



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 ?	\$1,000 individual/ \$2,000 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st).
Are there services covered before you meet your deductible ?	Yes.	In-network preventive care.
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan ?	Individual: \$2,500 medical and \$2,500 prescription drugs. Family: \$6,000 medical, \$5,900 prescription drugs, and \$1,800 specialty drugs.	The <u>out-of-pocket limit</u> 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 , Health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <u>specialist</u> 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.

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	\$25 copayment	30% co-insurance	None
	Specialist visit	\$25 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 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 at 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 at 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. Certain drugs subject to additional or different limitations or co-insurance. See SPD.
	Preferred brand drugs	20% co-insurance	20% co-insurance	\$2,500 individual/\$5,000 family Out-of-Pocket Maximum. Certain drugs subject to additional or different limitations or co-insurance. See SPD.
	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/\$5,900 family Out-of-Pocket Maximum. Additional \$1,800 family Out-of-Pocket Maximum for specialty drugs. Specialty drugs must be obtained from CVS's specialty pharmacy to be covered. Certain drugs subject to additional or different limitations or co-insurance. See SPD.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	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)	
	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
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 subject to 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 subject to 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 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 an emergency, in which case it is subject to 20% co-insurance.
If you need help recovering or have	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

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)	
other special health needs				by a physician.
	Habilitation services	20% co-insurance	30% co-insurance	Habilitation services must be prescribed by a physician.
	Skilled nursing care	20% co-insurance	30% 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 • Prophylactic treatment	• 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.

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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	\$1000
■ Specialist [cost sharing]	\$25
■ 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1000
Copayments	\$0
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$3,000

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1000
■ Specialist [cost sharing]	\$25
■ 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1000
Copayments	\$300
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,100

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1000
■ Specialist [cost sharing]	\$25
■ 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1000
Copayments	\$75
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1475

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.