



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 <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> ?	\$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 https://healthcare.gov/coverage/preventive-care-benefits/
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 www.premiera.com/sharedadmin 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 referral to see a specialist ?	No	You can see the specialist you choose without a referral .
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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 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.VytOneMembers.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	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% 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-preferred brand drugs	Retail 30% coinsurance	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 VytOne Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	

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	Emergency room care	\$150 <u>copay</u> per visit 20% <u>coinsurance</u>	\$150 <u>copay</u> per visit 20% <u>coinsurance</u>	\$150 <u>copay</u> waived if admitted to hospital
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to transport to nearest facility equipped to treat condition
	Urgent care	\$25 <u>copay</u> per visit 20% <u>coinsurance</u>	\$25 <u>copay</u> per visit 40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> per visit 20% <u>coinsurance</u>	\$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.
If you are pregnant	Office visits	\$25 <u>copay</u> per visit 20% <u>coinsurance</u>	\$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>	
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	120 visits/year
	Rehabilitation services	\$25 <u>copay</u> per visit 20% <u>coinsurance</u>	\$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.
	Habilitation services	\$25 <u>copay</u> per visit 20% <u>coinsurance</u>	\$25 <u>copay</u> per visit 40% <u>coinsurance</u>	
	Skilled nursing care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	120 visits for same or related condition
	Durable medical equipment	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.
	Hospice services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	120-day lifetime maximum
If your child needs dental or eye care	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

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 .)		
<ul style="list-style-type: none">• Bariatric Surgery• Cosmetic Surgery• Infertility Treatment	<ul style="list-style-type: none">• Long-term Care• Non-emergency care when traveling outside the U.S.	<ul style="list-style-type: none">• 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.)		
<ul style="list-style-type: none">• Acupuncture• Chiropractic Care (24 visits per year, paid at 100% after copay)	<ul style="list-style-type: none">• Dental Care (separate plan)• Hearing Aids (up to \$3,000 per aid per ear; every three years)	<ul style="list-style-type: none">• Routine Eye Care

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, 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*)

Total Example Cost	\$12,700
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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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$120
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 and coinsurance	\$150
■ 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
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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