**Important Questions**  |  **Answers**  |  **Why this Matters:**
--- | --- | ---
What is the overall deductible?  | Per Calendar Year: for Network and Non-Network providers $2,600/person, $5,200/family. Does not apply to network preventive care, vision & hearing exams.  | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?  | No.  | You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?  | Yes, per Calendar Year: for Network providers $2,600/person, $5,200/family; for Non-Network providers $8,200/person, $16,400/family.  | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?  | Premiums, balance-billed 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 do not count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?  | No.  | The chart starting on page 2 describes any limits in what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?  | Yes. for a list of Network providers see www.providrscare.net or call (800) 801-9772.  | If you use a network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your Network doctor or hospital may use a Non-Network provider for some services. Plans use the term network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?  | No.  | You can see the specialist you choose without permission from this plan.
Are there services this plan doesn’t cover?  | Yes.  | Some of the services this plan doesn’t cover are listed on page 5. See your policy or plan document for additional information about excluded services.

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**Common Medical Event** | **Services You May Need** | **Your cost if you use an** | **Limitations & Exceptions**
--- | --- | --- | ---
If you visit a health care provider’s office or clinic | Primary care visit to treat an injury or illness | After deductible*, No Charge | None
Specialist visit | After deductible*, No Charge | 50% co-insurance* | None
Other practitioner office visit | Chiropractic Care – After deductible*, No Charge | Chiropractic Care - 50% co-insurance* | None
Preventive care/ screening/ immunization | No Charge | 50% co-insurance* | Preventive Care Services shall be provided as required by the Patient Protection and Affordable Care Act.
If you have a test | Diagnostic test (x-ray, blood work) | After deductible*, No Charge | None
Imaging (CT/PET scans, MRIs) | After deductible*, No Charge | 50% co-insurance* | None

*Benefit subject to Medical Deductible
**Common Medical Event** | **Services You May Need** | **Network Provider** | **Non-Network Provider** | **Limitations & Exceptions**
---|---|---|---|---
If you need drugs to treat your illness or condition | Generic drugs | After deductible*, No Charge |  | Reimbursement is at the **Network Allowed Amount** for the drug. Prescription drugs are subject to the Medical Deductible and out-of-pocket maximum. Experimental and Investigational drugs are not covered. |
 | Formulary drugs | After deductible*, No Charge |  |  |
 | Non-Formulary drugs | After deductible*, No Charge |  |  |
If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | After deductible*, No Charge | 50% co-insurance * | None |
 | Physician/surgeon fees | After deductible*, No Charge | 50% co-insurance * | None |
If you need immediate medical attention | Emergency room services | After deductible*, No Charge |  | None |
 | Emergency medical transportation | After deductible*, No Charge |  | Transport to the nearest hospital or skilled nursing facility capable of treating your injury or illness. |
 | Urgent care | After deductible*, No Charge | 50% co-insurance * | None |
If you have a hospital stay | Facility fee (e.g., hospital room) | After deductible*, No Charge | 50% co-insurance * | Pre-certification required. Failure to pre-certify will result in a penalty of $250/confined. |
 | Physician/surgeon fee | After deductible*, No Charge | 50% co-insurance * | None |

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<tr>
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<td>If you have mental</td>
<td>Mental/Behavioral</td>
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<td>50% co-insurance *</td>
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<tr>
<td>health, behavioral</td>
<td>health outpatient</td>
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<tr>
<td></td>
<td>Mental/Behavioral</td>
<td>After deductible*, No</td>
<td>50% co-insurance *</td>
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<tr>
<td></td>
<td>health inpatient</td>
<td>Charge</td>
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<td>services</td>
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<td></td>
<td>Substance use disorder</td>
<td>After deductible*, No</td>
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<tr>
<td></td>
<td>outpatient services</td>
<td>Charge</td>
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<tr>
<td></td>
<td>Substance use disorder</td>
<td>After deductible*, No</td>
<td>50% co-insurance *</td>
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<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No Charge</td>
<td>50% co-insurance *</td>
</tr>
<tr>
<td></td>
<td>Delivery and all</td>
<td>After deductible*, No</td>
<td>50% co-insurance *</td>
</tr>
<tr>
<td></td>
<td>inpatient services</td>
<td>Charge</td>
<td></td>
</tr>
<tr>
<td>If you need help</td>
<td>Home health care</td>
<td>After deductible*, No</td>
<td>50% co-insurance *</td>
</tr>
<tr>
<td>recovering or have</td>
<td></td>
<td>Charge</td>
<td></td>
</tr>
<tr>
<td>other special health</td>
<td>Rehabilitation services</td>
<td>After deductible*, No</td>
<td>50% co-insurance *</td>
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<tr>
<td>needs</td>
<td></td>
<td>Charge</td>
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<td></td>
<td>Habilitation services</td>
<td>After deductible*, No</td>
<td>50% co-insurance *</td>
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<tr>
<td></td>
<td>Skilled nursing care</td>
<td>After deductible*, No</td>
<td>50% co-insurance *</td>
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<td></td>
<td></td>
<td>Charge</td>
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<tr>
<td></td>
<td>Durable medical</td>
<td>After deductible*, No</td>
<td>50% co-insurance *</td>
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<tr>
<td></td>
<td>equipment</td>
<td>Charge</td>
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<tr>
<td></td>
<td>Hospice service</td>
<td>After deductible*, No</td>
<td>50% co-insurance *</td>
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<td></td>
<td></td>
<td>Charge</td>
<td></td>
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<tr>
<td>If your child needs</td>
<td>Eye exam</td>
<td>No Charge</td>
<td>No Charge</td>
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<tr>
<td>dental or eye care</td>
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<td></td>
<td>Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental care
- Experimental and Investigational treatment
- Glasses – except first pair following cataract surgery
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery – when Medically Necessary for Morbid Obesity
- Chiropractic Care
- Hearing Aids – limited to one (1) hearing aid/every three (3) Benefit Years to $1,500/aid
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care limited to one exam with refractions/calendar year

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (800) 290-1368. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (877) 267-2323 x 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Benefit Management, Inc., PO Box 1090 Great Bend, Kansas 67530, (800) 290-1368. You may also contact the Department of Labor’s Employee Benefits Security Administration at (866)444-EBSA (3272) or

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Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-290-1368.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-290-1368.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-290-1368.

Navajo (Dine): Dinek'ehgo shika a'tohwol ninisingo, kwijigo holne' 1-800-290-1368.

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To see examples of how this plan might cover costs for a sample medical situation, see the next page.
## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540  
- **Plan pays:** $4,000  
- **Patient pays:** $3,540

**Sample care costs:**

- Hospital charges (mother) $2,700  
- Routine obstetric care $2,100  
- Hospital charges (baby) $900  
- Anesthesia $900  
- Laboratory tests $500  
- Prescriptions $200  
- Radiology $200  
- Vaccines, other preventive $40  

**Total** $7,540

**Patient pays:**

- **Deductibles** $3,500  
- Co-pays $0  
- Co-insurance $0  
- Limits or exclusions $40  

**Total** $3,540

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400  
- **Plan pays:** $2,760  
- **Patient pays:** $2,640

**Sample care costs:**

- Prescriptions $2,900  
- Medical Equipment and Supplies $1,300  
- Office Visits and Procedures $700  
- Education $300  
- Laboratory tests $100  
- Vaccines, other preventive $100  

**Total** $5,400

**Patient pays:**

- Deductibles $2,600  
- Co-pays $0  
- Co-insurance $0  
- Limits or exclusions $40  

**Total** $2,640

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

☒ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

☒ No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

☑ Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

☑ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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