




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](http://www.dol.gov/ebsa/healthreform) or call 1-800-331-6158 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<b>\$500</b> per person / <b>\$1,000</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>	Yes. Teladoc and <a href="#">Preventive care</a> services 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 preventive services 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>	No.	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>	Medical: <b>\$4,000</b> per person / <b>\$8,000</b> per family. Prescription drugs: <b>\$1,000</b> per person / <b>\$2,000</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>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, out-of-network (Non-PPO) coinsurance charges, health care this <a href="#">plan</a> doesn't cover, expenses in excess of usual, customary and reasonable (UCR), penalties for failure to follow <a href="#">preauthorization</a> requirements, non-formulary <a href="#">prescription drugs</a> , vision and dental benefits.	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>	Yes. 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> . For Teladoc see <a href="http://Teladoc.com/Premera">Teladoc.com/Premera</a> or 1-855-332-4059.	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

Important Questions	Answers	Why This Matters:
		<a href="#">provider</a> 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 <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	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</a> office or clinic	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /visit + 10% <a href="#">coinsurance</a>	\$30 <a href="#">copay</a> /visit plus 40% <a href="#">coinsurance</a> of the Allowed Charge	All services must be medically necessary. Copay and deductible waived for Teladoc visits. Massage therapy, chiropractic and acupuncture limited to a combined maximum of 25 visits per calendar year. No annual maximum.
	<a href="#">Specialist</a> visit			
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">deductible</a> does not apply	\$30 <a href="#">copay</a> + 40% <a href="#">coinsurance</a> of the Allowed Charge	Preventive benefits are HHS and CDC recommendations. Preventative services provided outside these recommendations are subject to applicable <a href="#">copays</a> and <a href="#">coinsurance</a> . 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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a> of the Allowed Charge	40% <a href="#">coinsurance</a> 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 <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	Retail: \$15 <a href="#">copay</a> /prescription Mail: \$15 <a href="#">copay</a> /prescription	Member pays out-of-pocket and must submit to Express Scripts for reimbursement. In-network <a href="#">copays</a> apply	<a href="#">Copay</a> 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
	Preferred brand drugs	Retail: \$15 <a href="#">copay</a> /prescription Mail: \$15 <a href="#">copay</a> /prescription		

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% <a href="#">coinsurance</a> Mail: 50% <a href="#">coinsurance</a>		maintenance medication. Specialty medications must be purchased through Accredo Specialty Pharmacy. Rx annual <u>out-of-pocket maximum</u> is \$1,000 per person/\$2,000 per family for High Performance Formulary drugs. There is no <u>out-of-pocket limit</u> for non-formulary drugs.
	<a href="#">Specialty drugs</a>	Same as generic/brand benefit		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a> of the Allowed Charge	40% <a href="#">coinsurance</a> of the Allowed Charge	None
	Physician/surgeon fees	10% <a href="#">coinsurance</a> of the Allowed Charge	40% <a href="#">coinsurance</a> of the Allowed Charge	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a> /visit	\$250 <a href="#">copay</a> /visit	<a href="#">Copay</a> waived if admitted within 24 hours.
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a> of the Allowed Charge	40% <a href="#">coinsurance</a> of the Allowed Charge	None
	<a href="#">Urgent care</a>	\$30 <a href="#">copay</a> /visit + 10% <a href="#">coinsurance</a>	\$30 <a href="#">copay</a> /visit plus 40% <a href="#">coinsurance</a> of the Allowed Charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a> of the Allowed Charge	40% <a href="#">coinsurance</a> of the Allowed Charge	<a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained, the reimbursement rate will be 50%.
	Physician/surgeon fees	10% <a href="#">coinsurance</a> of the Allowed Charge	40% <a href="#">coinsurance</a> of the Allowed Charge	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <a href="#">copay</a> /visit + 10% <a href="#">coinsurance</a>	\$30 <a href="#">copay</a> /visit plus 40% <a href="#">coinsurance</a> of the Allowed Charge	None
	Inpatient services	10% <a href="#">coinsurance</a> of the Allowed Charge	40% <a href="#">coinsurance</a> of the Allowed Charge	<a href="#">Preauthorization</a> and completion of inpatient program is required. If <a href="#">preauthorization</a> or the treatment program is not completed, the reimbursement rate will be 50%.
If you are pregnant	Office visits	\$30 <a href="#">copay</a> /visit + 10% <a href="#">coinsurance</a>	\$30 <a href="#">copay</a> /visit plus 40% <a href="#">coinsurance</a> of the Allowed Charge	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> or <a href="#">copay</a> may apply.
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a> of the Allowed Charge	\$30 <a href="#">copay</a> /visit plus 40% <a href="#">coinsurance</a> of the Allowed Charge	Ultrasound payable as a diagnostic test. Office visits are generally included in global fee for delivery. Maternity benefits for a pregnant

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.psbenefitstrust.com](http://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)	
				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	10% <a href="#">coinsurance</a> of the Allowed Charge	40% <a href="#">coinsurance</a> of the Allowed Charge	No coverage for a dependent child or child of dependent child.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a> of the Allowed Charge	40% <a href="#">coinsurance</a> of the Allowed Charge	None
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a> of the Allowed Charge for speech therapy.	40% <a href="#">coinsurance</a> of the Allowed Charge	Referral from treating physician required.
	<a href="#">Habilitation services</a>	\$30 <a href="#">copay</a> /visit + 10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> of the Allowed Charge	Habilitative services limited to neurodevelopment treatment of a mental health condition or congenital birth defect.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a> of the Allowed Charge	40% <a href="#">coinsurance</a> of the Allowed Charge	Maximum of 90 days.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> of the Allowed Charge	40% <a href="#">coinsurance</a> of the Allowed Charge	Rental or purchase of medically necessary equipment. Cost of rental covered up to purchase price.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a> of the Allowed Charge	40% <a href="#">coinsurance</a> of the Allowed Charge	Limited to 30 days inpatient/6 months outpatient.
<b>If your child needs dental or eye care</b>	Children's eye exam	If separate vision plan: costs in excess of \$60. \$30 <a href="#">copay</a> for preferred/40% <a href="#">coinsurance</a> 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 \$85 bifocal / \$120 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	<a href="#">Preferred provider coinsurance</a> 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:

### 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](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 1-800-331-6158.

### 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.*

## 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>	\$500
■ <a href="#">Specialist copay</a> + <a href="#">coinsurance</a>	\$30 +10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ 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>	\$250
<a href="#">Copayments</a>	\$30
<a href="#">Coinsurance</a>	\$1,200
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,540</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>	\$500
■ <a href="#">Specialist copay</a> + <a href="#">coinsurance</a>	\$30 +10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ 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>	\$250
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$900
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,470</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>	\$500
■ <a href="#">Specialist copay</a> + <a href="#">coinsurance</a>	\$30 +10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ 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>	\$250
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$500
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,150</b>

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