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.myLuminareHealth.com. 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 https://www.healthcare.gov/sbc-glossary or call 800-848-3012 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1 Network providers: $400 / individual or $1,200 / family per plan year. Tier 2 Network providers: $400 / individual or $1,200 / family per plan year. Tier 3 Out-of-network providers: $550 / individual or $1,650 / family per plan year.	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. Certain preventive care, services that charge a copay, prescription drugs, and emergency room 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?	Yes. Prescription drug coverage: $50 / individual or $150 / family per plan year. There are no other specific deductibles.	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?	Tier 1 Network providers: $1,400 / individual or $4,200 / family per plan year. Tier 2 Network providers: $1,400 / individual or $4,200 / family per plan year. Prescription drug coverage: $1,000 / individual or $3,000 / family per plan year. Tier 3 Out-of-network providers: Unlimited per plan year.	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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Penalties for failure to obtain preauthorization for services, 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.healthlink.com or call 800-624-2356 or see www.phcs.com or call 800-922-4362 for a list of participating 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.	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 1 (Healthlink) (You will pay the least)	Tier 2 PPO (Healthlink & PHCS) (You will pay more)	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	Office visit: $30 copay / visit All other services: 20% coinsurance	Office visit: $30 copay / visit All other services: 25% coinsurance	30% coinsurance	Copay applies to office visit only. Nutritional counseling: $50 copay / visit Acupuncture: 20%/25%/30%, $500 maximum per plan year. Chiropractic care out-of-network provider: $1,000 maximum per plan year. Coverage for chiropractic care & spinal manipulation is limited to 60 visits per plan year, combined with physical, speech & occupational therapy.
	Specialist visit	Office visit: $50 copay / visit All other services: 20% coinsurance	Office visit: $50 copay / visit All other services: 25% coinsurance	30% coinsurance	
	Preventive care / screening / immunization	No charge (deductible does not apply)	No charge (deductible does not apply)	Not covered	Shingles vaccine for ages 50 and over. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Healthlink) (You will pay the least)	Tier 2 PPO (Healthlink & PHCS) (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	Outpatient Hospital: $50 copay / visit then 20% coinsurance Physician's office: 20% coinsurance Obesity Testing: 20% coinsurance	Outpatient Hospital: $50 copay / visit then 25% coinsurance Physician's office: 25% coinsurance Obesity Testing: 25% coinsurance	Outpatient Hospital: $50 copay / visit then 30% coinsurance Physician's office: 30% coinsurance; Obesity Testing: Not covered	Blood work and labs performed at LeadWell will be covered at no charge. Non-preventive blood work and labs are subject to $100 copay / visit then coinsurance of 20%, 25% and 30% regardless of location where test is performed.
	Imaging (CT/PET scans, MRIs)				
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.elixirsolutions.com or call 800-771-4648	Generic drugs	$15 copay retail for 1-34 day supply / prescription $45 copay retail for 84-90 day supply / prescription $37.50 copay mail order for 84-90 day supply / prescription		Not covered	Note: After three fills at retail of a maintenance drug, the retail copays for an 84 to 90 day supply will apply. If you purchase a brand name drug when a generic drug is available, you must pay the brand copay plus the difference in cost between the generic and brand name drug.
	Preferred brand drugs	$25 copay retail for 1-34 day supply / prescription $75 copay retail for 84-90 day supply / prescription $62.50 copay mail order for 84-90 day supply / prescription		Not covered	
	Non-preferred brand drugs	$45 copay retail for 1-34 day supply / prescription $135 copay retail for 84-90 day supply / prescription $112.50 copay mail order for 84-90 day supply / prescription		Not covered	
	Specialty drugs	$50 copay for 30 day supply / prescription		Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Healthlink) (You will pay the least)	Tier 2 PPO (Healthlink & PHCS) (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copay / visit then 20% coinsurance	$50 copay / visit then 25% coinsurance	$50 copay / visit then 30% coinsurance	Benefits for non-emergency services in an out-of-network provider hospital will be reduced by $2,000.
	Physician/surgeon fees	20% coinsurance	25% coinsurance	30% coinsurance	None.
If you need immediate medical attention	Emergency room care	$250 copay / visit then 20% coinsurance	$250 copay / visit then 20% coinsurance	$250 copay / visit then 20% coinsurance	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	None.
	Urgent care	Outpatient facility: $50 copay / visit then 20% coinsurance Outpatient facility testing: $50 copay / visit Physician: $50 copay / visit	Outpatient facility: $50 copay / visit then 25% coinsurance Outpatient facility testing: $50 copay / visit Physician: $50 copay / visit	Outpatient facility: $50 copay / visit then 30% coinsurance Outpatient facility testing: $50 copay / visit Physician: $50 copay / visit	Outpatient facility = Hospital Outpatient facility testing = Hospital diagnostics/labs/x-rays Physician = All other Urgent care facilities

