




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](http://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 <a href="#">deductible</a> ?	<b>\$1,500</b> Individual / <b>\$3,000</b> Family.	Generally, you must pay all of the costs from <a href="#">provider</a> up to the <a href="#">deductible</a> amount before this plan begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	<b>Yes.</b> In-network preventive care, outpatient lab and radiology, services that require a <a href="#">copay</a> , <a href="#">prescription drugs</a> and vision services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this plan covers certain <a href="#">preventive services</a> without cost sharing and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Medical: <b>\$2,250</b> Individual / <b>\$4,500</b> Family. Prescription Drugs: <b>\$250</b> Individual / <b>\$500</b> Family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billed</a> charges, and health care this <a href="#">plan</a> does not cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	<b>Yes.</b> See <a href="http://premera.com/sharedadmin">premera.com/sharedadmin</a> or call 1-800-810-2583 for a list of <a href="#">network providers</a> . For Teladoc see <a href="http://www.Teladoc.com/Premera">www.Teladoc.com/Premera</a> or 855-332-4059.	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> 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 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 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	<a href="#">Copay</a> and <a href="#">deductible</a> waived for Teladoc visits. Spinal manipulations limited to 24 visits per calendar year, Acupuncture limited to 24 visits per calendar year. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
	<a href="#">Specialist</a> visit			
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	None.
	Imaging (CT/PET scans, MRIs)	No charge <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> 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 <a href="#">prescription drug coverage</a> is available at <a href="https://www.savrx.com/?Link=formulary">https://www.savrx.com/?Link=formulary</a>	Generic drugs	\$5 <a href="#">copay</a> /prescription (retail); \$10 <a href="#">copay</a> /prescription (mail)	\$5 <a href="#">copay</a> + 40% <a href="#">coinsurance</a> /prescription (retail)	Covers up to a 30-day supply (retail), covers up to a 90-day supply (mail). No charge for specific preventive drugs. <a href="#">Prior authorization</a> recommended for some drugs. Non-formulary drugs may not be covered without approval through the prior-authorization process.
	Preferred brand drugs	\$25 <a href="#">copay</a> /prescription (retail); \$50 <a href="#">copay</a> /prescription (mail)	\$25 <a href="#">copay</a> + 40% <a href="#">coinsurance</a> /prescription (retail)	
	Non-preferred brand drugs	\$50 <a href="#">copay</a> /prescription (retail); \$100 <a href="#">copay</a> /prescription (mail)	\$50 <a href="#">copay</a> + 40% <a href="#">coinsurance</a> /prescription (retail)	
	<a href="#">Specialty drugs</a>	Generic: \$5 <a href="#">copay</a> /prescription Pref Brand: \$25 <a href="#">copay</a> /prescription	Not covered	Covers up to a 30-day supply. Only covered at specific contracted specialty pharmacies. <a href="#">Prior authorization</a> recommended for some drugs.

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

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.sffbt.com](http://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)	
				planned inpatient stays. Penalty for out-of-network: no penalty.
	<a href="#">Habilitation services</a>	Outpatient: \$20 <a href="#">copay</a> /visit Inpatient: 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Limited to 45 outpatient visits per calendar year. Neurodevelopmental therapy limited to members under age 26. <a href="#">Prior authorization</a> recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Limited to 60 days per calendar year. <a href="#">Prior authorization</a> recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> recommended to buy some medical equipment over \$500. Does not apply to C-PAP. Penalty for out-of-network: no penalty.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Limited to 240 respite hours, limited to 14 inpatient days - 6 month overall lifetime benefit limit.
<b>If your child needs dental or eye care</b>	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](http://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](http://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](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 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](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,310</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>	\$1,500
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$800
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,420</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>	\$1,500
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,690</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.