




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](http://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 <a href="#">deductible</a> ?	\$1,000 individual/\$2,000 family	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st).
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes.	In-network preventive care.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>Individual: \$2,500</b> medical and \$2,500 prescription drugs. <b>Family: \$6,000</b> medical, \$5,900 prescription drugs, and \$1,800 specialty drugs.	The <b>out-of-pocket limit</b> 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 <a href="#">out-of-pocket limit</a> ?	<b>Deductibles</b> , health care this plan does not cover, and balance billing	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Will you pay less if you use a <a href="#">network provider</a> ?	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 <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see a <b>specialist</b> you choose without permission from this plan.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.health49.org](http://www.health49.org).

 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 <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$25 copayment	30% co-insurance	None
	<a href="#">Specialist</a> visit	\$25 copayment	30% co-insurance	None
	<a href="#">Preventive care/screening/immunization</a>	<u>Routine Immunizations:</u> 0% co-insurance <u>Preventive care/Screening:</u> 0% co-insurance	<u>Routine Immunizations:</u> 20% co-insurance <u>Preventive care/Screening:</u> 20% co-insurance	Physicals covered at 100% if obtained through a participating provider.
If you have a test	<a href="#">Diagnostic test</a> (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 <a href="#">prescription drug coverage</a> is available at <a href="http://www.health49.org">www.health49.org</a>	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.
	<a href="#">Specialty drugs</a>	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

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)	
				SPD.
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	<a href="#">Emergency room care</a>	20% co-insurance	20% co-insurance	None
	<a href="#">Emergency medical transportation</a>	20% co-insurance	20% co-insurance	Transportation must be to nearest local facility as medically necessary.
	<a href="#">Urgent care</a>	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%	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%

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)	
			co-insurance.	co-insurance.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% co-insurance	30% co-insurance	Maximum of 90 visits per calendar year.
	<a href="#">Rehabilitation services</a>	20% co-insurance	30% co-insurance	Rehabilitation services must be prescribed by a physician.
	<a href="#">Habilitation services</a>	20% co-insurance	30% co-insurance	Habilitation services must be prescribed by a physician.
	<a href="#">Skilled nursing care</a>	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.
	<a href="#">Durable medical equipment</a>	20% co-insurance	30% co-insurance	Plan pays up to the actual purchase price. Must be prescribed by a health care provider.
	<a href="#">Hospice services</a>	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.
<b>If your child needs dental or eye care</b>	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](#).)**

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"> <li>• Custodial Care</li> <li>• Infertility treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Prophylactic treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Weight loss programs</li> </ul> |
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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- |  |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Chiropractic Care</li> </ul> | <ul style="list-style-type: none"> <li>• Acupuncture</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing Aids</li> </ul> |
|--|---|--|

**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](http://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](http://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](http://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:** Para obtener asistencia en Espanol, llame al (952) 854-0795.

*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](#) \$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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

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

### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

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

### 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

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

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