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, see your Human Resources Department. 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.consociatehealth.com or call 1-800-798-2422 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$600** individual / **$1,200** family for SBL **$1,200** individual / **$2,400** family for Tier 1 **$2,500** individual / **$5,000** family for Tier 2 **$4,000** individual / **$8,000** family for Tier 3	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.	There are no additional specific deductible amounts before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$1,500** individual / **$3,000** family for SBL **$2,500** individual / **$5,000** family for Tier 1 **$7,500** individual / **$15,000** family for Tier 2 **$15,000** individual / **$30,000** family for Tier 3	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?	Premiums, balance-billing charges, pre-certification penalties, 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 consociatehealth.com for the list of network providers or call Consociate Health at 1-800-798-2422 for assistance.	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. You do not need a referral to see a specialist.	A referral is not required to see a specialist for covered services.

All **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
		Sarah Bush Lincoln Health Center	Tier 1: Network Partner Vendors (Services unavailable at SBL)	Tier 2: Network HealthLink OA III (Services unavailable at SBL)	Tier 3: Out-of-Network Providers (Also for Services available at SBL but performed elsewhere)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay	$25 copay	25% coinsurance	50% coinsurance	None
	Specialist visit	$40 copay	$40 copay	25% coinsurance	50% coinsurance	
	Preventive care/screening/ immunization	No Charge	No Charge	No Charge	50% coinsurance	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)	0% coinsurance	0% coinsurance	25% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	0% coinsurance	25% coinsurance	50% coinsurance	Preauthorization required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.rxbenefits.com		**Purchased at Prairie Medical Center**		**Purchased at All Other Pharmacies**		When purchased at Prairie Medical Pharmacy, medications on the Standard Plus Preventive Medications List are covered at a $0 copay for generics and diabetic medications and supplies. Brand name drugs will be subject to applicable copays. Covers up to 30-day supply.
	Generic drugs	$10 copay		$15 copay		
	Preferred brand drugs	$35 copay		$40 copay		
	Non-preferred brand drugs	$60 copay		$70 copay		
	Specialty drugs	50% coinsurance up to $200		Not Available		Specialty Drugs Must be filled through Prairie Medical Center Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) and Physician/surgeon fees	$250 copay	$250 copay	25% coinsurance	50% coinsurance	Preauthorization required.
If you need immediate medical attention	Emergency room care	$300 copay, then covered 100%				Preauthorization required if admitted to Hospital from ER. Copay waived if admitted to Hospital.
	Emergency medical transportation	Not Available	25% coinsurance	25% coinsurance	25% coinsurance	Inter-facility Air transport must be pre-certified through Sentinel Air Medical Alliance at 1-877-542-8828
	Urgent care	Not Available	0% coinsurance	25% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Sarah Bush Lincoln Health Center	Tier 1: Network Partner Vendors (Services unavailable at SBL)	Tier 2: Network HealthLink OA III (Services unavailable at SBL)	Tier 3: Out-of-Network Providers (Also for Services available at SBL but performed elsewhere)	
If you have a hospital stay	Facility fee (e.g., hospital room) and Physician/Surgeon fees	$250 copay	$250 copay	25% coinsurance	50% coinsurance	Preauthorization is required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Available	0% coinsurance	25% coinsurance	50% coinsurance	None
	Inpatient services	Not Available	$250 copay	25% coinsurance	50% coinsurance	Preauthorization is required
If you are pregnant	Office visits	$25 copay	0% coinsurance	25% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is required for some maternity hospital stays.
	Childbirth/delivery professional services	0% coinsurance	0% coinsurance	25% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	0% coinsurance	25% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	0% coinsurance	25% coinsurance	50% coinsurance	Preauthorization is required
	Rehabilitation services	$25 copay	$25 copay	25% coinsurance	50% coinsurance	Preauthorization is required. Limited to 60 visits per therapy type
	Habilitation services					
	Skilled nursing care	0% coinsurance	0% coinsurance	25% coinsurance	50% coinsurance	Preauthorization is required
	Durable medical equipment	0% coinsurance	0% coinsurance	25% coinsurance	50% coinsurance	Preauthorization is required for equipment over $500.
	Hospice Outpatient	0% coinsurance	0% coinsurance	25% coinsurance	50% coinsurance	Preauthorization is required
	Hospice Inpatient	$250 copay	$250 copay	25% coinsurance	50% coinsurance	
If your child needs dental or eye care	Children's eye exam	Not Covered				Coverage available with separate election of Dental and Vision coverage.
	Children's glasses	Not Covered				
	Children's dental check-up	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
- Hearing Aids
- Long Term Care
- Non-emergency care when outside the U.S.
- Routine foot care, except for diabetics.

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Treatment • Chiropractic (Limited to 20 visits per calendar year)	• Infertility Treatment (Maximum of 6 attempts) • Private Duty Nursing (Limited to 70 visits per calendar year)	• Sleep Disorder treatment • TMJ treatment

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: Consociate Health: 1-800-798-2422. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-232 x 61565 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: Consociate Health: 1-800-798-2422.

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 1-800-798-2422

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-798-2422

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-798-2422

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-798-2422

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	**$600**
OB copayment	**$25**
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	$600
Copayments	$25
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$625**

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

The plan's overall deductible	**$600**
Specialist copayment	**$40**
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	$600
Copayments	$100
Coinsurance	$0
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	**$600**
ER & Specialist copayment	**$340**
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	$600
Copayments	$340
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$940**

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