

CBE Companies Inc Traditional PPO



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, visit www.wellmark.com or call 1-800-524-9242 for Wellmark or 1-888-884-6331 for MedOne. 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.healthcare.gov/sbc-glossary or call 1-800-524-9242 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: \$2,000 person/ \$3,500 family per calendar year. Out-of-Network: \$4,000 person/ \$7,000 family per calendar year.	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Well-child care, <u>in-network preventive care</u> , <u>in-network prosthetic limbs</u> , your drug card costs and services subject to <u>copayments</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No. There are no other <u>deductibles</u> . Drug card has no <u>deductible</u> .	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Health In-Network: \$4,000 person/ \$7,000 family per calendar year. Health Out-Of-Network: \$8,000 person/ \$14,000 family per calendar year. Drug Card: \$3,600 person/ \$7,200 family per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billed charges</u> , and health care this <u>plan</u> doesn't 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. See www.wellmark.com or call 1-800-524-9242 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> per <u>provider</u> per date of service	50% <u>coinsurance</u>	Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners, Certified Nurse Midwives and PAs. \$150 <u>copay</u> per <u>provider</u> per date of service for in- <u>network</u> office administered <u>specialty</u> drugs.
	<u>Specialist</u> visit	\$50 <u>copay</u> per <u>provider</u> per date of service	50% <u>coinsurance</u>	Applies to Non-PCP <u>providers</u> . Chiropractic services apply <u>deductible</u> and <u>coinsurance</u> ; these services waive <u>deductible</u> and <u>coinsurance</u> for mental health/substance abuse. Hearing exams are covered according to ACA guidelines. \$150 <u>copay</u> per <u>provider</u> per date of service for in- <u>network</u> office administered <u>specialty</u> drugs.
	<u>Preventive care/screening/immunization</u>	No charge	50% <u>coinsurance</u>	One preventive exam and one mammogram per calendar year. Well- child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above. Advanced imaging, CT, MRA, MRI, and PET Scans - apply <u>deductible</u> and <u>coinsurance</u> .

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242 or MedOne at 1-888-884-6331

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medone-rx.com or call 1-888-884-6331 to speak with a MedOne Member Advocate.	Generic drugs (Tier 1)	\$15 copay 30-day supply*, \$30 copay 31-60-day supply*, \$45 copay 61-90 day supply* <i>*Retail or Mail Order</i>	\$15 copay 30-day supply*, \$30 copay 31-60-day supply*, \$45 copay 61-90 day supply* <i>*Retail or Mail Order</i>	
	Preferred brand drugs (Tier 2)	\$35 copay 30-day supply*, \$70 copay 31-60-day supply*, \$105 copay 61-90 day supply* <i>*Retail or Mail Order</i>	\$35 copay 30-day supply*, \$70 copay 31-60-day supply*, \$105 copay 61-90 day supply* <i>*Retail or Mail Order</i>	
	Non-preferred brand drugs (Tier 3)	\$60 copay 30-day supply*, \$120 copay 31-60-day supply*, \$180 copay 61-90 day supply* <i>*Retail or Mail Order</i>	\$60 copay 30-day supply*, \$120 copay 31-60-day supply*, \$180 copay 61-90 day supply* <i>*Retail or Mail Order</i>	
	Specialty drugs (Tier 4)	Excluded	Excluded	Specialty medications are managed through the RxAllly program. Members can reach their dedicated Patient Care Coordinator at 877-794-2218 for assistance with acquiring specialty medications.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----None-----
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----None-----
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For <u>emergency medical conditions</u> treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For covered non-emergent situations, out-of-network ambulance services are NOT reimbursed at the in-network level. The member may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	<u>Urgent care</u>	\$25 <u>copay</u> per provider per date of service for facility and physician(s) combined	50% <u>coinsurance</u>	\$150 <u>copay</u> per provider per date of service for in-network office administered <u>specialty drugs</u> .

If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----None-----
	<u>Physician</u> /surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----None-----

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Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$25 PCP/\$50 Non-PCP copay per provider per date of service Facility: 20% coinsurance	50% coinsurance	-----None-----
	Inpatient services	20% coinsurance	50% coinsurance	-----None-----
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Except for complications of pregnancy and mandated preventive services, maternity services for dependent children are not covered. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services. For any in-network services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	-----None-----

For more information about limitations and exceptions, see your [plan](#) document or call Wellmark at 1-800-524-9242 or MedOne at 1-888-884-6331

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----None-----
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Inhalation, occupational, physical, respiratory and speech therapy - apply <u>deductible</u> and <u>coinsurance</u> ; these services waive <u>deductible</u> and <u>coinsurance</u> for mental health/substance abuse. \$150 <u>copay</u> per <u>provider</u> per date of service for in- <u>network</u> office administered <u>specialty</u> <u>drugs</u> .
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Inhalation, occupational, physical, respiratory and speech therapy - apply <u>deductible</u> and <u>coinsurance</u> ; these services waive <u>deductible</u> and <u>coinsurance</u> for mental health/substance abuse. \$150 <u>copay</u> per <u>provider</u> per date of service for in- <u>network</u> office administered <u>specialty</u> <u>drugs</u> .
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----None-----
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----None-----
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
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-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242 or MedOne at 1-888-884-6331

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
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Eye exam
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care - Adult
- Routine foot care
- Weight loss programs

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

- Applied Behavior Analysis therapy
- Chiropractic care (12 visits per calendar year)
- Extended home skilled nursing
- 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 those agencies is: the U.S. Department of Labor, 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, you can contact: see your plan document or call Wellmark at 1-800-524-9242 or MedOne at 1-888-884-6331

or 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.

[To see examples of how this plan might cover costs for a sample medical situation, see the next page.](#)

This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.

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 <u>deductible</u>	\$2,000
■ PCP <u>copayment</u>	\$25
■ Hospital(facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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:

Cost Sharing	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$100
<u>Coinsurance</u> <i>What isn't covered</i>	\$1,800
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$3,970

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

■ The plan's overall <u>deductible</u>	\$2,000
■ <u>Specialist</u> <u>copayment</u>	\$50
■ Hospital(facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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:

Cost Sharing	
<u>Deductibles</u>	\$50
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$400
The total Joe would pay is	\$850

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

■ The plan's overall <u>deductible</u>	\$2,000
■ <u>Specialist</u> <u>copayment</u>	\$50
■ Hospital(facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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:

Cost Sharing	
<u>Deductibles</u>	\$1,900
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$2,110

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby. The plan would be responsible for the other costs of these EXAMPLE covered services.

