
 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.healthlink.com or call 1-877-379-5802. 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/ or call 1-877-379-5802 to request a copy.

Important Questions	Answers				Why This Matters:
<p>What is the overall deductible?</p>	<p>Per participant:</p>	<p>Tier I \$0</p>	<p>Tier II \$300</p>	<p>Non-Network \$400</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. For Tier I: all services are covered before a deductible. Tier II providers: preventive care, emergency room services, and ambulance services.</p>				<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>Yes. \$150 per plan participant for <u>prescription drugs</u>. There are no other specific deductibles.</p>				<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>Per participant:</p>	<p>Tier I \$3,000</p>	<p>Tier II \$6,000</p>	<p>Non-Network unlimited</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p><u>Premiums</u>, <u>balance-billed</u> charges, health care this <u>Plan</u> doesn't cover, charges in excess of benefit maximums, charges in excess of maximum allowed amounts, pre-certification penalties, and non-medically necessary services.</p>				<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>

Will you pay less if you use a <u>network provider</u>?	<p>Yes, for medical: Healthlink. See www.healthlink.com or call 1-877-379-5802 for a list of network providers.</p> <p>Yes, for prescription drugs: CVS. For a list of retail and mail pharmacies, log on to www.caremark.com or call 1-877-232-8128.</p>	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		Tier I Provider (You will pay the least)	Tier II Provider (You will pay more)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 co-payment/visit	10% co-insurance, after deductible	40% co-insurance, after deductible	The office visit <u>copayment</u> will apply to the office visit only and applies per provider.
	<u>Specialist</u> visit	\$35 co-payment/visit	10% co-insurance, after deductible	40% co-insurance, after deductible	All other services rendered during the physician's office visit are paid at the applicable benefit level.
	<u>Preventive care/screening/immunization</u>	No Charge	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for. Flu shots/mist are covered at no cost sharing for plan participants at both <u>network</u> providers and <u>non-network</u> providers.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	10% co-insurance, after deductible	40% co-insurance, after deductible	—————none—————
	Imaging (CT/PET scans, MRIs)	\$30 co-payment/visit	10% co-insurance, after deductible	40% co-insurance, after deductible	

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I Provider (You will pay the least)	Tier II Provider (You will pay more)	Non-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com</p>	Generic drugs	<p>Retail: \$16 co-payment/prescription</p> <p>Mail Order: \$40 co-payment/prescription</p> <p>Maintenance Choice: \$16.25 co-payment/prescription</p>	<p>Retail: \$16 co-payment/prescription</p> <p>Mail Order: \$40 co-payment/prescription</p> <p>Maintenance Choice: \$16.25 co-payment/prescription</p>	<p>Retail: \$16 co-payment/prescription</p> <p>Mail Order: \$40 co-payment/prescription</p> <p>Maintenance Choice: \$16.25 co-payment/prescription</p>	<p>Retail: limited to a thirty (30) day supply.</p> <p>Mail Order: limited to a ninety (90) day supply.</p> <p>Not all <u>prescription drugs</u> are covered. To determine if a specific drug is covered under your <u>plan</u>, log into your account at www.caremark.com.</p> <p>Maintenance Choice is a ninety (90) day supply program for chronic conditions that is filled through CVS Caremark mail service or at any CVS pharmacy location.</p>
	Preferred brand drugs	<p>Retail: \$33 co-payment/prescription</p> <p>Mail Order: \$82.50 co-payment/prescription</p> <p>Maintenance Choice: \$38.75 co-payment/prescription</p>	<p>Retail: \$33 co-payment/prescription</p> <p>Mail Order: \$82.50 co-payment/prescription</p> <p>Maintenance Choice: \$38.75 co-payment/prescription</p>	<p>Retail: \$33 co-payment/prescription</p> <p>Mail Order: \$82.50 co-payment/prescription</p> <p>Maintenance Choice: \$38.75 co-payment/prescription</p>	
	Non-preferred brand drugs	<p>Retail: \$57 co-payment/prescription</p> <p>Mail Order: \$142.50 co-payment/prescription</p> <p>Maintenance</p>	<p>Retail: \$57 co-payment/prescription</p> <p>Mail Order: \$142.50 co-payment/prescription</p> <p>Maintenance</p>	<p>Retail: \$57 co-payment/prescription</p> <p>Mail Order: \$142.50 co-payment/prescription</p> <p>Maintenance</p>	

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I Provider (You will pay the least)	Tier II Provider (You will pay more)	Non-Network Provider (You will pay the most)	
		Choice: \$68.75 co-payment/ prescription	Choice: \$68.75 co-payment/ prescription	Choice: \$68.75 co-payment/ prescription	
	<u>Specialty drugs</u>	Not Applicable	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$300 co-payment/visit	\$300 co-payment/visit, then 10% co-insurance, after deductible	\$300 co-payment/visit, then 40% co-insurance, after deductible	Pre-certification is required. Failure to obtain pre-certification for non-network services will result in a \$500 penalty per hospital confinement, course of treatment, or therapy. This requirement does not apply for office surgeries, pain injections, and screening colonoscopies.
	Physician/surgeon fees	No Charge	10% co-insurance, after deductible	40% co-insurance, after deductible	
If you need immediate medical attention	<u>Emergency room care</u>	\$275 co-payment/visit			<u>Co-payment</u> is waived if plan participant is admitted to <u>inpatient</u> .
	<u>Emergency medical transportation</u>	No Charge			Pre-certification is required for non-emergent air ambulance. Failure to obtain pre-certification for non-network services will result in a \$500 penalty per hospital confinement, course of treatment, or therapy.
	<u>Urgent care</u>	\$30 co-payment/visit	10% co-insurance, after deductible	40% co-insurance, after deductible	Retail clinics are covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$425 co-payment/admission	\$475 co-payment/admission then 10% co-insurance, after deductible	\$575 co-payment/admission then 40% co-insurance, after deductible	Pre-certification is required. Failure to obtain pre-certification for non-network services will result in a \$500 penalty per hospital confinement, course of treatment, or therapy. This requirement does not apply for office surgeries, pain injections, and screening colonoscopies.

