
 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](http://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](http://www.dol.gov/ebsa/healthreform) call 1-800-795-7772 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p><b>\$600</b> person / <b>\$1,200</b> family per calendar year for In-Network providers  <b>\$1,200</b> person / <b>\$2,400</b> family per calendar year for Out-of-Network providers</p>	<p>Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Physician service office visits, prescription drugs, and preventive care services are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>Yes. \$50 person per calendar year for dental benefits.</p>	<p>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.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p><b>\$1,600</b> person / <b>\$3,200</b> family per calendar year for In-Network providers  <b>\$3,200</b> person / <b>\$6,400</b> family per calendar year for Out-of-Network providers  <b>\$2,400</b> for Specialty Drugs obtained through a participating pharmacy.</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><a href="#">Premiums</a>, <a href="#">balance-billing</a> charges, Health care this <a href="#">plan</a> doesn't cover, and penalties for failure to obtain <a href="#">pre-authorization</a></p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

	for services.	
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	<p>Yes, this plan accesses different network depending on your location.</p> <p>See <a href="http://www.midlandschoice.com">www.midlandschoice.com</a> or call 800-605-8259 for a list of Midlands Choice Providers.</p> <p>See <a href="http://www.ProviDRsCare.net">www.ProviDRsCare.net</a> or call 800-901-9772 for a list of ProviDRs Care Network Providers.</p>	<p>This <a href="#">plan</a> uses a provider <a href="#">network</a>. You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a>. You will pay the most if you use an <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays (<a href="#">balance billing</a>). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</p>
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /office visit and 20% <a href="#">coinsurance</a> for other services	\$30 <a href="#">copay</a> /office visit and 40% <a href="#">coinsurance</a> for other services	Deductible does not apply to In-Network Providers for the office visit charge only.
	<a href="#">Specialist</a> visit	\$30 <a href="#">copay</a> /office visit and 20% <a href="#">coinsurance</a> for other services  Chiropractic Care: 20% <a href="#">coinsurance</a>	\$30 <a href="#">copay</a> /office visit and 40% <a href="#">coinsurance</a> for other services  Chiropractic Care: 20% <a href="#">coinsurance</a>	Deductible does not apply to In-Network office visit charges. Chiropractic care is limited to 50 visits/calendar year.
	<a href="#">Preventive care/screening/immunization</a>	No charge	40% <a href="#">coinsurance</a>	Deductible does not apply to in-network providers. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Deductible applies.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Deductible applies.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.elixirsolutions.com">www.elixirsolutions.com</a> or 800-771-4550	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
	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	
	<a href="#">Specialty drugs</a>	Retail: 20% <a href="#">coinsurance</a> 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)	
				order drug costing more than \$1,000. When a prescription drug is obtained through a non-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. Drugs required as part of evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, as required by the Affordable Care Act are covered at 100% not subject to any <a href="#">copay</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> .
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Deductible applies.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Deductible applies.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Deductible applies. <a href="#">Precertification</a> is required within 1 business day after an inpatient admission. Failure to obtain <a href="#">precertification</a> may result in a reduction in benefits.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Deductible applies.
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Deductible applies.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Deductible applies. <a href="#">Precertification</a> 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
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	

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)	
				<a href="#">precertification</a> 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.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <a href="#">copay</a> /office visit and 20% <a href="#">coinsurance</a> for other services	40% <a href="#">coinsurance</a>	Deductible does not apply to In-Network office visit charge only.
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Deductible applies. <a href="#">Precertification</a> is required 48 hours in advance of a non-emergency admission and within 1 business day after an emergency admission. Failure to obtain <a href="#">precertification</a> may result in a reduction in benefits.
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Deductible applies. <a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. 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% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Deductible applies. Coverage is limited to a 100 day calendar year maximum.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Deductible applies.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Deductible applies. Only speech therapy is covered and only when it is following a surgery for the correction of a congenital condition of the oral cavity, throat or nasal complex.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Deductible applies. Precertification is required 48 hours in advance of a non-emergency

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)	
				admission. Failure to obtain precertification may result in a reduction of benefits. Services must be received within 14 days of a 3 day Hospital Stay. Coverage is limited to 60 day calendar year.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Deductible applies.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Deductible applies. Includes bereavement counseling.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	A vision screening is covered as part of your child's wellness visit with his or her family Physician under preventive care.
	Children's glasses	Not Covered	Not Covered	-----None-----
	Children's dental check-up	Preventive Care – 0% <a href="#">coinsurance</a> Basic Services - 80% <a href="#">coinsurance</a> Major Services - 50% <a href="#">coinsurance</a> Orthodontia – Not Covered		Dental deductible does not apply to preventive 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](#).)**

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic Surgery</li> <li>• Habilitative Services</li> <li>• Hearing Aids</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility Treatment</li> <li>• Long Term Care</li> <li>• Non-emergency care outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care</li> <li>• Routine Foot Care</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.)**

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|--|---|--|
| <ul style="list-style-type: none"> <li>• Bariatric Surgery, for those morbidly obese</li> <li>• Chiropractic Care</li> </ul> | <ul style="list-style-type: none"> <li>• Dental Care</li> <li>• Private-duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Weight Loss Programs, for those morbidly obese</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 those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-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 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](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:**

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, kwijjigo 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*)

<b>Total Example Cost</b>	<b>\$11,071</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$0
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,660</b>

**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*)

<b>Total Example Cost</b>	<b>\$5,780</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$975
Coinsurance	\$25
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,655</b>

**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*)

<b>Total Example Cost</b>	<b>\$909</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,016
Copayments	\$600
Coinsurance	\$326
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,016</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact your HR Department.