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Healthlink) (You will pay the least)	Tier 2 PPO (Healthlink & PHCS) (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	25% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service. Benefits for non-emergency services in an out-of-network provider hospital will be reduced by $2,000.
	Physician/surgeon fees	20% coinsurance	25% coinsurance	30% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $30 copay / visit All other services: 20% coinsurance	Office visits: $30 copay / visit All other services: 25% coinsurance	30% coinsurance	None.
	Inpatient services	20% coinsurance	25% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service. Benefits for non-emergency services in an out-of-network provider hospital will be reduced by $2,000.
If you are pregnant	Office visits	$30 copay / visit	$30 copay / visit	30% coinsurance	Copay applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copay, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	25% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	25% coinsurance	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Healthlink) (You will pay the least)	Tier 2 PPO (Healthlink & PHCS) (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	25% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Rehabilitation services	Outpatient Hospital: $30 copay / visit then 20% coinsurance Physician's office: 20% coinsurance	Outpatient Hospital: $30 copay / visit then 25% coinsurance; Physician's office: 25% coinsurance	30% coinsurance	Coverage for physical, occupational, and speech therapy is limited to 60 visits per plan year, combined with chiropractic care and spinal manipulation.
	Habilitation services	Outpatient Hospital: $30 copay / visit then 20% coinsurance Physician's office: 20% coinsurance	Outpatient Hospital: $30 copay / visit then 25% coinsurance; Physician's office: 25% coinsurance	30% coinsurance	Coverage is limited to children under age 19. Coverage for physical, occupational, and speech therapy is limited to 60 visits per plan year, combined with chiropractic care and spinal manipulation.
	Skilled nursing care	20% coinsurance	25% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Durable medical equipment	20% coinsurance	25% coinsurance	30% coinsurance	None.
	Hospice services	20% coinsurance	25% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	No coverage for eye exams under medical.
	Children's glasses	Not covered	Not covered	Not covered	No coverage for glasses under medical.
	Children's dental check-up	Not covered	Not covered	Not covered	No coverage for dental check-ups under medical.

Excluded Services & Other Covered Services:

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

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery • Dental care	• Long-term care • Routine eye care	• Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric surgery (subject to $25,000 while covered by this plan) • Chiropractic care	• Hearing aids (max $2,500/instrument and related services per 24 months) • Infertility treatment (subject to $25,000 while covered by this plan)	• Non-emergency care when traveling outside the U.S. • Private-duty nursing

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 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 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: Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-800-848-3012.
Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-848-3012.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-848-3012.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-848-3012.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-848-3012.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-848-3012.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-848-3012.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-848-3012.

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	**$400**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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	$400
Copayments	$600
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,460**

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

The plan's overall deductible	**$400**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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	$450
Copayments	$900
Coinsurance	$30
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,400**

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

The plan's overall deductible	**$400**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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	$400
Copayments	$600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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