




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](http://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](http://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 <u>deductible</u> ?	\$300 Individual \$900 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan 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> .
Are there services covered before you meet your <u>deductible</u> ?	Preventive Care, Office Visits, Chiropractic Care, Prescription Drugs and Routine Eye Care	This plan 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 <a href="https://healthcare.gov/coverage/preventive-care-benefits/">https://healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Medical: <u>Network Providers</u> \$5,000 Individual / \$10,000 Family <u>Out-of-Network providers</u> None <u>Prescription Drugs</u> : \$2,900 Individual \$5,800 Family	The <u>out-of-pocket limit</u> 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.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Out-of-network copayments</u> and <u>balance billing</u> charges, pre-auth. penalty, premiums and services the <u>plan</u> does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. For a list of network providers see <a href="http://www.premiera.com/sharedadmin">www.premiera.com/sharedadmin</a> or call (800) 810-2583.	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 <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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 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	\$25 copay per visit	\$25 <a href="#">copay</a> per visit and 40% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a> per visit	\$25 <a href="#">copay</a> per visit and 40% <a href="#">coinsurance</a>	Limited to 24 visits/year for acupuncture, naturopath and massage practitioner.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	\$25 <a href="#">copay</a> per visit and 40% <a href="#">coinsurance</a>	None
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
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.maxorplus.com">www.maxorplus.com</a>	Generic drugs	Retail 15% <a href="#">coinsurance</a> Mail Order \$15 <a href="#">copay</a>	Retail 15% <a href="#">coinsurance</a> Mail Order \$15 <a href="#">copay</a>	Retail covers up to a 30-day supply Mail order covers up to a 90-day supply
	Preferred brand drugs	Retail 30% <a href="#">coinsurance</a> Mail Order \$50 <a href="#">copay</a>	Retail 30% <a href="#">coinsurance</a> Mail Order \$50 <a href="#">copay</a>	
	Non-preferred brand drugs	Retail 50% <a href="#">coinsurance</a> minimum \$50 <a href="#">copay</a> Mail Order \$100 <a href="#">copay</a>	Retail 50% <a href="#">coinsurance</a>	
	<a href="#">Specialty drugs</a>	Retail 30% <a href="#">coinsurance</a> Mail Order \$50 <a href="#">copay</a> brand drugs; \$100 <a href="#">copay</a> non-brand drugs	Retail 30% <a href="#">coinsurance</a>	Retail and Mail Order limited to 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. \$250 penalty if surgery is not preauthorized
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> per visit 20% <a href="#">coinsurance</a>	\$150 <a href="#">copay</a> per visit 20% <a href="#">coinsurance</a>	\$150 <a href="#">copay</a> waived if admitted to hospital
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Limited to transport to nearest facility equipped to treat condition

\* For more information about limitations and exceptions, see the plan or policy document at [www.unitedemployees.org](http://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)	
	<a href="#">Urgent care</a>	\$25 <u>copay</u> per visit	\$25 <u>copay</u> per visit 40% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required. \$250 penalty if in-patient stay is not preauthorized
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 <u>copay</u> per visit	\$25 <u>copay</u> per visit 40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required. \$250 penalty if in-patient stay is not preauthorized
<b>If you are pregnant</b>	Office visits	\$25 <u>copay</u> per visit	\$25 <u>copay</u> per visit 40% <u>coinsurance</u>	<u>Cost Sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	120 visits/year
	<a href="#">Rehabilitation services</a>	\$25 <u>copay</u> per visit	\$25 <u>copay</u> per visit 40% <u>coinsurance</u>	48 visits/year. Includes physical therapy, speech therapy and occupational therapy. <u>Copay</u> applies to outpatient services.
	<a href="#">Habilitation services</a>	\$25 <u>copay</u> per visit	\$25 <u>copay</u> per visit 40% <u>coinsurance</u>	
	<a href="#">Skilled nursing care</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	120 visits for same or related condition
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Orthotics limited to \$500 every 24 months Excludes vehicle modifications, home modifications, exercise and bathroom equipment, deluxe equipment.
	<a href="#">Hospice services</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	120-day lifetime maximum
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Charges over \$101	Once per calendar year
	Children's glasses	No charge	Charges over \$140	Once per calendar year
	Children's dental check-up	Not covered	Not covered	Covered under separate dental plan

\* For more information about limitations and exceptions, see the plan or policy document at [www.unitedemployees.org](http://www.unitedemployees.org).

## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Bariatric Surgery</li><li>• Cosmetic Surgery</li><li>• Infertility Treatment</li></ul>	<ul style="list-style-type: none"><li>• Long-term Care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Private-duty Nursing</li><li>• Routine Foot Care</li><li>• Weight Loss Programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Chiropractic Care (24 visits per year, paid at 100% after <a href="#">copay</a>)</li></ul>	<ul style="list-style-type: none"><li>• Dental Care (separate plan)</li><li>• Hearing Aids (up to \$1,000 per aid; no more than two aids every five years)</li></ul>	<ul style="list-style-type: none"><li>• Routine Eye Care</li></ul>

**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](http://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](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 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 27<sup>th</sup> 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](http://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, kwijigo 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 \(anesthesia\)](#)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	0
Coinsurance	\$2,410
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,770</b>

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$120
Copayments	\$130
Coinsurance	\$760
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,030</b>

**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](#) and [coinsurance](#) \$150 and 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$280
Coinsurance	\$330
<i>What isn't covered</i>	
Limits or exclusions	\$0.00
<b>The total Mia would pay is</b>	<b>\$910</b>