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 Plan Booklet/Summary Plan Description and Summary Material Modifications, visit **www.engineerstrust.com** or call 1-877-441-1212. 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 or call 1-877-441-1212 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300** person / **$600** family. The overall deductible period is July 1 through June 30. Does not apply to all services. Also, copayments, coinsurance and balance-billed charges do not count toward the deductible.	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.** Covered preventive care services provided by a Preferred Provider.	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?	Preferred Providers: **$2,300** person / $**4,600** family (including the overall deductible); No limit for non-preferred providers. Prescription Drugs: $**4,300** person / **$8,600** family. The out-of-pocket limit period is July 1 through June 30.	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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, dental services, vision services, alternative provider benefits, expenses in excess of usual, customary and reasonable (UCR), benefits for foot orthotics, coinsurance and copays for services from non-preferred providers or hospitals, and expenses in excess of Plan limits.	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 for a list of network providers (BlueCard PPO).	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
		Preferred Provider (You will pay the least)	Non-Preferred 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% coinsurance	30% coinsurance	Alternative providers: registered naturopaths, registered certified hypnotherapists, acupuncturists, registered dietitians, certified nutritionists are limited to a maximum of $50 per visit and $300 per year and do not count toward the out-of-pocket limit. Services of alternative providers are eligible only if they are covered expenses under the plan.
	Specialist visit	20% coinsurance	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge Deductible does not	Charges in excess of PPO allowed amount or the UCR	You may have to pay for services that aren't preventive. Ask your provider if the services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
		apply.	amount	you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance No cost for charges in connection with ACA preventive services	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	Preauthorization is recommended for some imaging services to determine medical necessity.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	$10 copay/prescription at retail $20 copay/ prescription for mail order	$10 copay/prescription at retail $20 copay/ prescription for mail order	Covers up to a 34-day supply (retail prescription): 35 – 90-day supply (mail order prescriptions). Prescription drugs purchased out-of-network must be paid in full and member must file claim. Out-of-pocket limit for covered prescription drugs is $4,300 person/$8,600 family.
	Preferred brand drugs	$25 copay/prescription at retail $40 copay/ prescription for mail order	$25 copay/prescription at retail $40 copay/ prescription for mail order	
	Non-preferred brand drugs	$40 copay/prescription at retail $60 copay/ prescription for mail order	$40 copay/prescription at retail $60 copay/ prescription for mail order	
	Specialty drugs	Same as the generic/brand benefit	Same as the generic/brand benefit	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Preauthorization is strongly recommended for outpatient surgeries.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	$75 copay/visit + 20% coinsurance	$75 copay/visit + 20% coinsurance	Copay waived if an accident or of admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	$100 copay/visit + 30% coinsurance	Preauthorization is required for inpatient hospital stays.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	Providers must be approved or certified in the state in which they practice.
	Inpatient services	20% coinsurance	$100 copay/visit + 30% coinsurance for use of non-preferred hospital	Preauthorization is required for inpatient treatment.
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	Benefits for member and spouse only.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Preauthorization is required. Limited to 130 visits per calendar year.
	Rehabilitation services	20% coinsurance	30% coinsurance	Preauthorization is required. Outpatient physical occupational and speech therapy limited to 20 visits per calendar year if unrelated to a mental health condition.
	Habilitation services	20% coinsurance	30% coinsurance	
	Skilled nursing care	20% coinsurance	30% coinsurance	Coinsurance does not apply to the out-of-pocket limit. Preauthorization is required for inpatient admissions.
	Durable medical equipment	20% coinsurance	30% coinsurance	Preauthorization is required if equipment purchase price exceeds $2,000 or monthly rental exceeds $500.
	Hospice services	20% coinsurance	30% coinsurance	Covered to a maximum of 6 months of combined inpatient and outpatient hospice care. Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	$20 copay for exam and/or glasses	Fees in excess of benefit schedule	Vision coverage provided through Vision Service Plan (www.vsp.com). Limited to one exam once every 12 months and one set of lenses every 12 months and one frame every 24 months. Charges from a non-VSP doctor must be paid in full and member must file a claim. Vision services does not apply toward the out-of-pocket limit.
	Children's glasses	$20 copay for exam and/or glasses	Lenses and frames – fees in excess of benefit schedule	
	Children's dental check-up	Fees in excess of benefit schedule	Fees in excess of benefit schedule	Limited to once every 6 months. Benefits listed apply only to active participants. Retirees must elect dental through Delta Dental at time of

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
				retirement or at annual open enrollment.

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 to repair injury or congenital defect)
- Infertility Treatment
- Long-term Care
- Maternity expenses for dependent children.
- Routine Foot Care
- Services that could be covered by Medicare (only applies to persons eligible to enroll in Medicare, but failed to do so)
- Services or treatment which is not medically necessary or is experimental or investigational
- 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 (must meet all plan requirements)
- Chiropractic Care (limit to 20 visits per year)
- Dental Care (Adult – Active plan only)
- Hearing Aids (limits apply)
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing (if medically necessary)
- 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 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. 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or contact the Administration Office at 1-877-441-1212.
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.

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 1-877-441-1212.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-441-1212.

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	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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$40
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,400**

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	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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$600
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,560**

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

The plan's overall deductible	$300
Specialist coinsurance	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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

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