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, contact the Plan's Administrator, Wilson-McShane Corporation at 1-800-535-6373 or 952-854-0795. 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.dol.gov/ebsa/healthreform or call 1-866-444-EBSA (3272) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$800** individual/**$1,600** family.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your plan document to see when the **deductible** starts over (usually, but not always, January 1st).
Are there services covered before you meet your deductible?	**Yes.**	In-network primary care visits to treat an injury or illness and specialist visits are subject to a $15 copayment.
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?	**Individual: $3,550** medical and **$2,500** prescription drugs. **Family: $7,100** medical, **$5,000** prescription drugs, $1,800 specialty drugs	The **out-of-pocket limit** is the most you could pay during a year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	**Deductibles, h**ealth care this plan does not 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.**	Non-network providers are subject to 30% co-insurance rather than 20% co-insurance in-network; no coverage for out-of-network inpatient expenses except in an emergency.
Do you need a referral to see a specialist?	**No.**	You can see a **specialist** you choose without permission from this plan.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

* For more information about limitations and exceptions, see the plan or policy document at www.health49.org.

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	$15 copayment	30% co-insurance	None
	Specialist visit	$15 copayment	30% co-insurance	None
	Preventive care/screening/ immunization	Routine Immunizations: 0% co-insurance Preventive care/Screening: 0% co-insurance	Routine Immunizations: 20% co-insurance Preventive care/Screening: 20% co-insurance	Physicals covered at 100% if obtained through Health Dynamics or a participating provider.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	30% co-insurance	Diagnostic imaging and testing performed at Rayus Radiology is covered 100%. Examinations for routine check-up purposes are excluded.
	Imaging (CT/PET scans, MRIs)	20% co-insurance	30% co-insurance	Diagnostic imaging and testing performed at Rayus Radiology is covered 100%.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.health49.org	Generic drugs	20% co-insurance	20% co-insurance	$2,500 individual/$5,000 family Out-of-Pocket Maximum.
	Preferred brand drugs	20% co-insurance	20% co-insurance	$2,500 individual/$5,000 family Out-of-Pocket Maximum.
	Non-preferred brand drugs	Not Covered.	Not Covered.	There is no coverage for non-formulary drugs.
	Specialty drugs	20% co-insurance	Not Covered.	$2,500 individual/$5,000 family Out-of-Pocket Maximum. Additional $1,800 family Out-of-Pocket Maximum for specialty drugs. Specialty drugs must be obtained from Optum's specialty pharmacy to be covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	30% co-insurance	None
	Physician/surgeon fees	20% co-insurance	30% co-insurance	None
If you need immediate medical attention	Emergency room care	20% co-insurance	20% co-insurance	None
	Emergency medical transportation	20% co-insurance	20% co-insurance	Transportation must be to nearest local facility as medically necessary.
	Urgent care	20% co-insurance	30% co-insurance	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 have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	Not covered except in emergencies, in which case it is subject to 20% co-insurance.	Out-of-network inpatient expenses are not covered except in an emergency, in which case it is covered at 20% co-insurance
	Physician/surgeon fees	20% co-insurance	Not covered except in emergencies, in which case it is subject to 20% co-insurance.	Out-of-network inpatient expenses are not covered except in an emergency, in which case it is covered at 20% co-insurance
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance	30% co-insurance	None
	Inpatient services	20% co-insurance	Not covered except in emergencies, in which case it is subject to 20% co-insurance.	Out-of-network inpatient expenses are not covered except in an emergency, in which case it is subject to 20% co-insurance.
If you are pregnant	Office visits	Prenatal: 0% Postnatal: 20% co-insurance	Prenatal: 30% co-insurance Postnatal: 30% co-insurance	Coverage is excluded for individuals acting as surrogate mothers.
	Childbirth/delivery professional services	20% co-insurance	30%. Not covered if inpatient, except in emergencies, in which case it is subject to 20% co-insurance.	Coverage is excluded for individuals acting as surrogate mothers. Out-of-network inpatient expenses are not covered except in the case of an emergency, in which case it is subject to 20% co-insurance.
	Childbirth/delivery facility services	20% co-insurance	30%. Not covered if inpatient, except in emergencies, in which case it is subject to 20% co-insurance.	Coverage is excluded for individuals acting as surrogate mothers. Out-of-network inpatient expenses are not covered except in the case of an emergency, in which case it is subject to 20% co-insurance.
If you need help recovering or have other special health needs	Home health care	20% co-insurance	30% co-insurance	Maximum of 90 visits per calendar year.
	Rehabilitation services	20% co-insurance	30% co-insurance	Rehabilitation services must be prescribed by a physician.
	Habilitation services	20% co-insurance	30% co-insurance	Habilitation services must be prescribed by a physician.

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)	
	Skilled nursing care	20% co-insurance	20% co-insurance	Maximum of 2 days of skilled nursing care for each day of Hospital confinement, up to a cumulative maximum of 60 days of care.
	Durable medical equipment	20% co-insurance	30% co-insurance	Plan pays up to the actual purchase price. Must be prescribed by a health care provider.
	Hospice services	0% co-insurance, up to 180 days of hospice service	0% co-insurance, up to 180 days of hospice service	Maximum of 180 days of hospice service; maximum may be waived when continued hospice care would be a cost savings to this plan.
If your child needs dental or eye care	Children's eye exam	0% co-insurance	0% co-insurance	The maximum allowance does not apply to exams for children under age 18.
	Children's glasses	0% co-insurance up to a benefit maximum of $500 every even numbered calendar year	0% co-insurance up to a benefit maximum of $500 every even numbered calendar year	The plan offers a $500 benefit replenished on the first day of every even numbered calendar year, this benefit applies to glasses, and contact lenses.
	Children's dental check-up	0% co-insurance	0% co-insurance	None

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.)

- Custodial Care
- Infertility treatment
- Wigs
- Weight loss programs

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

- Bariatric surgery
- Chiropractic Care
- Acupuncture
- Hearing Aids

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 the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-44-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 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 the Plan's Administrator, Wilson-McShane Corporation at 1-800-535-6373 or 952-854-0795. You may also contact the U.S. Department of Labor's Employee Benefit Security Administration at 1-866-444-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.

*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	**$800**
Specialist *[cost sharing]*	**$15**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**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	$800
Copayments	$0
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,200**

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

The plan's overall deductible	**$800**
Specialist *[cost sharing]*	**$15**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**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	$800
Copayments	$200
Coinsurance	$700
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,700**

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

The plan's overall deductible	**$800**
Specialist *[cost sharing]*	**$15**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**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	$800
Copayments	$45
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,645**

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