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: $3,500/individual, $7,000/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. Preventive care is 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: $7,000/individual, $14,000/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, 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?	No. This is an Open Access Plan.	This plan treats providers the same in determining payment for the same 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 OPEN ACCESS PLAN	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	After deductible – No Charge	Chiropractic limited to 20 visits/Calendar year. Pre-certification required for Infusion therapy or any drug above $1,500/dose, Biologic drugs, Chemotherapeutic drugs, Dialysis and On-going wound care.
	Specialist visit	After deductible – No Charge	
	Preventive care/screening/ immunization	No Charge	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)	After deductible – No Charge	Pre-certification required for Genetic Testing, radiation treatments and endoscopic procedures. Pre-certification required for EBCT, MRI, CT, PET scans (bone density studies are exempt).
	Imaging (CT/PET scans, MRIs)	After deductible – No Charge	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.EHiMrx.com	Generic drugs (Tier 1)	**After Medical Deductible:** $1 copay/script if drug cost is less than $150 $15 copay/script if drug cost is $150 + up	Medications (not including Specialty drugs) available: • 1 to 30-day supply at copay/script shown • 31 to 60-day supply at 2 times copay/script • 61 to 90-day supply at 2.5 times copay/script Specialty drugs limited to a 30-day supply. Contact EHiM (800) 311-3446 for Specialty drug assistance. Experimental & investigational drugs are not covered.
	Formulary drugs (Tier 2)	**After Medical Deductible:** $50 copay/script	
	Non-Formulary drugs (Tier 3)	**After Medical Deductible:** $80 copay/script	
	Specialty drugs (Tier 4)	**After Medical Deductible:** 50% coinsurance; minimum of $100 copay/script to a maximum of $250 copay/script	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	After deductible – No Charge	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, Varicose vein ligation, on-going wound care.
	Physician/surgeon fees	After deductible – No Charge	
If you need immediate medical attention	Emergency room care	$250 copay and deductible	Copayment waived if confined under observation hours or admitted inpatient. Pre-certification required for observation stays that exceed 48 hours.
	Emergency medical transportation	Ambulance, except Air: After deductible – No Charge Air Ambulance: $2,500 Copay and deductible	Transportation limited to the nearest facility that can provide the necessary medical treatment.
	Urgent care	After deductible – No Charge	None

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

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 OPEN ACCESS PLAN	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	After deductible – No Charge	Pre-certification required. Failure to pre-certify will result in a penalty of $500/confinement.
	Physician/surgeon fees	After deductible – No Charge	None
If you need mental health, behavioral health, or substance abuse services	Outpatient Office Visit	After deductible – No Charge	None
	Inpatient services	After deductible – No Charge	Pre-certification required for Intensive Outpatient, Residential, Partial Hospitalization Treatment Programs. Inpatient Pre-certification required. Failure to pre-certify will result in a penalty of $500/confinement. Residential Treatment Facility & Partial Hospitalization- Limited to 60 days/calendar year each.
If you are pregnant	Office visits	No charge	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	After deductible – No Charge	
	Childbirth/delivery facility services	After deductible – No Charge	
If you need help recovering or have other special health needs	Home health care	After deductible – No Charge	Pre-certification required. Limited to 60 visits/calendar year.
	Rehabilitation services	After deductible – No Charge	Pre-certification required for Inpatient Rehab limited to 60 days/calendar year -failure to pre-certify will result in a penalty of $500/ confinement. Pre-certification required for Physical, Occupational & Speech therapies - Limited to 30 visits each/calendar year.
	Habilitation services	After deductible – No Charge	
	Skilled nursing care	After deductible – No Charge	Limited to 60 days/calendar year. Pre-certification required. Failure to pre-certify will result in a penalty of $500/ confinement.
	Durable medical equipment	After deductible – No Charge	Rental up to the purchase price.
	Hospice services	After deductible – No Charge	Inpatient stays: Pre-certification required. Failure to pre-certify will result in a penalty of $500/confinement.
If your child needs dental or eye care	Children's eye exam	No Charge - Birth up to 19 years	Limited to one exam/calendar year.
	Children's glasses	Not Covered	
	Children's dental check-up	No Charge – Birth up to 19 years	1 exam, cleaning, polishing/calendar year. No X-rays.

*** For more information about limitations and exceptions, see the plan or policy document at www.benefitmanagmentllc.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
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long-Term Care
- 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.)

- Bariatric Surgery – when Medically Necessary for Morbid Obesity
- Chiropractic Care
- 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.
- Private-Duty Nursing (Home Health only)

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 on how 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.

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.

*** For more information about limitations and exceptions, see the plan or policy document at www.benefitmanagmentllc.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	**$3,500**
Primary care physician 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 test *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,500
Copayment	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,560**

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

The plan's overall deductible	**$3,500**
Specialist cost sharing	**0%**
Hospital (facility) cost sharing	**0%**
Other cost sharing	**0%**

This EXAMPLE event includes services like:
Specialist physician office visits *(including disease education)*
Diagnostic test *(blood work)*
Prescription drug
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,500
Copayment	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,820**

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

The plan's overall deductible	**$3,500**
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 test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayment	$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.