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 Regional Care, Inc. at 1-800-795-7772 or www.regionalcare.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 www.dol.gov/ebsa/healthreform call 1-800-795-7772 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$600** person / **$1,200** family per calendar year for In-Network providers **$1,200** person / **$2,400** family per calendar year for Out-of-Network providers	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?	Physician office visit charges and prescription drugs 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.
Are there other deductibles for specific services?	Yes. $50 person per calendar year for dental benefits.	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?	**$1,600** person / **$3,200** family per calendar year for In-Network providers **$3,200** person / **$6,400** family per calendar year for Out-of-Network providers **$2,400** for Specialty Drugs obtained through a participating pharmacy.	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?	Copayments, Premiums, balance-billing charges, Health care this plan doesn't cover, and penalties for failure to obtain pre-authorization for services.	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, this plan accesses different networks depending on your location. See www.midlandschoice.com or call 800-605-8259 for a list of Midlands Choice Providers. See www.ProviDRsCare.net or call 1-800-901-9772 for a list of ProviDRs Care Network 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
		In-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	$30 copay/office visit and 20% coinsurance for other services	$30 copay/office visit and 40% coinsurance for other services	Deductible does not apply to In-Network Providers for the office visit charge only.
	Specialist visit	$30 copay/office visit and 20% coinsurance for other services Chiropractic Care: 20% coinsurance	$30 copay/office visit and 40% coinsurance for other services Chiropractic Care: 20% coinsurance	Deductible does not apply to In-Network office visit charges. Chiropractic care is limited to 50 visits/calendar year.
	Preventive care/screening/ immunization	Not covered	Not covered	----------None----------
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Deductible applies.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Deductible applies.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.elixirsolutions.com or 1-800-771-4648	Generic drugs	Retail: $15 copay/prescription Mail Order: $37.50 copay/prescription	Retail: $15 copay/prescription Mail Order: Not Covered	Deductible does not apply. Covers up to a 90 day supply at retail (for 3 copays) and up to a 90 day supply through mail order. You are required to receive the generic drug when the generic drug is available. If you request a brand drug over a generic you will be responsible for the applicable copay plus the difference in cost between the brand and the generic. However, if you physician specified "Dispense as Written", you will only pay the applicable copay. Certain drugs used for preventive care will be covered at no charge to you if you have a prescription. Prior authorization is required for any single retail drug costing more than $500 and any single mail order drug costing more than $1,000. When a prescription drug is obtained through a non-
	Preferred brand drugs (Formulary)	Retail: $47.50 copay/prescription Mail Order: $118.75 copay/prescription	Retail: $47.50 copay/prescription Mail Order: Not Covered	
	Non-preferred brand drugs (Non-Formulary)	Retail: $47.50 copay/prescription Mail Order: $118.75 copay/prescription	Retail: $47.50 copay/prescription Mail Order: Not Covered	
	Specialty drugs	Retail: 20% coinsurance up to a maximum payment of $200/prescription		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				participating pharmacy or through a participating pharmacy and you fail to use your ID Card, you will have to pay for the entire cost of the drug at the time of purchase and then submit the claim for reimbursement. You will be reimbursed minus the applicable copayment and minus the cost difference of the drug between the participating pharmacy and the non-participating pharmacy. Specialty drugs are subject to a separate out of pocket limit and must be filled through a participating pharmacy or a preferred specialty provider.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Deductible applies.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Deductible applies.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Deductible applies. Precertification is required within 1 business day after an inpatient admission. Failure to obtain precertification may result in a reduction in benefits.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Deductible applies.
	Urgent care	20% coinsurance	40% coinsurance	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Deductible applies. Precertification is required 48 hours in advance of a non-emergency admission and within 48 hours of the first business day after an emergency admission. Failure to obtain precertification may result in a reduction in benefits. Hospital and Physician charges covered under the Plan which are incurred at the Mayo Clinic, or its affiliated Hospitals, which include Saint Mary's Hospital and Rochester Methodist Hospital, are payable at the In-Network provider rate.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/office visit and 20% coinsurance for other services	40% coinsurance	Deductible doesn't apply to In-Network office visit charge only.
	Inpatient services	20% coinsurance	40% coinsurance	Deductible applies. Precertification is required 48 hours in advance of a non-emergency admission and within 1 business day after an emergency admission. Failure to obtain precertification may result in a reduction in benefits.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Deductible applies. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Deductible applies. Coverage is limited to a 100 day calendar year maximum.
	Rehabilitation services	20% coinsurance	40% coinsurance	Deductible applies.
	Habilitation services	20% coinsurance	40% coinsurance	Deductible applies. Only speech therapy is covered and only when it's following a surgery for the correction of a congenital condition of the oral cavity, throat or nasal complex.
	Skilled nursing care	20% coinsurance	20% coinsurance	Deductible applies. Precertification is required 48 hours in advance of a non-emergency admission. Failure to obtain precertification may result in a reduction in benefits. Services must be received 60 days per Calendar Year within 14 days of a 3 day Hospital stay.
	Durable medical equipment	20% coinsurance	40% coinsurance	Deductible applies.
	Hospice services	20% coinsurance	20% coinsurance	Deductible applies. Includes bereavement counseling.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	----------None----------
	Children's glasses	Not Covered	Not Covered	----------None----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Preventive Care – 80% coinsurance Basic Services - 80% coinsurance Major Services – 50% coinsurance Orthodontia – Not Covered		Dental deductible applies to all types of services. The plan will pay up to $1,000 in covered charges.

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
- Bariatric Surgery
- Chiropractic Care
- Cosmetic Surgery
- Habilitative Services
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when outside the U.S.
- Preventive Care
- Routine eye care
- Routine Foot Care

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

- Bariatric Surgery, for those morbidly obese
- Chiropractic Care
- Dental Care
- Private-duty nursing
- Weight loss programs, for those morbidly obese

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 1-866-444-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 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 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 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-795-7772.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-795-7772.

Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-800-795-7772.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-795-7772.

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
Specialist copayment	$30
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	**$11,071**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,660**

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	$30
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	**$5,780**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copayments	$975
Coinsurance	$25
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,655**

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

The plan's overall deductible	$600
Specialist copayment	$30
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	**$909**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$90
Coinsurance	$326
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,016**

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