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 1-866-314-4239. 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.dol.gov/ebsa/healthreform or call 1-866-314-4239 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300** per person / **$600** per family for network providers; $**750** per person/ $**1,500** per family for out-of-network providers. The network and out-of-network deductibles are separate and do not accumulate together.	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.** Preventive care from network providers, 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 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: network providers **$5,500** per person / **$11,000** per family; out-of-network providers **$8,000** per person. Prescription drug: $**1,350** per person / $**2,700** per family for network prescription drug copays; no out-of-pocket limit for out-of-network prescription drug copays. Out-of-pocket limits are calculated on a calendar year basis.	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, deductibles and copays for out-of-network providers, balance billed charges, prescription drug copays for out-of-network pharmacies, penalties for failure to obtain preauthorization, health care this plan does not cover, and coinsurance for out-of-network chiropractic, acupuncture, diabetic education, home health care, hospice, naturopathic, orthotics, outpatient	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
	therapies and skilled nursing care.	
Will you pay less if you use a network provider?	Yes. See www.premera.com/sharedadmin or call 1-800-BLUE (2583) for a list of network providers. For Teladoc see www.Teladoc.com/Premera or call 1-855-332-4059 (Not applicable for Medicare Eligible Retirees).	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	10% coinsurance	50% coinsurance	Coinsurance and deductible waived for Teladoc visits. Acupuncture and chiropractic care (combined) limited to 24 visits per calendar year; pediatric chiropractic services for children six years old and younger are excluded; 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.
	Specialist visit			
	Preventive care/screening/ immunization	No charge Deductible does not apply	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	50% coinsurance	None.
	Imaging (CT/PET scans, MRIs)			

* For more information about limitations and exceptions, see the plan or policy document at www.psewtrusts.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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.elixirsolutions.com.	Generic drugs	$3 copay/prescription retail at Costco; $10 copay/prescription retail at other network pharmacies $7.50 copay/prescription mail order	$10 copay/prescription retail mail order not covered	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 copay when generic is available unless medical documentation confirms intolerance of the generic alternative. For out-of-network pharmacies you pay the difference in cost between the pharmacy's charge and Elixir'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. Copay is waived for preventive medications that have a rating of "A" or "B" in the current United States Preventive Services Task Force's recommendations at in-network pharmacies . Non-formulary drugs may not be covered without approval through the prior-authorization process. To review preferred prescription drugs, see the formulary at www.elixirsolutions.com. For more information, call 1-800-361-4542.
	Preferred brand drugs	$25 copay/prescription retail $62.50 copay/prescription mail order	$25 copay/prescription retail mail order not covered	
	Non-preferred brand drugs	$50 copay/prescription retail $125 copay/prescription mail order	$50 copay/prescription retail mail order not covered	
	Specialty drugs	Same as generic/brand benefit	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	Preauthorization is required. Fees are reduced by 25%, up to $1,200, if preauthorization requirement is not followed.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	10% coinsurance plus $100 copay/visit	10% coinsurance plus $100 copay/visit	$100 copay waived if admitted to hospital or if injury/accident related.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	10% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	Preauthorization is required. Plan benefits are reduced by 25%, up to $1,200, if preauthorization requirement is not followed.
	Physician/surgeon fees	10% coinsurance	50% 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 mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	50% coinsurance	None
	Inpatient services	10% coinsurance	50% coinsurance	Preauthorization is required. Plan benefits are reduced by 25%, up to $1,200, if preauthorization requirement is not followed.
If you are pregnant	Office visits	10% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services from a network provider. Depending on the type of services, coinsurance may apply.
	Childbirth/delivery professional services	10% coinsurance	50% coinsurance	For member and spouse only. Dependent children and dependents of dependent children are not eligible for this benefit.
	Childbirth/delivery facility services	10% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance Deductible does not apply	50% coinsurance Deductible does not apply	Limited to 130 visits per calendar year. Must be considered homebound; prescription and nursing notes required.
	Rehabilitation services	10% coinsurance	50% coinsurance	Outpatient rehabilitation services limited to 45 visits per calendar year. A treatment plan is required after the 25th visit.
	Habilitation services	10% coinsurance	50% coinsurance	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 25th visit.
	Skilled nursing care	10% coinsurance Deductible does not apply	50% coinsurance Deductible does not apply	Limited to 30 days per calendar year. Preauthorization is required for inpatient facility services. Fees are reduced by 25%, up to $1,200, if preauthorization requirement is not followed.
	Durable medical equipment	10% coinsurance	50% coinsurance	Prescription and purchase price required; Plan pays monthly rental fees up to purchase price.
	Hospice services	10% coinsurance Deductible does not apply	50% coinsurance Deductible does not apply	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)	
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 once 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 24 visits per calendar year, combined with Chiropractic Care) • Bariatric surgery • Chiropractic Care (limited to 24 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: 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 1-866-314-4239.

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 1-866-314-4239.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,570**

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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

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