

 **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, call 1-800-290-1368 or go to www.benefitmanagementllc.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.healthcare.gov/sbc-glossary or call 1-800-290-1368 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Per calendar year: Network and non-network providers \$500/individual, \$1,000/family.	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. Network copayments , preventive care including vision & hearing exam, 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. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No. There are no other specific deductibles .	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Per calendar year: Network and non-network providers \$4,000/individual, \$8,000/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 , prescription drugs , balance-billing charges, health care this plan doesn't cover, and penalties for failure to obtain pre-certification 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. ProviDRs Care Network. See www.providrscare.net or call (800) 801-9772 for a list of 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 a non-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 a non-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 don't need a referral to see a specialist .	You can see the specialist you choose without a referral .



All [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)	Non-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	\$35 copay /visit	50% coinsurance	<p>Copayment covers services performed in an office setting.</p> <p>Pre-certification required for Infusion therapy or any drug above \$1,500/dose, Biologic drugs, and Chemotherapeutic drugs.</p> <p>Chiropractic care is subject to deductible and coinsurance.</p> <p>You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.</p>
	Specialist visit	\$50 copay /visit	50% coinsurance	
	Preventive care/screening/immunization	No Charge	50% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	50% coinsurance	Pre-certification required for Genetic Testing, radiation treatments and endoscopic procedures.
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	Pre-certification required for EBCT, MRI, CT, PET scans (bone density studies are excluded).
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medtrakrx.com	Generic drugs (Tier 1)	The greater of \$10 copay /prescription, or 20%, up to \$100 max	Reimbursement is at the network allowed amount for the drug, less applicable copay .	<p>The maximum prescription drug out-of-pocket limit is \$3,350/individual and \$6,700/family. After the prescription out-of-pocket is met, drugs are covered at 100%.</p> <p>Retail Medications: Pharmacy Option – up to a 34-day supply or 100 units whichever is greater.</p> <p>Specialty Drugs: up to a 30-day supply.</p> <p>Experimental & investigational drugs are not covered.</p>
	Formulary drugs (Tier 2)	The greater of \$30 copay /prescription, or 20%, up to \$100 max		
	Non-Formulary drugs (Tier 3)	The greater of \$50 copay /prescription, or 20%, up to \$100 max		
	Specialty Drugs (Tier 4)	The greater of \$50 copay /prescription, or 20%, up to \$250 max	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	Pre-certification required for outpatient surgery not performed in an office setting, Deviated Septum/Nasal surgery, Endoscopic procedures, and Epidural/facet and trigger point injections and Varicose Vein Ligation.
	Physician/surgeon fees	25% coinsurance	50% coinsurance	



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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$100 copay and 25% coinsurance		Copayment waived if confined under observation hours or admitted inpatient. Pre-certification required for observation stays that exceed 48 hours.
	Emergency medical transportation	25% coinsurance		Transportation to the nearest facility that can provide the necessary medical treatment.
	Urgent care	\$50 copay /visit	50% coinsurance	Copayment covers services performed in an urgent care or urgent care office setting.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	Pre-certification required. Failure to pre-certify will result in a penalty of \$250/confinement.
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 copay /visit	50% coinsurance	Copayment covers services performed in an office setting. Pre-certification required for Intensive Outpatient, Residential or Partial Hospitalization Treatment Programs.
	Inpatient services	25% coinsurance	50% coinsurance	Pre-certification required. Failure to pre-certify will result in a penalty of \$250/confinement.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, deductible and coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	Pre-certification required. Limited to 100 visits/calendar year.
	Rehabilitation services	25% coinsurance	50% coinsurance	Pre-certification required for Physical, Occupational & Speech therapies. Inpatient Rehabilitation: Pre-certification required. Failure to pre-certify will result in a penalty of \$250/confinement. .
	Habilitation services	25% coinsurance	50% coinsurance	
	Skilled nursing care	25% coinsurance	50% coinsurance	Limited to 120 days/calendar year. Pre-certification required. Failure to pre-certify will result in a penalty of \$250/confinement.



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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Durable medical equipment	25% coinsurance	50% coinsurance	Rental up to the purchase price. Pre-certification required for Durable medical equipment over \$2,500 or from a non-network provider .
	Hospice services	25% coinsurance	50% coinsurance	<u>Inpatient</u> : Pre-certification required. Failure to pre-certify will result in a penalty of \$250/confinement.
If your child needs dental or eye care	Children's eye exam	No Charge		Limited to one exam/calendar year.
	Children's glasses	Not Covered		
	Children's dental check-up	No Charge – Birth up to 19 years		Limited to one exam, cleaning & polishing/calendar year. Excludes dental x-rays.

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](#).)

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|---|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Cosmetic Surgery | <ul style="list-style-type: none"> • Dental Care (Adult) • Infertility Treatment • Long-Term Care | <ul style="list-style-type: none"> • Routine Foot Care • Weight Loss Programs |
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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"> • Bariatric Surgery – when Medically Necessary for Morbid Obesity • Chiropractic Care | <ul style="list-style-type: none"> • Hearing Aids (limited to 1 each ear every 3 benefit years and \$1,500 per aid) • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private-Duty Nursing (Home Health only) • Routine Eye Care – limited to 1 exam/calendar year |
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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: Benefit Management, LLC, PO Box 1090, Great Bend, KS 67530, (800) 290-1368; or the Department of Labor, Employee benefits Security Administration at 1-866-444-3272 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: Benefit Management, LLC, PO Box 1090, Great Bend, KS 67530, (800) 290-1368; or the Department of Labor, Employee benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Kansas Insurance Department, Consumer Assistance Division, 420 SW 9th St, Topeka, KS 66612 (800) 432-2484, www.ksinsurance.org or CAP@ksinsurance.org.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 (800) 290-1368.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 290-1368.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 290-1368.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 290-1368.

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](#) \$500
- [Primary care copayment](#) \$35
- [Hospital \(facility\) coinsurance](#) 25%
- Other [coinsurance](#) 25%

This EXAMPLE event includes services like:

Primary care office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,840
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$110
Coinsurance	\$3,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,770

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$50
- [Hospital \(facility\) coinsurance](#) 25%
- Other [coinsurance](#) 25%

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	\$7,460
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$110
Copayments	\$1,330
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,500

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$50
- [Hospital \(facility\) coinsurance](#) 25%
- Other [coinsurance](#) 25%

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	\$2,010
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$150
Coinsurance	\$410
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,060