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, www.unitedemployees.org or (253) 474-1214. 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 1-800-824-4427 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300 Individual $900 Family	Generally, you must pay all of the costs from providers 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?	Preventive Care, Office Visits, Chiropractic Care and prescription drugs	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://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: Network Providers $5,000 Individual / $10,000 Family Out-of-Network providers None Prescription Drugs: $2,900 Individual $5,800 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?	Out-of-network copayments and balance billing charges, pre-auth. penalty, premiums and services the plan does not cover.	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. For a list of network providers see	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

	www.premera.com/sharedadmin or call (800) 810-2583.	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.
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 per visit and 20% coinsurance	$25 copay per visit and 40% coinsurance	None
	Specialist visit	$25 copay per visit and 20% coinsurance	$25 copay per visit and 40% coinsurance	Limited to 24 visits/year for acupuncture, naturopath and massage practitioner.
	Preventive care/screening/ immunization	No Charge	$25 copay per visit 40% coinsurance	None
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.maxorplus.com	Generic drugs	Retail 15% coinsurance Mail Order $15 copay	Retail 15% coinsurance Mail Order $15 copay	Retail covers up to a 30-day supply Mail order covers up to a 90-day supply
	Preferred brand drugs	Retail 30% coinsurance Mail Order $50 copay	Retail 30% coinsurance Mail Order $50 copay	
	Non-preferred brand drugs	Retail 50% coinsurance minimum $50 copay Mail Order $100 copay	Retail 50% coinsurance	
	Specialty drugs	Retail 30% coinsurance Mail Order $50 copay brand drugs; $100 copay non-brand drugs	Retail 30% coinsurance	Retail and Mail Order limited to 30-day supply

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

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization is required. $250 penalty if surgery is not preauthorized
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copay per visit 20% coinsurance	$150 copay per visit 20% coinsurance	$150 copay waived if admitted to hospital
	Emergency medical transportation	20% coinsurance	20% coinsurance	Limited to transport to nearest facility equipped to treat condition
	Urgent care	$25 copay per visit 20% coinsurance	$25 copay per visit 40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required. $250 penalty if in-patient stay is not preauthorized
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay per visit 20% coinsurance	$25 copay per visit 40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required. $250 penalty if in-patient stay is not preauthorized
If you are pregnant	Office visits	$25 copay per visit 20% coinsurance	$25 copay per visit 40% coinsurance	Cost Sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

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

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	120 visits/year
	Rehabilitation services	$25 copay per visit 20% coinsurance	$25 copay per visit 40% coinsurance	48 visits/year. Includes physical therapy, speech therapy and occupational therapy. Copay applies to outpatient services.
	Habilitation services	$25 copay per visit 20% coinsurance	$25 copay per visit 40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	120 visits for same or related condition
	Durable medical equipment	20% coinsurance	40% coinsurance	Orthotics limited to $500 every 24 months Excludes vehicle modifications, home modifications, exercise and bathroom equipment, deluxe equipment.
	Hospice services	20% coinsurance	40% coinsurance	120-day lifetime maximum
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Covered under separate vision plan
	Children's glasses	Not covered	Not covered	Covered under separate vision plan
	Children's dental check-up	Not covered	Not covered	Covered under separate dental plan

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.)

- Bariatric Surgery
- Cosmetic Surgery
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- Routine Foot Care
- Weight Loss Programs

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

- Acupuncture
- Chiropractic Care (24 visits per year, paid at 100% after copay)
- Dental Care (separate plan)
- Hearing Aids (up to $1,000 per aid; no more than two aids every five years)
- Routine Eye Care (separate plan)

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 (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: United Employees Benefit Trust, 220 S 27th St, Suite B, Tacoma WA 98402 or call (253) 474-1214. You may also contact the Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 (253) 474-1214.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (253) 474-1214.
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (253) 474-1214.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (253) 474-1214.

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 plan's overall deductible** **$300**
- **Specialist copayment** **$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	$300
Copayments	0
Coinsurance	$2,410
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,770**

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

- **The plan's overall deductible** **$300**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **20%**
- **Other prescription drug** **15%**

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	$122
Copayments	$130
Coinsurance	$890
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,160**

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

- **The plan's overall deductible** **$300**
- **Specialist copayment** **$25**
- **Hospital (facility) copayment** **$150**
  and 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	$300
Copayments	$280
Coinsurance	$440
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$1,020**

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