



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 <https://www.healthcare.gov/sbc-glossary/> or call 1-800-223-2449 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$200 Individual \$600 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 and prescription drugs	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. There is no <u>deductible</u> for prescription drug coverage.
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</u> charge 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> per visit and 10% <a href="#">coinsurance</a>	\$20 <a href="#">copay</a> per visit and 30% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> per visit and 10% <a href="#">coinsurance</a>	\$20 <a href="#">copay</a> per visit and 30% <a href="#">coinsurance</a>	Limited to 24 visits/year for acupuncture, naturopath and massage practitioner.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	\$20 <a href="#">copay</a> per visit 30% <a href="#">coinsurance</a>	None
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
<b>If you need drugs to treat your illness or condition</b> 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="#">coinsurance</a> max of \$15	Retail 15% <a href="#">coinsurance</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 30% <a href="#">coinsurance</a> max of \$50	Retail 30% <a href="#">coinsurance</a>	DAW Copay Differential – If the member or physician requests a brand name drug when a generic equivalent exists, the brand copay plus the cost difference between the brand and generic will apply.
	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> generic or 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 Specialty medications limited to be filled 2 times at retail then Specialty Medications must be filled through Maxor Specialty Pharmacy.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. \$250 penalty if surgery is not preauthorized
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	

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 need immediate medical attention	<a href="#">Emergency room care</a>	\$150 <u>copay</u> per visit 10% <u>coinsurance</u>	\$150 <u>copay</u> per visit 10% <u>coinsurance</u>	\$150 <u>copay</u> waived if admitted to hospital
	<a href="#">Emergency medical transportation</a>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Limited to transport to nearest facility equipped to treat condition
	<a href="#">Urgent care</a>	\$20 <u>copay</u> per visit 10% <u>coinsurance</u>	\$20 <u>copay</u> per visit 30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Preauthorization is required. \$250 penalty if in-patient stay is not preauthorized
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> per visit 10% <u>coinsurance</u>	\$20 <u>copay</u> per visit 30% <u>coinsurance</u>	None
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Preauthorization is required. \$250 penalty if in-patient stay is not preauthorized
If you are pregnant	Office visits	\$20 <u>copay</u> per visit 10% <u>coinsurance</u>	\$20 <u>copay</u> per visit 30% <u>coinsurance</u>	Cost Sharing does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	120 visits/year
	<a href="#">Rehabilitation services</a>	\$20 <u>copay</u> per visit 10% <u>coinsurance</u>	\$20 <u>copay</u> per visit 30% <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>	\$20 <u>copay</u> per visit 10% <u>coinsurance</u>	\$20 <u>copay</u> per visit 30% <u>coinsurance</u>	
	<a href="#">Skilled nursing care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	120 visits for same or related condition
	<a href="#">Durable medical equipment</a>	10% <u>coinsurance</u>	30% <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>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	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 <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 <u>copay</u>)</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 (separate plan)</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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$200
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

**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	
Deductibles	\$200
Copayments	\$0
Coinsurance	\$1,220
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,480</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>	\$200
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">prescription drug</a>	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:**

Cost Sharing	
Deductibles	\$120
Copayments	\$100
Coinsurance	\$850
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,090</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>	\$200
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">copayment</a> and <a href="#">coinsurance</a>	\$150
■ Other <a href="#">coinsurance</a>	10%

**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	
Deductibles	\$200
Copayments	\$250
Coinsurance	\$260
What isn't covered	
Limits or exclusions	\$0.00
<b>The total Mia would pay is</b>	<b>\$710</b>