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 1-866-314-4239. 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 or call 1-866-314-4239 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.** Covered medical benefits under this plan.	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?	Medical: network providers **$5,500** per person / **$11,000** per family; providers who do not accept Medicare assignment: **$8,000** per person. Prescription drug: $**1,350** per person for network prescription drug copays; no out-of-pocket limit for out-of-network prescription drug copays.	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 provided by a provider who does not accept Medicare assignment or expenses that are not covered by Medicare, premiums, balance billed charges, prescription drug copays for out-of-network pharmacies, health care this plan does not cover and coinsurance for out-of-network chiropractic, acupuncture, diabetic education, home health care, hospice, naturopathic, orthotics, outpatient therapies and skilled nursing care.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you	Yes. Medicare approved providers.	This plan uses a provider network. You will pay less if you use a provider in the

Important Questions	Answers	Why This Matters:
use a network provider?		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
		Network Provider (You will pay the least)	Out-of-Network 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	No charge for Medicare approved charges	20% of Medicare limited charge and up to 50% of the difference between Medicare limited charge and billed amount	Only expenses recognized as covered charges by Medicare are considered eligible expenses.
	Specialist visit			
	Preventive care/screening/ immunization			You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for Medicare approved charges	20% of Medicare limited charge and up to 50% of the difference between Medicare limited charge and billed amount	Only expenses recognized as covered charges by Medicare are considered eligible expenses.
	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.elixirsolutions.com.	Generic drugs	$3 copay/prescription retail through Costco; $7.50 copay/prescription through Costco mail order	$10 copay/prescription retail non-Costco $30 copay/prescription mail order non-Costco	Up to a 90-day supply allowed at retail or mail order. Copays shown apply per 30-day supply at retail and 90-day supply at mail order. Step Therapy, prior authorization and quantity limit guidelines may apply. Copay is waived at network pharmacies for preventive medications that have a rating of "A" or "B" in the current United States Preventive Services Task Force's recommendations. Non-formulary drugs may not be covered without approval through the prior-authorization
	Preferred brand drugs	$25 copay/prescription retail $62.50 copay/prescription through Costco mail order	$25 copay/prescription retail $75 copay/prescription mail order non-Costco	
	Non-preferred brand drugs	$50 copay/prescription retail $125 copay/prescription	$50 copay/prescription retail $150 copay/prescription	

* For more information about limitations and exceptions, see the plan or policy document at www.psewtrusts.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)	
		through Costco mail order	mail order non-Costco	process. To determine if a prescription drug is in the formulary, see the formulary list at www.envisionrxplus.com. For more information, call 1-844-293-4760
	Specialty drugs	Same as generic/brand benefit	Same as generic/brand benefit	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge for Medicare approved charges	20% of Medicare limited charge and up to 50% of the difference between Medicare limited charge and billed amount	Only expenses recognized as covered charges by Medicare are considered eligible expenses.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	No charge for Medicare approved charges	No charge for Medicare approved charges	Only expenses recognized as covered charges by Medicare are considered eligible expenses.
	Emergency medical transportation	No charge for Medicare approved charges	20% of Medicare limited charge and up to 50% of the difference between Medicare limited charge and billed amount	
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge for Medicare approved charges	20% of Medicare limited charge and up to 50% of the difference between Medicare limited charge and billed amount	Only expenses recognized as covered charges by Medicare are considered eligible expenses.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for Medicare approved charges	20% of Medicare limited charge and up to 50% of the difference between Medicare limited charge and billed amount	Only expenses recognized as covered charges by Medicare are considered eligible expenses.
	Inpatient services			
If you are pregnant	Office visits	No charge for Medicare approved charges	20% of Medicare limited charge and up to 50% of the difference between Medicare limited charge and billed amount	Only expenses recognized as covered charges by Medicare are considered eligible expenses.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health	Home health care	No charge for Medicare approved charges	20% of Medicare limited charge and up to 50% of the difference between	Only expenses recognized as covered charges by Medicare are considered eligible expenses.
	Rehabilitation services			
	Habilitation services			

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)	
needs	Skilled nursing care Durable medical equipment Hospice services		Medicare limited charge and billed amount	
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to one visit per calendar year.
	Children's glasses	No cost for expenses provided by National Vision except for costs in excess of basic services.	Costs over $60.00 for a pair of single vision lenses and costs over $80.00 for a frame.	Exam allowed once per calendar year. Lenses once each calendar year. Frames **once** each calendar year for children under age 18, or once each two calendar years for children 18 or older.
	Children's dental check-up	No charge	No charge	Limited to two exams and cleanings per calendar year; must be separated by a period of at least five months.

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 • Dental Care (Adult)	• Hearing aids • Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S. • Routine foot care • 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	• Chiropractic Care • Private-duty nursing	• 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 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. 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 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. You may also contact the Trust Administration Office at 1-866-314-4239.

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 1-866-314-4239.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-314-4239.

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$00
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$420**

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	**$2,800**

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.