This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the plan's summary plan description at www.psbenefitstrust.com or by calling **(206) 441-7574, Option 0 or (800) 331-6158, Option 0**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$150** per person/**$450** per family The following services are not subject to the **deductible** and copayments related to such services do not apply toward the **deductible**: Covered preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other Deductibles for specific services?	**No.**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Yes.** $**2,650** per person/**$10,000** per family for in-network (PPO) medical benefits. **$1,500** per person/**$3,000** per family for High Performance Formulary drugs.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, out-of-network (non-PPO) coinsurance chargers, health care this plan doesn't cover, expenses in excess of usual, customary and reasonable (UCR), penalties for failing to follow the preauthorization requirements, vision and dental benefits.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	**No.**	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	**Yes.** For a list of **PPO or preferred providers**, see www.premera.com or call **(800) 810-BLUE (2583)**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Do I need a referral to see a specialist?	**No.** You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	**Yes.**	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per office visit	$15 copay per office visit plus 30% coinsurance of the Allowed Charge	All services must be medically necessary. Preventive benefits are HHS and CDC recommendations. Preventative services provided outside these recommendations are subject to applicable copays and coinsurance.
	Specialist visit			
	Other practitioner office visit			
	Preventive care/screening/immunization	No charge	30% coinsurance of the Allowed Charge	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance of the Allowed Charge	

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance of the Allowed Charge	Covered under the inpatient hospital benefit if done in patient or as a prerequisite to surgery.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$10 retail/$10 mail (no copay for generic FDA-approved contraceptives)	50% co-pay	Generic and preferred brand coverage limited to drugs listed on High Performance Formulary. No mail benefit for non-preferred brand drugs. Covers up to a 30-day supply for a retail prescription and up to a 90-day supply for a mail order prescription. Rx annual out-of-pocket maximum is $1,500 per person and $3,000 per family.
	Preferred brand drugs	$10 retail/$10 mail		
	Non-preferred brand drugs	50% retail/50% mail		
	Specialty drugs	Same as generic/brand benefit.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance of the Allowed Charge	---none---
	Physician/surgeon fees	No charge	30% coinsurance of the Allowed Charge	---none---
If you need immediate medical attention	Emergency room services	$50 copay	$50 copay	Copayment waived if admitted within 24 hours.
	Emergency medical transportation	30% coinsurance of the Allowed Charge	30% coinsurance of the Allowed Charge	---none---
	Urgent care	$15 copay per office visit	$15 copay per office visit plus 30% coinsurance of the Allowed Charge	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance of the Allowed Charge	

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Physician/surgeon fee	No charge	30% coinsurance of the Allowed Charge	Preauthorization is required. If preauthorization is not obtained, the reimbursement rate will be 50%.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copay per office visit.	$15 copay per office visit plus 30% coinsurance of the Allowed Charge	---none---
	Mental/Behavioral health inpatient services	No charge	30% coinsurance of the Allowed Charge	Preauthorization is required. If preauthorization is not obtained, the reimbursement rate will be 50%.
	Substance use disorder outpatient services	$15 copay per office visit.	$15 copay per office visit plus 30% coinsurance of the Allowed Charge	---none---
	Substance use disorder inpatient services	No charge	30% coinsurance of the Allowed Charge	Preauthorization and completion of the inpatient program is required. If preauthorization or the treatment program is not completed, the reimbursement rate will be 50%.
If you are pregnant	Prenatal and postnatal care	No charge	$15 copay per office visit plus 30% coinsurance of the Allowed Charge	Ultrasound payable as a diagnostic test. Office visits are generally included in global fee for delivery.
	Delivery and all inpatient services	No charge	30% coinsurance of the Allowed Charge	No coverage for a dependent child or child of dependent child.
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance of the Allowed Charge	---none---
	Rehabilitation services	No charge	30% coinsurance of the Allowed Charge	---none---
	Habilitation services	$15 copay per office visit.	30% coinsurance of the Allowed Charge	Habilitative services limited to neurodevelopment treatment of a mental health condition.
	Skilled nursing care	No charge	30% coinsurance of the Allowed Charge	Maximum of 90 days.
	Durable medical equipment	20% coinsurance of the Allowed Charge	30% coinsurance of the Allowed Charge	Rental or purchase of medically necessary equipment. Cost of rental covered up to purchase price.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Hospice service	No charge	30% coinsurance of the Allowed Charge	Limited to 30 days inpatient.
If your child needs dental or eye care	Eye exam	If separate vision plan: costs in excess of $60. $15 copay for preferred/30% coinsurance of Allowed Charge for non-preferred provider		Benefit limited to once every 12 months. Benefit applicable to children up to age 18.
	Glasses	Only if provided in the collective bargaining agreement. Lens: Costs in excess of $60 (single vision) Frames: Costs in excess of $100		Frame benefit limited to once every 24 months. Lens benefit limited to once every 12 months. Benefit applicable to children up to age 18.
	Dental check-up	Up to 30% of Allowed Charge	Preferred provider coinsurance amount plus any amount in excess of Allowed Charge	Only if provided in the collective bargaining agreement. Benefit applicable to children up to age 18. Older children subject to annual maximum of $2,000/non-preferred provider or $2,500/preferred provider.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan's summary plan description for other excluded services.)

- Benefits when Medicare is or could be primary. **(This exclusion applies if you are eligible to enroll in Medicare, but fail to do so.)**
- Cosmetic surgery (except to correct function disorder)
- Hearing aids
- Infertility treatment
- Injury or Illness for which a third-party may be responsible.
- Long term care
- Pregnancy for a Dependent Child
- Private duty nursing
- Routine foot care
- Weight loss programs
- Work related injury or illness

Other Covered Services (This isn't a complete list. Check your plan's summary plan description for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Dental Care (adult) (if provided for in your CBA)
- Habilitation services (limited to neurodevelopmental treatment)
- Non-emergency care when traveling outside the United States, (care must be medically necessary and considered standard care in the U.S.)
- Routine eye care (adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **(206) 441-7574, Option 0 or (800) 331-6158, Option 0**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: **www.psbenefitstrust.com** or by calling **(206) 441-7574, Option 0 or (800) 331-6158, Option 0**. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform for additional information.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al **(206) 441-7574, Opción 0 o (800) 331-6158, Opción 0.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,370
- **Patient pays** $170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$20
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,400
- **Patient pays** $1,000

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$150
Copays	$550
Coinsurance	$220
Limits or exclusions	$80
Total	**$1,000**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.