Northwest Laborers-Employers Health & Security Trust:

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: **01/01/2018– 12/31/2018**

Premera Blue Cross: Plan 1

Coverage for: Individual / Family | Plan Type: PPO

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 www.zenith-american.com or by calling 1-800-826-2102. 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.zenith-american.com or call 1-800-826-2102 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 Individual/$1,500 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary 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?	No.	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?	For network providers $4,500 individual / $4,500 family; Overall in-network medical and prescription drug out-of-pocket limit: $6,600 Individual $13,200 Family; for out-of-network providers unlimited.	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?	Non-PPO copayments and coinsurance, premiums, balance-billing charges, and health care this plan doesn't cover.	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?	Yes. See www.premera.com or call 1-800-810-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the 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.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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	$20 copay/visit plus 15% coinsurance	$20 copay/visit plus 30% coinsurance	All services must be medically necessary.
	Specialist visit	$20 copay/visit plus 15% coinsurance	$20 copay/visit plus 30% coinsurance	All services must be medically necessary.
	Preventive care/screening/ immunization	No charge	$20 copay/visit plus 30% coinsurance after deductible	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.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	30% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	15% coinsurance	30% coinsurance	Precertification required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.zenith.com	Generic drugs	No charge for mail-order, $5 copay at retail	$15 copay plus 50% coinsurance	30-day supply at retail/100-day supply at mail order.
	Preferred brand drugs	$15 copay plus 15% coinsurance	$15 copay plus 50% coinsurance	30-day supply at retail/100-day supply at mail order.
	Non-preferred brand drugs	$15 copay plus 15% coinsurance	$15 copay plus 50% coinsurance	30-day supply at retail/100-day supply at mail order.
	Specialty drugs	$15 copay plus 15% coinsurance	Not covered	Up-to a 30-day supply. Specialty drugs are supplied directly from the Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	30% coinsurance	
	Physician/surgeon fees	15% coinsurance	30% coinsurance	---none---
If you need immediate medical attention	Emergency room care	$150 copay plus 15% coinsurance	$150 copay plus 30% coinsurance	Copay waived if visit is within 24-hours of an accidental injury, or for a life threatening illness.
	Emergency medical transportation	15% coinsurance	15% coinsurance	To nearest hospital.
	Urgent care	15% coinsurance	30% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	30% coinsurance	Benefits will be reduced by $150 for failure to pre-certify non-emergent hospitalizations.
	Physician/surgeon fees	15% coinsurance	15% coinsurance	---none---

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit plus 15% coinsurance	$20 copay/visit plus 30% coinsurance	---none---
	Inpatient services	15% coinsurance	30% coinsurance	Benefits will be reduced by $150 for failure to pre-certify non-emergent hospitalizations.
If you are pregnant	Office visits	$20 copay/visit plus 15% coinsurance	$20 copay/visit plus 30% coinsurance	Postnatal care benefits are not covered for female dependent children. Benefits for employee or spouse only.
	Childbirth/delivery professional services	15% coinsurance	30% coinsurance	Postnatal care benefits are not covered for female dependent children. Benefits for employee or spouse only.
	Childbirth/delivery facility services	15% coinsurance	30% coinsurance	Postnatal care benefits are not covered for female dependent children. Benefits for employee or spouse only.
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Precertification required.
	Rehabilitation services	15% coinsurance	30% coinsurance	30 visit maximum per calendar year for physical and occupational therapy.
	Habilitation services	15% coinsurance	30% coinsurance	Limited to treatment of developmental disorders identified as mental disorders.
	Skilled nursing care	15% coinsurance	30% coinsurance	Precertification required. Limited to 60-days per occurrence.
	Durable medical equipment	15% coinsurance	30% coinsurance	---none---
	Hospice services	No charge	No charge	Precertification required.
If your child needs dental or eye care	Children's eye exam	$10 copay	$10 copay plus charges in excess of $55	Not covered under the Retiree Medical Plan. Exams covered once per calendar year.
	Children's glasses	No charge for lenses. Charges in excess of $130 for frames.	Single vision lenses charges in excess of $50. Charges in excess of $50 for frames.	Not covered under the Retiree Medical Plan. Lenses covered once each calendar year. Frames covered once each two calendar years.
	Children's dental check-up	No charge, two per year.	No charge, two per year.	Not covered under the Retiree Medical Plan.

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.)

- Bariatric surgery
- 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
- Habilitative services, unless for treatment of developmental disorders identified as mental disorders
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Specialty Drugs received out-of-network
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic care (subject to visit limits)
- Dental care (Adult) - No coverage under the Retiree Medical plan.
- Hearing aids (up to $500 max)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) - No coverage under the Retiree Medical Plan.

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: Zenith-American Solutions at 1-800-826-2102 or the Department of Labor's Employee Benefits Security Administration at 1-866-444 3272 or www.dol.gov/ebsa/healhreform.

Does this plan provide Minimum Essential Coverage?

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. This plan or policy does provide minimum essential coverage.

Does this plan meet the Minimum Value Standards?

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. This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Individuals With Limited English Proficiency of Language Assistance Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-826-2102.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-826-2102.。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-826-2102.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-826-2102.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-826-2102.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-826-2102.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером

1-800-826-2102.

ប្រយ័តន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ជូរ ទូរស័ព្ទ 1-800-826-2102។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-826-2102.

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-826-2102.

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-826-2102.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-826-2102-

ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-826-2102.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-826-2102.

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ,ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-826-2102

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	$500
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	15%
Other *[cost sharing]*	15%

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

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$180
Coinsurance	$2780
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3520

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	15%
Other *[cost sharing]*	15%

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

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$480
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,340

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	15%
Other *[cost sharing]*	15%

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

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$20
Coinsurance	$210
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$730

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