

 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](http://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](http://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 <a href="#">deductible</a> ?	Per <a href="#">plan</a> year: <a href="#">Network</a> and <a href="#">non-network providers</a> \$700/individual, \$1,400/family.	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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Prescription drugs</a> (after the prescription <a href="#">deductible</a> has been met), preventive eye exams and the first \$400 of <a href="#">preventive care</a> and immunizations are covered before you meet your <a href="#">deductible</a> .	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> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. Per <a href="#">plan</a> year: <a href="#">Prescription drugs</a> \$100/ individual, \$200/family. Generic drugs are not subject to this <a href="#">deductible</a> . There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Per <a href="#">plan</a> year: <a href="#">Network providers</a> \$1,700/individual, \$3,400/family; <a href="#">non-network</a> \$2,700/individual, \$5,400/family. <a href="#">Network</a> and <a href="#">non-network out-of-pocket limits</a> accumulate together.	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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">prescription drugs</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-certification</a> for services.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. In Kansas (except northeast): <a href="http://www.providrscare.net">www.providrscare.net</a> or call (800) 801-9772. All other Employees: <a href="http://www.myfirsthealth.net">www.myfirsthealth.net</a> call (800) 226-5116. Refer to the member ID card for assigned <a href="#">network</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use a <a href="#">non-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use a <a href="#">non-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No. You don't need a referral to see a <a href="#">specialist</a> .	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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)	
<b>If you visit a health care <a href="#">provider's office</a> or clinic</b>	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Chiropractic care is limited to 30 visits/ <a href="#">plan</a> year.
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	After the <a href="#">plan</a> has paid 100% of the first \$400/individual/ <a href="#">plan</a> year; then you will pay 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> .  Immunizations – No Charge	40% <a href="#">coinsurance</a>  ( <a href="#">Non-network preventive care</a> is limited to <a href="#">plan</a> payment of \$400/ <a href="#">plan</a> year.)	<p><b>Preventive Adult Care</b> Services for <a href="#">Employee and Covered Spouse Only</a>.</p> <p><b>Preventive Child Care</b> Services for <a href="#">Dependent Children under the age of 16</a>: Well child office visits, preventive physical exam, preventive lab and x-ray.</p>
<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>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<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.medtrakrx.com">www.medtrakrx.com</a>	Generic drugs	\$10 <a href="#">copay</a> /prescription, <a href="#">deductible</a> waived	Reimbursement is at the <a href="#">network allowed amount</a> for the drug. You may have higher out-of-pocket expenses if you use a non-participating pharmacy.	Brand Name Prescriptions separate <a href="#">deductible</a> of \$100/individual, \$200/family. <a href="#">Prescription drugs</a> have a separate <a href="#">out-of-pocket limit</a> (excluding <a href="#">deductibles</a> ) of \$2,000/individual, \$4,000/family.  <a href="#">Pharmacy Option</a> : up to a 34-day supply. <a href="#">Maintenance Medication</a> : Mail Order or Performance 90 Pharmacies: up to a 90-day supply. <a href="#">Specialty Drugs</a> : 30-day supply and must be purchased from a Specialty Pharmacy Experimental & investigational drugs are not covered.  For Diabetic monitor & supplies covered at 100% by the Plan: Contact LivingConnected (800) 274-1853.
	Brand Name drugs	20% of <a href="#">allowed amount</a> after prescription <a href="#">deductible</a> has been satisfied		



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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>		None
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>		Transportation limited to the nearest hospital or skilled nursing facility that can provide the necessary medical treatment.
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Pre-certification</a> required. Failure to pre-certify will result in a benefit reduction of 50% up to a maximum penalty of \$750/confinement.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Pre-certification</a> required. Failure to pre-certify will result in a benefit reduction of 50% up to a maximum penalty of \$750/confinement.
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">deductible</a> and <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	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>	



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 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>	None
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Limited to 60 days/ <a href="#">plan</a> year. <a href="#">Pre-certification</a> required. Failure to pre-certify will result in a benefit reduction of 50% up to a maximum penalty of \$750/confinement.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Rental up to the purchase price.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Inpatient stays: <a href="#">Pre-certification</a> required. Failure to pre-certify will result in a benefit reduction of 50% up to a maximum penalty of \$750/confinement.
If your child needs dental or eye care	Children's eye exam	No Charge		Limited to one exam including refraction/ <a href="#">plan</a> year.
	Children's glasses	Not Covered		
	Children's dental check-up	Not Covered		Must enroll in the independent Dental Benefits plan.

### 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> </ul> | <ul style="list-style-type: none"> <li>• Dental Care</li> <li>• Infertility Treatment</li> <li>• Long-Term Care</li> </ul> | <ul style="list-style-type: none"> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</li> </ul> |
|---|--|---|

**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 – when Medically Necessary for Morbid Obesity</li> <li>• Chiropractic Care</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing Aids (limited to 1 each ear every 3 benefit years and \$1,500 per aid)</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-Duty Nursing (Home Health only)</li> <li>• Routine Eye Care – limited to 1 exam including refraction/benefit year</li> </ul> |
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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](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: Benefit Management, LLC, PO Box 1090, Great Bend, KS 67530, (800) 290-1368; Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Kansas Insurance Department, Consumer Assistance Division, 420 SW 9<sup>th</sup> St, Topeka, KS 66612 (800) 432-2484, [www.ksinsurance.org](http://www.ksinsurance.org) or [CAP@ksinsurance.org](mailto: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.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$700
■ <a href="#">Primary care copayment</a>	\$0
■ <a href="#">Hospital (facility) coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,840</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$700
Copayments	\$10
Coinsurance	\$1,000
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,770</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$700
■ <a href="#">Specialist copayment</a>	\$0
■ <a href="#">Hospital (facility) coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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>\$7,460</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$800
Copayments	\$150
Coinsurance	\$780
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,790</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$700
■ <a href="#">Specialist copayment</a>	\$0
■ <a href="#">Hospital (facility) coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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>\$2,010</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$700
Copayments	\$0
Coinsurance	\$390
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,090</b>