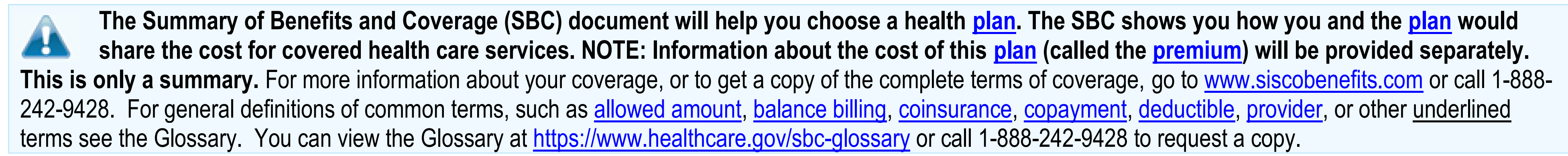
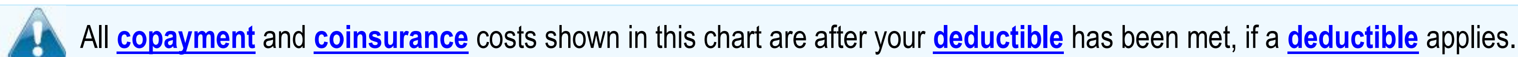

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.siscobenefits.com or call 1-888-242-9428. 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 https://www.healthcare.gov/sbc-glossary or call 1-888-242-9428 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	The fully insured plan starts at: For in-network providers: $6,000 / individual or $12,000 / family; For out-of-network providers: $7,500 / individual or $15,000 / family. After partial self-funding, the deductible becomes: $250 / individual or $500 / family.	Benefits under this plan are supplemental to Jackson County's fully insured health plan with Wellmark Blue Cross and Blue Shield. Refer to the Wellmark plan for information about its benefits. 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?	Yes. Well-child care, in-network preventive care, in-network independent labs, in-network prosthetic limbs, and services subject to a copayment 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. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible.
Are there other deductibles for specific services?	No.	See the Common Medical Events chart below for your costs for services this plan covers.
What is the out-of-pocket limit for this plan?	The fully insured plan starts at: For in-network providers $8,500 / individual or $17,000 / family; For out-of-network providers: $17,000 / individual or $34,000 / family. After partial self-funding, the out-of-pocket becomes: $500 / individual or $1,000 / family.	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?	Premiums, balance-billing charges, pre-service review penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-800-524-9242 for a list of participating 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
		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	$20 copay / visit, deductible does not apply	20% coinsurance	None
	Specialist visit	$20 copay / visit, deductible does not apply	20% coinsurance	Refer to the SBC of the fully insured plan for limitations and exceptions.
	Preventive care/screening/ immunization	No Charge	20% coinsurance	Refer to the SBC of the fully insured plan for limitations and exceptions.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	Refer to the SBC of the fully insured plan for limitations and exceptions.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.wellmark.com	Tier 1	$10 copay / prescription		Deductible does not apply to prescription drugs. Refer to the SBC of the fully insured plan for limitations and exceptions.
	Tier 2	$25 copay / prescription		
	Tier 3	$40 copay / prescription		
	Specialty drugs	$85 copay / prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	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	10% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	Refer to the SBC of the fully insured plan for limitations and exceptions.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Refer to the SBC of the fully insured plan for limitations and exceptions.
	Urgent care	$20 copay / visit, deductible does not apply	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	None
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	20% coinsurance	None
	Inpatient services	10% coinsurance	20% coinsurance	
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	Refer to the SBC of the fully insured plan for limitations and exceptions.
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	Refer to the SBC of the fully insured plan for limitations and exceptions.
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	None
	Rehabilitation services	$20 copay / visit, deductible does not apply; Other outpatient: 10% coinsurance	20% coinsurance	None
	Habilitation services	$20 copay / visit, deductible does not apply; Other outpatient: 10% coinsurance	20% coinsurance	
	Skilled nursing care	10% coinsurance	20% coinsurance	Refer to the SBC of the fully insured plan for limitations and exceptions.
	Durable medical equipment	10% coinsurance	20% coinsurance	Refer to the SBC of the fully insured plan for limitations and exceptions.

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)	
	Hospice services	10% coinsurance	20% coinsurance	Refer to the SBC of the fully insured plan for limitations and exceptions.
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
	Children's dental check-up	Not covered	Not covered	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.)

- Bariatric surgery
- Cosmetic surgery
- Custodial care – in home or facility
- Dental Care – Adult
- Dental check-up
- Extended home skilled nursing
- Eye exam
- Glasses
- Long-term care
- Routine eye care – Adult
- Routine foot care
- Some pharmacy drugs are not covered
- Weight loss programs

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

- Acupuncture (limited to 4 visits per calendar year)
- Applied Behavior Analysis therapy-covered through age 18 subject to annual limits
- Chiropractic care
- Hearing aids (Limited to $2,500 every 36 months)
- Infertility treatment ($15,000 LTM)
- Most coverage provided outside the U.S.
- Private-duty nursing - short term intermittent home skilled nursing

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 Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x 61565 or www.cciio.cms.gov. You may also contact your human resources department for information about continuing your coverage; visit www.siscobenefits.com to find a copy of your plan; or call SISCO at 1-888-242-9428. 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: SISCO at 1-888-242-9428 or your employer.

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 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 1-888-242-9428.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-242-9428.
Vietnamese (tiếng Việt): Để được trợ giúp bằng tiếng Việt, xin gọi 1-888-242-9428.
Serbian (Српски): За помоћ у енглеском језику, позовите 1-888-242-9428.
German (Deutsch): Für Hilfe in Deutsch, rufen Sie 1-888-242-9428.
Arabic (عربى): للحصول على المساعدة في اللغة العربية، والدعوة 1-888-242-9428
Laotian (ລາວ): ສໍາລັບການຊ່ວຍເຫຼືອໃນລາວ, ໃຫ້ໂທຫາ 1-888-242-9428.
Korean (한국어): 한국어로 도움을 받으려면 1-888-242-9428로 전화하십시오
Hindi (हिंदी): हिंदी में सहायता के लिए, 1-888-242-9428 पर कॉल करें
French (français): Pour obtenir de l'aide en français, composez le 1-888-242-9428.
Pennsylvanian Dutch (Deitsch, Pennsylvania Deitsch, Pennsilfaanisch Deitsch): Fer die Hilf in Deitsch, rufe 1-888-242-9428.
Thai (ภาษาไทย): ขอความช่วยเหลือในภาษาไทยโทร 1-888-242-9428.
Tagalog (Tagalog – Filipino): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-242-9428.
Russian (русский): Для получения помощи на русском языке позвоните по телефону 1-888-242-9428.
Karen:
ဟ်သူဉ်ဟ်သး– နမ့ၢ်ကတိၤ ကညီ ကျိာ်အယိ, နမၤန့ၢ် ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး
1-888-242-9428.

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** **$250**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$250
Copayments	$0
Coinsurance	$250
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

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

- **The plan's overall deductible** **$250**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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*	$50
Copayments	$450
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$520**

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

- **The plan's overall deductible** **$250**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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*	$250
Copayments	$100
Coinsurance	$150
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

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