




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, visit [www.PSEWTrusts.com](http://www.PSEWTrusts.com) call 1-866-314-4239. 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.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-866-314-4239 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p>\$300 per person / \$600 per family for <a href="#">network providers</a>; \$750 per person/ \$1,500 per family for <a href="#">out-of-network providers</a>.  The <a href="#">network</a> and <a href="#">out-of-network deductibles</a> are separate and do not accumulate together.</p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> 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>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. <a href="#">Preventive care</a> from <a href="#">network providers</a>, skilled nursing facility care, home health care, hospice care, foot orthotics, diabetic education, and treatment of an accidental injury if treatment begins within 72 hours of the injury are covered before you meet your <a href="#">deductible</a>.</p>	<p>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 <a href="#">plan</a> 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>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p>Medical: <a href="#">network providers</a> \$5,500 per person / \$11,000 per family; for <a href="#">out-of-network providers</a> \$8,000 per person.  <a href="#">Prescription drug</a>: \$1,350 per person / \$2,700 per family for <a href="#">network prescription drug copays</a>; no <a href="#">out-of-pocket limit</a> for <a href="#">out-of-network prescription drug copays</a>.  <a href="#">Out-of-pocket limits</a> are calculated on a calendar year basis.</p>	<p>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.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p><a href="#">Premiums</a>, <a href="#">deductibles</a> and <a href="#">copays</a> for <a href="#">out-of-network providers</a>, <a href="#">balance billed charges</a>, <a href="#">prescription drug copays</a> for <a href="#">out-of-network</a> pharmacies, penalties for failure to obtain <a href="#">preauthorization</a>, health care this <a href="#">plan</a> does not cover and <a href="#">coinsurance</a> for <a href="#">out-of-network</a> chiropractic, acupuncture, diabetic education, home health care, hospice, naturopathic, orthotics, outpatient therapies and skilled nursing care.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.premera.com/sharedadmin">www.premera.com/sharedadmin</a> or call 1-800-BLUE (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 1-855-332-4059 (Not applicable for Medicare eligible Retirees).	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 <a href="#">provider's</a> 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 <a href="#">referral</a> .

 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	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Coinsurance</a> and <a href="#">deductible</a> waived for Teladoc visits. Acupuncture and chiropractic care (combined) limited to 15 visits per calendar year; diabetic education limited to 2 visits per lifetime when prescribed by a physician. Massage therapy services are covered when prescribed by a physician and provided by a covered health care professional for medically necessary treatment of an illness, injury or to alleviate pain.
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.

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)	
<p><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.envisionrx.com">www.envisionrx.com</a></p>	Generic drugs	\$3 <a href="#">copay</a> /prescription retail at Costco; \$10 <a href="#">copay</a> /prescription retail at other <a href="#">network</a> pharmacies \$7.50 <a href="#">copay</a> /prescription mail order	\$10 <a href="#">copay</a> /prescription retail Mail order not covered	<p>Covers up to a 30-day supply at retail and a 31 - 90-day supply at mail order. You pay the difference in cost between brand and generic in addition to <a href="#">copay</a> when generic is available unless medical documentation confirms intolerance of the generic alternative. For <a href="#">out-of-network</a> pharmacies you pay the difference in cost between the pharmacy's charge and Envision's discounted rate. Step Therapy guidelines apply. Specialty drugs are required to be filled at a Costco Specialty Pharmacy. A Letter of Medical Necessity (LMN) is required for all compound medications costing more than \$200. <a href="#">Copay</a> is waived <a href="#">at network pharmacies</a> for preventive medications that have a rating of "A" or "B" in the current United States Preventive Services Task Force's recommendations. Non-formulary drugs may not be covered without approval through the prior-authorization process. To review preferred <a href="#">prescription drugs</a>, see the formulary at <a href="http://www.envisionrx.com">www.envisionrx.com</a>. For more information, call 1-800-361-4542.</p>
	Preferred brand drugs	\$25 <a href="#">copay</a> /prescription retail \$62.50 <a href="#">copay</a> /prescription mail order	\$25 <a href="#">copay</a> /prescription retail Mail order not covered	
	Non-preferred brand drugs	\$50 <a href="#">copay</a> /prescription retail \$125 <a href="#">copay</a> /prescription mail order	\$50 <a href="#">copay</a> /prescription retail Mail order not covered	
	<a href="#">Specialty drugs</a>	Same as generic/brand benefit	Not covered	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<p><a href="#">Preauthorization</a> is required. Fees are reduced by 25%, up to \$1,200, if <a href="#">preauthorization</a> requirement is not followed.</p>
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
<p><b>If you need immediate medical attention</b></p>	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a> plus \$100 <a href="#">copay</a> /visit	10% <a href="#">coinsurance</a> plus \$100 <a href="#">copay</a> /visit	\$100 <a href="#">copay</a> waived if admitted to hospital or if injury/accident related.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	None.
	<a href="#">Urgent care</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
<p><b>If you have a hospital stay</b></p>	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	50% <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)	
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Fees are reduced by 25%, up to \$1,200, if <a href="#">preauthorization</a> requirement is not followed.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Inpatient services	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Fees are reduced by 25%, up to \$1,200, if <a href="#">preauthorization</a> requirement is not followed.
If you are pregnant	Office visits	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> from a <a href="#">network provider</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply.
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	For member and spouse only. Dependent children and dependents of dependent children are not eligible for this benefit.
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	Limited to 130 visits per calendar year. Must be considered homebound; prescription and nursing notes required.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Maximum benefit of \$60 per day for <a href="#">rehabilitation services</a> . A treatment plan is required after the 25 <sup>th</sup> visit.
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to prescribed, medically necessary treatment of mental health disorders identified in the ICD and DSM, and congenital birth defects. Treatment plan may be required upon request and is required after the 25 <sup>th</sup> visit.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	Limited to 30 days per calendar year. <a href="#">Preauthorization</a> is required for inpatient facility services. Fees are reduced by 25%, up to \$1,200, if <a href="#">preauthorization</a> requirement is not followed.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Prescription and purchase price required; Plan pays monthly rental fees up to purchase price.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Subject to 6 months lifetime maximum.

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="#">Deductible</a> does not apply	<a href="#">Deductible</a> does not apply	
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to one visit per calendar year.
	Children's glasses	No cost for expenses provided by National Vision except for costs in excess of basic services.	Costs over \$60.00 for a pair of single vision lenses and costs over \$80.00 for a frame.	Exam allowed once per calendar year. Lenses once each calendar year. Frames <b>once</b> each calendar year for children under age 18, or once each two calendar years for children 18 or older.
	Children's dental check-up	No charge	No charge	Limited to two exams and cleanings per calendar year; must be separated by a period of at least five months.

**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](#).)**

- Cosmetic surgery
- Infertility treatment
- Long-term care
- 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 (limited to 15 visits per calendar year, combined with Chiropractic Care)
- Bariatric surgery
- Chiropractic Care (limited to 15 visits per calendar year, combined with Acupuncture)
- Dental care (Adult)
- Hearing Aids (covers members only, limited to \$500 per ear every 3 years)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 x 61565 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 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or contact the Administration Office at 1-866-314-4239.

Additionally, a consumer assistance program can help you file your [appeal](#). Contact Washington Consumer Assistant Program at 1-800-562-6900 or [www.insurance.wa.gov](http://www.insurance.wa.gov).

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 1-866-314-4239.

-----*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 coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 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>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$10
Coinsurance	\$1300
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,670</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 coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$400
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,060</b>

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

- The [plan's](#) overall [deductible](#) \$300
- [Specialist coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 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>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$0
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$500</b>