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, contact Medova Healthcare Financial Group. 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.lifestylehealthbenefits.com or call 1-866-827-6607 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$3,500* person / $7,000* family** for participating providers. **$7,000* person / $14,000* family** for non-participating providers.	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. *Up to a $500 deductible credit is made available to plan members for the voluntary participation in the Lifestyle Health Wellness Program.
Are there services covered before you meet your deductible?	**Yes.**	Services listed as "Copayments" are not part of your overall plan deductible. Preventive Services are also covered at 100% with in-network providers.
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.
What is the out-of-pocket limit for this plan?	For participating providers **$3,500 person / $7,000 family.** For non-participating providers **$9,500 person / $19,000 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 healthcare expenses. Once this limit is achieved, copayments and Rx copayments may continue to accrue until the ACA out-of-pocket maximum limit, which for participating providers is $7,900 person / $15,800 family and for non-participating providers is unlimited.
What is not included in the out-of-pocket limit?	Premiums, copayments and Rx copayments, balance-billed charges, and health care this plan excludes.	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. See **www.PHCS.com or call 1-800-922-4362** for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-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.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

Do you need a referral to see a specialist?	No. You don't need a referral to use a specialist.	You can see the specialist you choose without permission from the plan.

⚠ 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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-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	$30 Copay, then 100% to $250 per visit, then Deductible / 0% Co-insurance	50% Coinsurance	$30 Copay, then 100% to $250 max per visit for all services provided during visit except lab services, then Deductible / Co-insurance
	Specialist visit	$50 Copay, then 100% to $250 per visit, then Deductible / 0% Co-insurance	50% Coinsurance	$50 Copay, then 100% to $250 max per visit for all services provided during visit except lab services, then Deductible / Co-insurance
	Chiropractor	0% Coinsurance	50% Coinsurance	After deductible is met
	Preventive care/screening/ immunization	No Charge	No Charge	None
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: Deductible / 0% Coinsurance Blood work: 100% Coverage if preferred vendor, otherwise Deductible / 0% Coinsurance	50% Coinsurance	X-ray: Deductible / Coinsurance. Bloodwork: 100% Coverage for laboratory services through DirectHealth program, otherwise Deductible / Coinsurance.
	Imaging (CT/PET scans, MRIs)	Pre-certification required prior to scheduling, then Deductible / 0% Coinsurance	50% Coinsurance	Requires pre-certification. If through physician office / freestanding imaging center, then Deductible / Coinsurance. If through hospital outpatient, $500 Copay, then Deductible / Coinsurance.

If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.prescriptionnetwork.info	Generic drugs	Tier 1: $1 Copay Tier 2: $15 Copay	Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	$50 Copay Retail	Not Covered	$50 Copay through standard Rx benefit. If a brand name drug is dispensed when a generic drug is available, the covered person will be responsible for the difference in cost between the brand name drug and the generic drug, in addition to the $50 Copay. Refer to Preferred Formulary & SPD for more details. $0 Copay option available for certain brand drugs through International Mail Order preferred Vendor (participation voluntary)
	Non-preferred brand drugs	$80 Copay Retail	Not Covered	None
	Specialty drugs	50% Copay Retail	Not Covered	None
	Diabetic Supplies	100% if preferred Vendor is utilized. Otherwise, 50% Copay Retail	50% Coinsurance	100% if preferred Vendor is utilized. Otherwise, 50% Copay Retail through pharmacy benefit or benefits applicable to Deductible / Coinsurance if through In-network DME supplier.
	Allergy Injections	$25 Copay	50% Coinsurance	$100 per injection maximum
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Pre-certification required prior to scheduling, then Deductible / 0% Coinsurance	50% Coinsurance	Requires pre-certification. If through physician office / freestanding imaging center, then Deductible / Coinsurance. If through hospital outpatient, $1,000 Copay per visit, then Deductible / Coinsurance.
	Physician/surgeon fees	Pre-certification required prior to scheduling, then Deductible / 0% Coinsurance	50% Coinsurance	Requires pre-certification. After Deductible is met.
If you need immediate medical attention	Emergency room care (facility charge only)	$250 Copay, then Deductible / 0% Coinsurance	$250 Copay, then Deductible / 50% Coinsurance	Copay waived if admitted. Out of Network Providers used during an emergency are paid preferred benefit levels based on negotiated preferred allowances.
	Emergency medical transportation	Deductible / 0% Coinsurance	50% Coinsurance	$2,500 Copay for Air Ambulance, then Deductible / Co-insurance.

	Urgent care	$50 Copay, then 100% to $500 per visit	50% Coinsurance	Then Deductible / Coinsurance for in-network providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 Copay per confinement, then Deductible / 0% Coinsurance	50% Coinsurance	$500 Copay per confinement, then Deductible Co-insurance. All non-emergency confinements must be pre-certified and emergency confinements must be reported within 48 hours of when confinement begins.
	Physician/surgeon fees	Deductible / 0% Coinsurance	50% Coinsurance	After Deductible is met
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% Coinsurance	50% Coinsurance	After Deductible is met
	Inpatient services	0% Coinsurance	50% Coinsurance	After Deductible is met
If you are pregnant	Prenatal Care and Postnatal Care	0% Coinsurance	50% Coinsurance	After Deductible is met
	Childbirth/delivery professional services	0% Coinsurance	50% Coinsurance	After Deductible is met
	Childbirth/delivery facility fee (e.g., hospital room)	0% Coinsurance	50% Coinsurance	After Deductible is met
If you need help recovering or have other special health needs	Home health care	0% Coinsurance	50% Coinsurance	After Deductible is met
	Rehabilitation services	0% Coinsurance	50% Coinsurance	After Deductible is met
	Habilitation services	0% Coinsurance	50% Coinsurance	After Deductible is met
	Skilled nursing care	0% Coinsurance	50% Coinsurance	After Deductible is met
	Durable medical equipment	0% Coinsurance	50% Coinsurance	After Deductible is met
	Hospice services	0% Coinsurance	50% Coinsurance	After Deductible is met
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	As set forth by the US Preventive Services Task Force as allowed by the Affordable Care Act (ACA).
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	No Charge	No Charge	As set forth by the US Preventive Services Task Force as allowed by the Affordable Care Act (ACA).

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
- Dental care (Adult)
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Chiropractic Care

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gove/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: Medova Healthcare Financial Group at 345 N. Riverview, Suite 600, Wichita, KS 67203 or The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes, this plan or policy does provide minimum essential coverage.**
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 the Minimum Value Standards? **Yes, this health coverage does meet the minimum value standard for the benefits it provides.**
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 1-866-827-6607.

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

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

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	$3500
Specialist *[cost sharing]*	$ 50
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,698
Copayments	$515
Coinsurance	$0
What isn't covered	
Limits or exclusions	$573
The total Peg would pay is	**$4,786**

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

The plan's overall deductible	$3500
Specialist *[cost sharing]*	$ 50
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$360
Copayments	$1,721
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,136**

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

The plan's overall deductible	$3500
Specialist *[cost sharing]*	$ 50
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,441
Copayments	$150
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,591**

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