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?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care services by a Preferred Provider and certain hospice care services 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?	Yes, **$100** person / **$200** family combined deductible for registered graduate nurse expenses, blood products, and hearing care expenses. deductible period is July 1 through June 30. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$6,600** person / **$13,200** family for covered medical expenses.	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?	Medical services you receive that are not covered by Medicare, naturopathy, hypnotherapy, acupuncture, services provided by a dietician, nutritionist, and hearing care.	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?	Not Applicable.	This plan does not use a provider network. You can receive covered services from any provider.
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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to usual, customary and reasonable (UCR) amounts. 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		
	Preventive care/screening/ immunization	No charge if provider accepts Medicare assignment	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Benefits for providers that do not accept Medicare assignment will be subject to UCR.
If you have a test	Diagnostic test (x-ray, blood work)	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Imaging (CT/PET scans, MRIs)		
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.UHCRetiree.com or call 1-866-628-4715.	Generic drugs	$10 copay/prescription at retail $20 copay/ prescription for mail order	Covers up to a 30-day supply for a retail prescription and 31-90-day supply for a mail order prescription. Subject to Medicare drug formulary. This is a Medicare Part D prescription drug plan through United Healthcare.
	Preferred brand drugs (no generic equivalent available)	$25 copay/prescription at retail $40 copay/ prescription for mail order	
	Non-preferred brand drugs (generic equivalent available)	$40 copay/prescription at retail $60 copay/ prescription for mail order	
	Specialty drugs	Same as generic/brand benefit	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Physician/surgeon fees		
If you need immediate medical attention	Emergency room care	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Emergency medical transportation		

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Urgent care		
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Physician/surgeon fees		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Inpatient services		
If you are pregnant	Office visits	No charge if provider accepts Medicare assignment	Benefits for member and spouse only. Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Childbirth/delivery professional services	No charge if provider accepts Medicare assignment	
	Childbirth/delivery facility services		
If you need help recovering or have other special health needs	Home health care	No charge if provider accepts Medicare assignment	Limited to 130 visits per calendar year. Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Rehabilitation services	No charge if provider accepts Medicare assignment	Outpatient physical, occupational and speech therapy limited to 20 visits per calendar year if unrelated to a mental health condition. Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Habilitation services	No charge if provider accepts Medicare assignment	Outpatient physical, occupational and speech therapy limited to 20 visits per calendar year if unrelated to a mental health condition. Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Skilled nursing care	No charge if provider accepts Medicare assignment	Limited to 100 days per condition. Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Durable medical equipment	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Hospice services	No charge if provider accepts Medicare	Limited to a maximum of 6 months of combined inpatient and

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		assignment		outpatient hospice care. Benefits for providers that do not accept Medicare assignment will be subject to UCR.
If your child needs dental or eye care		**PPO Provider**	**Non-Preferred Provider**	
	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 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.
	Children's glasses	$20 copay for exam and/or glasses	Lenses and frames – fees in excess of benefit schedule	
	Children's dental check-up	Not Covered		Retirees must elect dental coverage 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)
- Dental (Adult)
- Infertility Treatment
- Long-term Care
- Maternity expenses for dependent children
- Routine Foot Care
- Services that could be covered by Medicare. (This exclusion applies if you are eligible to enroll in Medicare, but fail 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 (Limited to 20 visits per year)
- Hearing Aids (for retired employees only)
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing (if medically necessary)
- Routine Eye Care (Adult – through VSP)

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	$0
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$100**

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

The plan's overall deductible	$0
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$7,387**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$660**

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

The plan's overall deductible	$0
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$1,925**

In this example, Mia would pay:

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

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