiropractic Care	• Dental Care (Adult – if provided for in your CBA) • Non-emergency care when traveling outside the U.S. (care must be medically necessary and considered standard care in the U.S.)	• Routine eye care (Adult) • Weight Loss programs

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.psbenefitstrust.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	$250
Specialist *copay* +*coinsurance*	$30+20%
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	$250
Copayments	$40
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,850

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

The plan's overall deductible	$250
Specialist *copay* +*coinsurance*	$30+20%
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	$250
Copayments	$400
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,670

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

The plan's overall deductible	$250
Specialist *copay* +*coinsurance*	$30+20%
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	$250
Copayments	$300
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,150

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