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I Provider (You will pay the least)	Tier II Provider (You will pay more)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	No Charge	10% co-insurance, after deductible	40% co-insurance, after deductible	_____none_____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 co-payment/visit	10% co-insurance, after deductible	40% co-insurance, after deductible	_____none_____
	Inpatient services	\$425 co-payment/admission	\$475 co-payment/admission then 10% co-insurance, after deductible	\$575 co-payment/admission then 40% co-insurance, after deductible	Pre-certification is required. Failure to obtain pre-certification for non-network services will result in a \$500 penalty per hospital confinement, course of treatment, or therapy.
If you are pregnant	Office visits	\$50 co-payment/pregnancy	10% co-insurance, after deductible	40% co-insurance, after deductible	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>co-payment</u> , <u>co-insurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery professional services	Included in Office Visit co-payment	10% co-insurance, after deductible	40% co-insurance, after deductible	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	\$425 co-payment/admission	\$475 co-payment/admission then 10% co-insurance, after deductible	\$575 co-payment/admission then 40% co-insurance, after deductible	Pre-certification is required if stay exceeds forty-eight (48) hours for vaginal delivery and ninety-six (96) hours for cesarean delivery. Failure to obtain pre-certification for non-network services will result in a \$500 penalty per hospital confinement, course of treatment, or therapy.
If you need help recovering or have other special needs	<u>Home health care</u>	\$35 co-payment/visit	10% co-insurance, after deductible	Not Covered	_____none_____

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I Provider (You will pay the least)	Tier II Provider (You will pay more)	Non-Network Provider (You will pay the most)	
	<u>Rehabilitation services</u>	\$35 co-payment/visit	10% co-insurance, after deductible	40% co-insurance, after deductible	Benefit Period Maximum: physical therapy and occupational therapy are limited to sixty (60) visits combined. Speech therapy is limited to sixty (60) visits.
	<u>Habilitation services</u>	\$35 co-payment/visit	10% co-insurance, after deductible	40% co-insurance, after deductible	
	<u>Skilled nursing care</u>	No Charge	10% co-insurance, after deductible	Not Covered	Benefit Period Maximum: one hundred twenty (120) days.
	<u>Durable medical equipment</u>	20% co-insurance	20% co-insurance, after deductible	40% co-insurance, after deductible	Pre-certification is required for items in excess of \$1,000. Failure to obtain pre-certification for non-network services will result in a \$500 penalty per hospital confinement, course of treatment, or therapy. Repair and/or replacement is covered unless due to negligence or loss of an item.
	<u>Hospice services</u>	No Charge	10% co-insurance, after deductible	Not Covered	Covered if plan participant life expectancy is one (1) year or less. Pre-certification is required. Failure to obtain pre-certification for non-network services will result in a \$500 penalty per hospital confinement, course of treatment, or therapy.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	_____none_____
	Children's glasses	Not Covered	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	Not Covered	

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.)

- | | | |
|--|---|--|
| <ul style="list-style-type: none"> • Acupuncture • Cosmetic Surgery (except when due to injury, congenital deformities, or reconstructive mammoplasty) | <ul style="list-style-type: none"> • Long-Term Care • Dental Care (Adult) • Weight Loss Programs | <ul style="list-style-type: none"> • Routine Eye Care (Adult) • Routine Foot Care (unless plan participant has been diagnosed with diabetes) |
|--|---|--|

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

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

- Bariatric Surgery
- Chiropractic Care (limited to twenty-five (25) visits)
- Hearing Aids (limited to \$2,500 per ear every twenty-four (24) months for adults. Pediatric hearing aids covered every thirty-six (36) months, no dollar limitation)
- Infertility Treatment
- Private-Duty Nursing
- Non-Emergency Care When Traveling Outside the U.S.

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. You may also contact Plan's COBRA Administrator, Morneau Shepell at 1-844-251-1777. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact:

HealthLink

Attention: Appeals Coordination

P.O. Box 7186

Boise, ID 83707

1-866-504-6814

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 1-877-379-5802.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-379-5802.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-379-5802.

Navajo (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwijigo holne' 1-877-379-5802.

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

* For more information about limitations and exceptions, see the plan or policy document at www.healthlink.com.

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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** \$0
- **Specialist co-payment** \$35
- **Hospital (facility) co-payment** \$425
- **Other co-insurance** 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 \$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles*	\$10
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Peg would pay is	\$530

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 co-payment** \$35
- **Hospital (facility) co-payment** \$425
- **Other co-insurance** 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 \$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$150
Copayments	\$650
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,000

Mia's Simple Fracture

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

- **The plan's overall deductible** \$0
- **Specialist co-payment** \$35
- **Hospital (facility) co-payment** \$275
- **Other co-insurance** 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 \$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$10
Copayments	\$500
Coinsurance	\$80
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$590

*This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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