
 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](http://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](http://www.healthcare.gov/sbc-glossary) or call 1-877-441-1212 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p><b>\$300</b> person / <b>\$600</b> family.                      The overall <a href="#">deductible</a> period is July 1 through June 30.                      Does not apply to all services. Also, <a href="#">copayments</a>, <a href="#">coinsurance</a> and balance-billed charges do not count toward the <a href="#">deductible</a>.</p>	<p>Generally, you must pay all of the costs from providers 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><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p><b>Yes.</b> Covered preventive care services provided by a <u>Preferred Provider</u>.</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><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p><b>No.</b></p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p><u>Preferred Providers</u>: <b>\$2,300</b> person / <b>\$4,600</b> family (including the overall <a href="#">deductible</a>);                      No limit for <u>non-preferred providers</u>.  <u>Prescription Drugs</u>: <b>\$4,300</b> person / <b>\$8,600</b> family.                      The <a href="#">out-of-pocket limit</a> period is July 1 through June 30.</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><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><u>Premiums</u>, <u>balance-billed charges</u>, health care this <a href="#">plan</a> doesn't cover, dental services, vision services, alternative <u>provider</u> benefits, expenses in excess of <u>usual, customary and reasonable (UCR)</u>, benefits for foot orthotics, <a href="#">coinsurance</a> and <a href="#">copays</a> for services from <u>non-preferred providers</u> or hospitals, and expenses in excess of Plan limits.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.premera.com">www.premera.com</a> for a list of <a href="#">network providers</a> (BlueCard PPO).	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 <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
		Preferred Provider (You will pay the least)	Non-Preferred 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	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	\$20 <a href="#">copay</a> /visit per person (waived for preventive) at the Fairbanks Coalition Health Center (CHC). Deductible waived at the CHC. Alternative <a href="#">providers</a> : 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 <a href="#">out-of-pocket limit</a> . Services of alternative <a href="#">providers</a> are eligible only if they are covered expenses under the <a href="#">plan</a> .
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge <a href="#">Deductible</a> does not apply.	Charges in excess of PPO allowed amount or the UCR amount	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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a> No cost for charges in connection with ACA preventive services	30% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is recommended for some imaging services to determine medical

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)	
				necessity.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.optumrx.com">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>	Generic drugs	\$10 <a href="#">copay</a> /prescription at retail \$20 <a href="#">copay</a> / prescription for mail order	\$10 <a href="#">copay</a> /prescription at retail \$20 <a href="#">copay</a> / prescription for mail order	Covers up to a 34-day supply (retail prescription): 35 – 90-day supply (mail order prescriptions).  <u>Prescription drugs</u> purchased out-of-network must be paid in full and member must file claim.  <u>Out-of-pocket limit</u> for covered <u>prescription drugs</u> is \$4,300 person/\$8,600 family.
	Preferred brand drugs	\$25 <a href="#">copay</a> /prescription at retail \$40 <a href="#">copay</a> / prescription for mail order	\$25 <a href="#">copay</a> /prescription at retail \$40 <a href="#">copay</a> / prescription for mail order	
	Non-preferred brand drugs	\$40 <a href="#">copay</a> /prescription at retail \$60 <a href="#">copay</a> / prescription for mail order	\$40 <a href="#">copay</a> /prescription at retail \$60 <a href="#">copay</a> / prescription for mail order	
	<a href="#">Specialty drugs</a>	Same as the generic/brand benefit	Same as the generic/brand benefit	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<u>Preauthorization</u> is strongly recommended for outpatient surgeries.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$75 <a href="#">copay</a> /visit + 20% <a href="#">coinsurance</a>	\$75 <a href="#">copay</a> /visit + 20% <a href="#">coinsurance</a>	<a href="#">Copay</a> waived if an accident or of admitted.
	<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="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	\$100 <a href="#">copay</a> /visit + 30% <a href="#">coinsurance</a>	<u>Preauthorization</u> is required for inpatient hospital stays.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<u>Providers</u> must be approved or certified in the state in which they practice.
	Inpatient services	20% <a href="#">coinsurance</a>	\$100 <a href="#">copay</a> /visit + 30% <a href="#">coinsurance</a> for use of non-preferred hospital	<u>Preauthorization</u> is required for inpatient treatment.
<b>If you are pregnant</b>	Office visits	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Benefits for member and spouse only.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	

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)	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Limited to 130 visits per calendar year.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Outpatient physical occupational and speech therapy limited to 20 visits per calendar year if unrelated to a mental health condition.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Coinsurance</a> does not apply to the <a href="#">out-of-pocket limit</a> . <a href="#">Preauthorization</a> is required for inpatient admissions.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required if equipment purchase price exceeds \$2,000 or monthly rental exceeds \$500.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Covered to a maximum of 6 months of combined inpatient and outpatient hospice care. <a href="#">Preauthorization</a> is required.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
<b>If your child needs dental or eye care</b>	Children's eye exam	\$20 <a href="#">copay</a> for exam and/or glasses	Fees in excess of benefit schedule	Vision coverage provided through Vision Service Plan ( <a href="http://www.vsp.com">www.vsp.com</a> ). Limited to one exam once every 12 months and one set of lenses every 12 months and one frame or contact lenses 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 <a href="#">out-of-pocket limit</a> .
	Children's glasses	\$20 <a href="#">copay</a> 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 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](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 1-877-441-1212.

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](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 1-877-441-1212.

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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300
■ <a href="#">Specialist coinsurance</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>\$12,800</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$40
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,400</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>	\$300
■ <a href="#">Specialist coinsurance</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>\$7,400</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$600
Coinsurance	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,560</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>	\$300
■ <a href="#">Specialist coinsurance</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>\$1,900</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$0
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$700</b>