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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Network Preventive Care Services and Preventive 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?	$0 for network services. Unlimited for non-network services and health care this plan doesn't cover.	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, non-network services and health care this plan doesn't cover.	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. First Health Network. See www.myfirsthealth.net or call (800) 226-5116 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	Not covered	Not covered	Annual routine wellness visits are covered at 100% by the plan.
	Specialist visit	Not covered	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	None
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.elixirsolutions.com	Acute and Maintenance Drugs	Not covered	Not covered	Only the specific Preventive Prescription Drugs, over the counter medications (prescription required), supplies and vaccinations required by the Affordable Care Act are covered by this plan.
	Preventive Prescription Drugs	No charge	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	None
	Physician/surgeon fees	Not covered	Not covered	None
If you need immediate medical attention	Emergency room care	Not covered	Not covered	None
	Emergency medical transportation	Not covered	Not covered	None
	Urgent care	Not covered	Not covered	None

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 a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	None
	Physician/surgeon fees	Not covered	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	None
	Inpatient services	Not covered	Not covered	None
If you are pregnant	Office visits	Not covered	Not covered	Benefits for pregnancy are limited to preventive care, prenatal obstetrical visits and certain limited laboratory services are covered at 100%. Such services as x-ray, sonograms, hospital and delivery expenses are not covered.
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility services	Not covered	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	None
	Rehabilitation services	Not covered	Not covered	None
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	Not covered	Not covered	None
	Durable medical equipment	Not covered	Not covered	None
	Hospice services	Not covered	Not covered	None
If your child needs dental or eye care	Children's eye exam	No Charge - Birth up to 21 years		Limited to one exam including refraction/plan year.
	Children's glasses	Not Covered		None
	Children's dental check-up	No Charge – Birth up to 21 years		Limited to one exam, cleaning & polishing/plan year. Excludes dental x-rays.

* For more information about limitations and exceptions, see the plan or policy document at www.benefitmanagementllc.com.

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
- Chiropractic Care
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing (Home Health only)
- Routine Eye Care
- 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.)

- Preventive Care Services only in compliance with the Affordable Care Act.

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: ValueHealth Benefit Administrators, 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: ValueHealth Benefit Administrators, 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 9th St, Topeka, KS 66612 (800) 432-2484, www.ksinsurance.org or CAP@ksinsurance.org.

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 (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, kwiijigo 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	$0
Primary care cost sharing	$0
Hospital (facility) cost sharing	0%
Other cost sharing	0%

This EXAMPLE event includes services like:
Primary care physician 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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,600
The total Peg would pay is	**$12,600**

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

The plan's overall deductible	$0
Specialist cost sharing	$0
Hospital (facility) cost sharing	0%
Other cost sharing	0%

This EXAMPLE event includes services like:
Specialist 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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$5,400
The total Joe would pay is	**$5,400**

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

The plan's overall deductible	$0
Specialist cost sharing	$0
Hospital (facility) cost sharing	0%
Other cost sharing	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services*(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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