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 1-888-563-0665. 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 1-888-563-0665 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,500** Individual / **$3,000** Family.	Generally, you must pay all of the costs from provider 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?	**Yes.** In-network preventive care, outpatient lab and radiology, services that require a copay, prescription drugs and vision services are covered before you meet your deductible..	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://www.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: **$2,250** Individual / $**4,500** Family. Prescription Drugs: $**250** Individual / **$500** 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?	Premiums, balance-billed charges, and health care this 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**. See premera.com/sharedadmin or call 1-800-810-2583 for a list of network providers. For Teladoc see www.Teladoc.com/Premera or 855-332-4059.	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 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	$20 copay/visit Deductible does not apply	40% coinsurance	Copay and deductible waived for Teladoc visits. Spinal manipulations limited to 24 visits per calendar year, Acupuncture limited to 24 visits per calendar year.
	Specialist visit			
	Preventive care/screening/ immunization	No charge Deductible does not apply.	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge Deductible does not apply	40% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	No charge Deductible does not apply	40% coinsurance	Prior authorization recommended for some outpatient imaging tests. Penalty for out-of-network: no penalty.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.savrx.com/?Link=formulary	Generic drugs	$5 copay/prescription (retail); $10 copay/prescription (mail)	$5 copay + 40% coinsurance/prescription (retail)	Covers up to a 30-day supply (retail), covers up to a 90-day supply (mail). No charge for specific preventive drugs. Prior authorization recommended for some drugs. Non-formulary drugs may not be covered without approval through the prior-authorization process.
	Preferred brand drugs	$25 copay/prescription (retail); $50 copay/prescription (mail)	$25 copay + 40% coinsurance/prescription (retail)	Covers up to a 30-day supply (retail), covers up to a 90-day supply (mail). Prior authorization recommended for some drugs.
	Non-preferred brand drugs	$50 copay/prescription (retail); $100 copay/prescription (mail)	$50 copay + 40% coinsurance/prescription (retail)	
	Specialty drugs	Generic: $5 copay/prescription Pref Brand: $25 copay/prescription	Not covered	Covers up to a 30-day supply. Only covered at specific contracted specialty pharmacies. Prior authorization recommended for some drugs.

* For more information about limitations and exceptions, see the plan or policy document at www.sffbt.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)	
		Non-Pref. Brand: $50 copay/prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Prior authorization recommended for some services. Penalty for out-of-network: no penalty.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay + 20% coinsurance	$100 copay + 20% coinsurance	Emergency room copay waived if admitted to hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$20 copay/visit Deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit Deductible does not apply	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
If you are pregnant	Office visits	$20 copay/visit Deductible does not apply	40% coinsurance	Cost-sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 130 visits per calendar year
	Rehabilitation services	Outpatient: $20 copay/visit Inpatient: 20% coinsurance	40% coinsurance	Limited to 45 outpatient visits per calendar year. Inpatient limited to 30 days per calendar year. Prior authorization recommended for all

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)	
				planned inpatient stays. Penalty for out-of-network: no penalty.
	Habilitation services	Outpatient: $20 copay/visit Inpatient: 20% coinsurance	40% coinsurance	Limited to 45 outpatient visits per calendar year. Neurodevelopmental therapy limited to members under age 26. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 60 days per calendar year. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Durable medical equipment	20% coinsurance	40% coinsurance	Prior authorization recommended to buy some medical equipment over $500. Penalty for out-of-network: no penalty.
	Hospice services	20% coinsurance	40% coinsurance	Limited to 240 respite hours, limited to 14 inpatient days - 6 month overall lifetime benefit limit.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to one exam per calendar year (under age 19).
	Children's glasses	No charge	No charge	Frames and lenses: Limited to 1 pair per calendar year (under age 19).
	Children's dental check-up	Not covered	Not covered	None

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
- Dental care (Adult)
- Expenses resulting from work related conditions
- Hearing aids
- Infertility treatment
- Long-term care
- 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 or other spinal manipulations
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)

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 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. 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 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. You may also contact the Trust Administration Office at 1-888-563-0665.

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 1-888-563-0665.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-563-0665.

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	**$1,500**
Specialist *copayment*	**$20**
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	$1,500
Copayments	$10
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,310**

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

The plan's overall deductible	**$1,500**
Specialist *copayment*	**$20**
Hospital (facility) *coinsurance*	**20%**
Other *coinsurance*	**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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$800
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

The plan's overall deductible	**$1,500**
Specialist *copayment*	**$20**
Hospital (facility) *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	$1,500
Copayments	$100
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,690**

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