




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, visit [www.nwrooferstrust.com](http://www.nwrooferstrust.com) or call 1-800-331-6158. 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 1-800-331-6158 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$350 individual / \$700 family ( <a href="#">Deductibles</a> applied in October, November, December will also apply to the next calendar year's <a href="#">deductible</a> .)	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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services provided by a <a href="#">Preferred Provider</a> are covered before you meet your <a href="#">deductible</a> .	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.
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$50 per person for dental services. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$2,000/person for <a href="#">Preferred Providers</a> ; \$4,000/person for <a href="#">Non-Preferred Providers</a> . \$10,000/person for Non-Preferred facilities.	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.
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> does not cover, <a href="#">prescription drugs</a> , penalties for failure to obtain <a href="#">preauthorization</a> , skilled nursing care, <a href="#">copay</a> , <a href="#">deductibles</a> , and charges in excess of <a href="#">allowed amounts</a> .	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> ?	Yes. See <a href="http://www.premiera.com">www.premiera.com</a> or call 800-810-BLUE (2583) 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 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	\$25 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	20% <a href="#">coinsurance</a>	All services must be <u>medically necessary</u> . Chiropractic limited to 20 visits per year; medical review required after 10 visits. Acupuncture must be performed by an MD for pain management and anesthesia only. Outpatient therapy subject to copayment. Massage therapy is not covered.  There is a \$200 calendar year limit on routine physicals for participants age 12 and over. Immunizations and cancer screenings subject to a 20% <a href="#">coinsurance</a> or 50% <a href="#">coinsurance</a> for services performed by a Non-Preferred hospital. 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 <u>preventive</u> . Then check what your <a href="#">plan</a> will pay for.
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	Charges in excess of \$200; No cost for dependents under age 12	Charges in excess of \$200; No cost for dependents under age 12; Charges in excess of UCR	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> for facility fees / 20% <a href="#">coinsurance</a> for physician fees	Pap smears limited to 1 per year. Prostate Specific Antigen (PSA) for ages 50 & over limited to once every 5 years. Mammogram under age 50 covered 1 time every 2 years. Age 50 & over covered once every year.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.envisionrx.com">www.envisionrx.com</a>	Generic drugs	\$15 <a href="#">copay</a> /prescription for retail \$30 <a href="#">copay</a> /prescription for mail order <a href="#">Deductible</a> does not apply.	100% <a href="#">coinsurance</a>	Covers up to a 34-day supply (retail prescription); 35 – 90-day supply (mail order prescription). Covers up to a 90-day supply of maintenance drugs with mail order <a href="#">copay</a> at retail Rx90 pharmacies. Brand drugs when a generic is available you pay the difference in cost between the generic and brand plus brand <a href="#">copay</a> . If you fill your prescription at a non-Network Pharmacy you must pay full cost of prescription and file a claim for reimbursement with EnvisionRxOptions.
	Preferred brand drugs	\$25 <a href="#">copay</a> /prescription for retail \$50 <a href="#">copay</a> /prescription for mail order <a href="#">Deductible</a> does not apply.	100% <a href="#">coinsurance</a>	
	Non-preferred brand drugs	\$50 <a href="#">copay</a> /prescription for retail	100% <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)	
		\$100 <a href="#">copay</a> /prescription for mail order <a href="#">Deductible</a> does not apply.		Contraceptives are only covered for treatment of a documented medical condition.
	<a href="#">Specialty drugs</a>	Same as generic/brand benefit <a href="#">Deductible</a> does not apply.	100% <a href="#">coinsurance</a>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	All services must be <u>medically necessary</u> .
	Physician/surgeon fees	\$25 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	To the nearest hospital equipped to furnish the necessary treatment.
	<a href="#">Urgent care</a>	\$25 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<u>Preauthorization</u> required except when Medicare is prime and emergency admits of less than 24 hours. If <u>preauthorization</u> is not obtained, penalty of 50% not to exceed \$500 applies.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	Inpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<u>Preauthorization</u> required except when Medicare is prime and emergency admits of less than 24 hours. If <u>preauthorization</u> is not obtained, penalty of 50%, not to exceed \$500 applies.
If you are pregnant	Office visits	\$25 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	No coverage for a dependent child or child of dependent child. Depending on the type of services, a <u>copayment</u> , or <u>deductible</u> may apply.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> for physician fees/50% <a href="#">coinsurance</a> for facility fees	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> for physician fees / 50% <a href="#">coinsurance</a> for facility fees	
If you need help recovering or have	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Treatment plan and letter of necessity required.

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)	
other special health needs	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Preauthorization required for inpatient. If preauthorization is not obtained benefits are reduced by 50%, not to exceed \$500.
	<a href="#">Habilitation services</a>	Not Covered	Not Covered	Neurodevelopmental therapy available to dependent children age 6 and under, \$2,000 maximum benefit.
	<a href="#">Skilled nursing care</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Covered if within 14 days following a covered inpatient hospital stay of at least 3 days. Limited to 70 days.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Requires a prescription.
	<a href="#">Hospice services</a>	No Charge <a href="#">Deductible</a> does not apply.	No Charge <a href="#">Deductible</a> does not apply.	Limited to \$7,500 lifetime benefit
If your child needs dental or eye care	Children's eye exam	\$25 <a href="#">copay</a> /exam	Fees in excess of \$40	Limited to one exam every 12 months
	Children's glasses	Fees in excess of \$120 for frames and single vision lenses	Fees in excess of \$40 for single vision lenses and fees in excess of \$46 for frames	Lenses limited to once every 12 months. Frames are limited to once every 24 months.
	Children's dental check-up	20% or usual, customary and reasonable charges <a href="#">Deductible</a> does not apply.	Not Covered	Participants age 12 and over subject to \$2,000 calendar year maximum.

## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric Surgery (unless medically necessary for morbid obesity)</li><li>• Cosmetic Surgery (except to correct function or disorder)</li></ul>	<ul style="list-style-type: none"><li>• Habilitation Services (except for treatment of neurodevelopmental disabilities in children age 6 and under)</li><li>• Hearing Aids</li><li>• Infertility Treatment</li></ul>	<ul style="list-style-type: none"><li>• Long-term Care</li><li>• Massage Therapy</li><li>• Routine Foot Care</li><li>• Weight Loss Programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Chiropractic Care (limited to 20 visits per year)</li><li>• Dental Care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-Duty Nursing</li></ul>	<ul style="list-style-type: none"><li>• Routine Eye Care (Adult – provided through VSP)</li></ul>

**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 1-800-331-6158.

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

An individual is required to have [Minimum Essential Coverage](#). Effective January 1, 2019, if you find yourself without coverage for a month, you will not be penalized when you file your tax return as the penalty for not having coverage was removed as part of the Tax Cut and Jobs Act of 2017.

### 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 1-800-331-6158.

-----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>	\$350
■ <a href="#">Specialist copay</a>	\$25
■ 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*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$350
Copayments	\$100
Coinsurance	\$1,700
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,210

### 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>	\$350
■ <a href="#">Specialist copay</a>	\$25
■ 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*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$350
Copayments	\$1,000
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$1,810

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$350
■ <a href="#">Specialist copay</a>	\$25
■ 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*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$350
Copayments	\$150
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$700