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:
What is the overall deductible?		**Tier I**	**Tier II**	**Non-Network**	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.
	Per participant:	$0	$300	$400	
Are there services covered before you meet your deductible?	Yes. **For Tier I:** all services are covered before a deductible. **Tier II providers:** preventive care, emergency room services, and ambulance services.				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?		**Tier I**	**Tier II**	**Non-Network**	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.
	Per participant:	$6,600		unlimited	
	Per family:	$13,200		unlimited	
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this Plan doesn't cover, charges in excess of benefit maximums, charges in excess of maximum allowed amounts, pre-certification penalties, and non-medically necessary services.				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, for medical:** Healthlink. See www.healthlink.com or call 1-877-379-5802 for a				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

	list of network providers. **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.	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
		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 provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-payment/visit	20% co-insurance, after deductible	40% co-insurance, after deductible	The office visit copayment will apply to the office visit only and applies per provider. All other services rendered during the physician's office visit are paid at the applicable benefit level.
	Specialist visit	$20 co-payment/visit	20% co-insurance, after deductible	40% co-insurance, after deductible	
	Preventive care/screening/ immunization	No Charge	No Charge	Not Covered	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. Flu shots/mist are covered at no cost sharing for plan participants at both network providers and non-network providers.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% co-insurance, after deductible	40% co-insurance, after deductible	——————————none——————————
	Imaging (CT/PET scans, MRIs)	No Charge	20% 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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cvs.com	Generic drugs	**Retail:** $10 co-payment/ prescription **Mail Order:** $20 co-payment/ prescription **Maintenance Choice:** $10 co-payment/ prescription	**Retail:** $10 co-payment/ prescription **Mail Order:** $20 co-payment/ prescription **Maintenance Choice:** $10 co-payment/ prescription	**Retail:** $10 co-payment/ prescription **Mail Order:** $20 co-payment/ prescription **Maintenance Choice:** $10 co-payment/ prescription	**Retail:** limited to a thirty (30) day supply. **Mail Order:** limited to a ninety (90) day supply. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.cvs.com. 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.
	Preferred brand drugs	**Retail:** $20 co-payment/ prescription **Mail Order:** $40 co-payment/ prescription **Maintenance Choice:** $20 co-payment/ prescription	**Retail:** $20 co-payment/ prescription **Mail Order:** $40 co-payment/ prescription **Maintenance Choice:** $20 co-payment/ prescription	**Retail:** $20 co-payment/ prescription **Mail Order:** $40 co-payment/ prescription **Maintenance Choice:** $20 co-payment/ prescription	
	Non-preferred brand drugs	**Retail:** $40 co-payment/ prescription **Mail Order:** $80 co-payment/ prescription **Maintenance Choice:** $40 co-payment/	**Retail:** $40 co-payment/ prescription **Mail Order:** $80 co-payment/ prescription **Maintenance Choice:** $40 co-payment/	**Retail:** $40 co-payment/ prescription **Mail Order:** $80 co-payment/ prescription **Maintenance Choice:** $40 co-payment/	

* 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)	
		prescription	prescription	prescription	
	Specialty drugs	Not Applicable	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 co-payment/visit	$150 co-payment/visit, then 20% co-insurance, after deductible	$150 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	20% co-insurance, after deductible	40% co-insurance, after deductible	——————————none——————————
If you need immediate medical attention	Emergency room care	$200 co-payment/visit			Co-payment is waived is plan participant is admitted to inpatient.
	Emergency medical transportation	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.
	Urgent care	$20 co-payment/visit	20% 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)	$250 co-payment/admission	$300 co-payment/admission then 20% co-insurance, after deductible	$400 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.
	Physician/surgeon fees	No Charge	20% co-insurance,	40% co-insurance,	——————————none——————————

* 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)	
			after deductible	after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 co-payment/visit	20% co-insurance, after deductible	40% co-insurance, after deductible	——————————none——————————
	Inpatient services	$250 co-payment/admission	$300 co-payment/admission then 20% co-insurance, after deductible	$400 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	20% co-insurance, after deductible	40% co-insurance, after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a co-payment, co-insurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). **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.
	Childbirth/delivery professional services	Included in Office Visit co-payment	20% co-insurance, after deductible	40% co-insurance, after deductible	
	Childbirth/delivery facility services	$250 co-payment/admission	$300 co-payment/admission then 20% co-insurance, after deductible	$400 co-payment/admission then 40% co-insurance, after deductible	
If you need help recovering or have other special needs	Home health care	$15 co-payment/visit	20% co-insurance, after deductible	Not Covered	——————————none——————————
	Rehabilitation services	$20 co-payment/visit	20% 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.
	Habilitation services	$20 co-	20% co-	40% co-	

* 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)	
		payment/visit	insurance, after deductible	insurance, after deductible	
	Skilled nursing care	No Charge	20% co-insurance, after deductible	Not Covered	**Benefit Period Maximum:** one hundred twenty (120) days.
	Durable medical equipment	20% co-insurance	20% co-insurance, after deductible	40% co-insurance, after deductible	**Pre-certification is required for items in excess of $3,000.** 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.
	Hospice services	No Charge	20% co-insurance, after deductible	Not Covered	Covered if plan participant life expectancy is one (1) year or less. **Pre-certification is required.**
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.)

- Acupuncture
- Cosmetic Surgery (except when due to injury, congenital deformities, or reconstructive mammoplasty)
- Long-Term Care
- Dental Care (Adult)
- Weight Loss Programs
- Routine Eye Care (Adult)
- Routine Foot Care (unless plan participant has been diagnosed with diabetes)

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.

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

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 at'ohwol ninisingo, kwiijigo holne' 1-877-379-5802.

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

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

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	$20
Hospital (facility) co-payment	$250
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	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$420**

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	$20
Hospital (facility) co-payment	$250
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	$0
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$700**

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

The plan's overall deductible	$0
Specialist co-payment	$20
Hospital (facility) co-payment	$200
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	$0
Copayments	$300
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$360**

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