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 1.800.351.6480. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. Call 1.800.351.6480 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$390 per individual or $780 per family.	Generally, you must pay all of the costs from providers 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. Routine physical exams, Chiropractic and Physical Therapy are covered before you meet your deductible. Co-insurance does not count toward the deductible.	This plan covers some services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	$50 per individual for prescription drugs	You must pay all of the costs for prescriptions up to the specific deductible amount before this plan begins to pay for prescriptions.
What is the out-of-pocket limit for this plan?	$3,250 per individual or $6,500 per family for medical. $1,000 per individual for prescription drugs.	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.
What is not included in the out-of-pocket limit?	Acupuncture, Chiropractic, Infertility treatment, amounts over benefit maximums, premiums, balance-billing charges and health care this plan doesn't 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 www.premera.com or call 1-800-810-2583 for a list of network providers.	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, not if the services are medically necessary.	As long as the specialist services you receive are medically necessary, then you do not need 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	$25 Plus 20% coinsurance	$25 Plus 20% coinsurance	In-network charges may be less.
	Specialist visit	$25 Plus 20% coinsurance	$25 Plus 20% coinsurance	In-network charges may be less.
	Preventive care/screening/ immunization	20% coinsurance	20% coinsurance	Deductible generally does not apply; Wellness exam and related tests for participants and dependents age five and older limited as follows: -one routine physical exam per year -one mammogram up to -one pap smear per year -one prostate test per year Immunization not covered for adults or children over age five. See Plan document for specific limitations.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	In-network charges may be less.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Optum.com	Generic drugs	20% coinsurance	20% coinsurance.	After $50 deductible, $1,000 out-of-pocket limit then Plan pays 100%
	Name Brand Drugs	30% coinsurance	30% coinsurance	Using an In-network pharmacy may result in a lower coinsurance amount.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	In-network charges may be less.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	In-network charges may be less.

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	$95 Plus 20% coinsurance	$95 Plus 20% coinsurance	Copay waived if admitted or as a result of an accident or life threatening illness; must give notice of emergency admission within 2 business days.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	Pre-certification required.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	In-network charges may be less.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	Pre-certification for Inpatient Mental Health services Required.
	Inpatient services	20% coinsurance	20% coinsurance	
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	Coverage for dependent child pregnancy excluded. In-network charges may be less.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Certain requirements must be met. 100 visits per year, $4000 calendar year maximum.
	Rehabilitation services	20% coinsurance	20% coinsurance	Rehabilitation requires precertification required, limited to 5 days.
	Habilitation services	20% coinsurance	20% coinsurance	Certain requirements must be met for Habilitation services. In-network charges may be less.
	Skilled nursing care	20% coinsurance	20% coinsurance	Must be hospitalized for 3 days within 14 days prior to skilled nursing care facility. $20 daily benefit, up to maximum of 180 days each occurrence separated by 60 days.
	Durable medical equipment	20% coinsurance	20% coinsurance	
	Hospice services	20% coinsurance	20% coinsurance	Must be medically necessary and recommended by physician, 6 month 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	$25 copay $60 max copay for contact lens exam (fitting/evaluation)	All Charges in excess of $50	Coverage limited to one exam every 12 months.
	Children's Glasses	$25 copay Lenses: no charge Frames: all charges in excess of $130.	Lenses: all charges in excess of $50 single vision, $75 bifocal, $100 trifocal, $125 lenticular, $105 elective contacts. Frames: all charges in excess of $70	Coverage limited to one set of lenses and frames every 12 months.
	Children's dental check-up	Trust Dental Plan: Exam – amount over $28.50 Cleaning – amount over $39 to age 14 or $62 age 14 and over Full Mouth X-ray – amount over $78 Willamette Dental Plan: Exam - $20 copay Cleaning - $45 copay X-rays - $10 to $50 copay	Trust Dental Plan: Exam – amount over $28.50 Cleaning – amount over $39 to age 14 or $62 age 14 and over Full Mouth X-ray – amount over $78 Willamette Dental Plan: Not covered	Coverage limited to two exams per year. Member elects coverage through the Trust Dental Plan or Willamette Dental of Washington during annual open enrollment in October. The Trust dental plan is based on a fee schedule. Plan will pay 100% up to scheduled amount. Member may be liable for anything over and above the scheduled benefit. Willamette Dental Services subject to a flat copayment at time of service.

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, except when medically necessary and specifically provided for under the Plan (see Plan Document for provisions)
- Coverage for dependent child's pregnancy
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- Bariatric surgery, when medically necessary and certain criteria are met (see Plan Document for provisions)
- Dental Care (Adult)
- Chiropractic Care
- Hearing Aids
- Infertility treatment (diagnostic services, lifetime maximum of $2500)
- 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: your state insurance department, HHS, DOL, and/or other applicable agency contact information]. 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: 1-800-351-6480.

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 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 1-800-351-6480.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-351-6480.]
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-800-351-6480.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-351-6480.]

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	$390
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$390
Copayments	$0
Coinsurance	$2470
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,920**

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

The plan's overall deductible	$390
Specialist copayment	$25
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$390
Copayments	$150
Coinsurance	$1622
What isn't covered	
Limits or exclusions	$21
The total Joe would pay is	**$2,183**

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

The plan's overall deductible	$390
Specialist copayment	$25
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$390
Copayments	$50
Coinsurance	$297
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$737**

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