




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 1-877-441-1212. 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.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-877-441-1212 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$800</b> person / <b>\$1,600</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> .	Generally, you must pay all of the costs from <a href="#">provider</a> up to the <a href="#">deductible</a> amount before this plan 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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	<b>Yes</b> . Covered preventive care services provided by a <a href="#">Preferred Provider</a> and virtual physical therapy through Transcarent.	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 plan covers certain <a href="#">preventive</a> services 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> .
Are there other <a href="#">deductibles</a> for specific services?	<b>No</b> .	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">Network providers</a> : <b>\$2,800</b> person / <b>\$5,600</b> family (including the overall <a href="#">deductible</a> ); No limit for <a href="#">out-of-network providers</a> ; <a href="#">Prescription Drugs</a> : <b>\$3,800</b> person / <b>\$7,600</b> family. The <a href="#">out-of-pocket limit</a> period is July 1 through June 30.	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="#">limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billed</a> charges, health care this <a href="#">plan</a> doesn't cover, dental services, vision services, alternative provider benefits, expenses in excess of usual, customary and reasonable (UCR), benefits for foot orthotics, <a href="#">coinsurance</a> and <a href="#">copays</a> for services from <a href="#">non-preferred providers</a> or hospitals, and expenses in excess of Plan limits.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	<b>Yes</b> . Actives and Non-Medicare only: See <a href="http://www.premera.com">www.premera.com</a> for a list of <a href="#">network providers</a>	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</a>

Important Questions	Answers	Why This Matters:
	(BlueCard PPO). For SwiftMD call 1-833-794-3863 or visit SwiftMD.com For Transcarent see <a href="http://experience.transcarent.com/surgery/">experience.transcarent.com/surgery/</a> or call 1-800-680-1366 (AK residents only). For Coalition Health Center see <a href="http://www.coalitionhealthcenter.com">www.coalitionhealthcenter.com</a> or call (907) 450-3300 (Fairbanks clinic – Alaska residents only).	<a href="#">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. Participants will only be liable for the in-network cost share for non-network emergency services, non-network providers at in-network facilities, and non-network air ambulance 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 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 <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) \$50 maximum copayment if 3 or more family members visit the clinic at the same time and receive services at the Fairbanks Coalition Health Center (CHC). <a href="#">Deductible</a> waived at the CHC. <a href="#">Deductible</a> and <a href="#">copay</a> waived for SwiftMD. Alternative <a href="#">providers</a> : registered naturopaths, registered certified hypnotherapists, acupuncturists, certified nutritionists are limited to a maximum of 50% coinsurance to a \$50 per visit and \$300 per year and do not count toward the <a href="#">out-of-pocket limit</a> . Services of alternative providers 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.	30% plus 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.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.engineerstrust.com](http://www.engineerstrust.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)	
<b>If you have a test</b>	<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>	<a href="#">Preauthorization</a> is required for genetic testing.
	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 necessity.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">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). 90-day supply at a network retail pharmacy subject to a copay for each 30-day portion. <a href="#">Prescription drugs</a> purchased out-of-network must be paid in full and member must file claim. <a href="#">Out-of-pocket limit</a> for covered <a href="#">prescription drugs</a> is \$3,800 person/\$7,600 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>	<a href="#">Preauthorization</a> is required for certain outpatient surgeries and is strongly recommended for all outpatient surgeries.
	Physician/surgeon fees			
<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>	30% <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>	<a href="#">Preauthorization</a> is required for inpatient treatment.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
<b>If you need mental health, behavioral</b>	Outpatient services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Providers</a> must be approved or certified in the state in which they practice.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.engineerstrust.com](http://www.engineerstrust.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)	
health, or substance abuse services	Inpatient services	20% <a href="#">coinsurance</a>	\$100 <a href="#">copay</a> /visit + 30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for inpatient treatment.
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Benefits for member and spouse only except for certain preventive screenings. No childbirth/delivery coverage for dependent daughter. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<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 condition per calendar year if unrelated to a mental health condition. Virtual physical therapy through Transcarent is unlimited and covered with no <a href="#">copay</a> or <a href="#">coinsurance</a> with no preauthorization required.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for certain items.
	<a href="#">Hospice services</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.
If your child needs dental or eye care	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	Not Covered	Not Covered	Retirees must elect dental through Delta Dental at time of retirement or at annual open enrollment.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.engineerstrust.com](http://www.engineerstrust.com).

## 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 Care (Adult -unless elected through Delta Dental at time of retirement)
- Infertility Treatment
- Long-term Care
- Childbirth/delivery expenses for pregnant 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, except when for pre-requisite to bariatric surgery
- Work related injury or illness

### 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)
- 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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 x61565 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 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](http://www.dol.gov/ebsa/healthreform). You may also contact the Trust Administration Office at 1-877-441-1212.

### 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 1-877-441-1212.

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.*

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## 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](#) \$800
- [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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$800
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,870</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$800
- [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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$800
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,520</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$800
- [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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$800
<a href="#">Copayments</a>	\$80
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,280</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.