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 Tasha Raine or CPM. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$600 / Individual $1,200 / 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 and primary care services 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?	There are no other specific deductibles.	Your Plan does not have deductibles for specific services that have to be met.
What is the out-of-pocket limit for this plan?	For network providers $1,600 individual / $3,200 family; for out-of-network $3,200 individual / $5,000 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?	Copayments for certain services, premiums, balance-billing charges, and 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. ProviDRs Care Network (www.ProviDRsCare.net); outside Kansas: First Health Network (www.FirstHealth.com)	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 an out-of-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 an out-of-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.	This plan will pay some or all of the costs to see a specialist for covered services.

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	$25 copay/office visit	40% coinsurance	None
	Specialist visit	$25 copay/visit	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	40% coinsurance	Preventive Care Immunizations are covered at 100% In- and Out-of-Network.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	First $300 per plan year paid at 100% then ded/coins.applies
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling 866-921-4047	Generic drugs (Tier 1)	$0	40% coinsurance	Prescriptions over $350 Excluded.
	Preferred brand drugs (Tier 2)	$35 copay/prescription	40% coinsurance	
	Non-preferred brand drugs (Tier 3)	$70 copay/prescription	40% coinsurance	
	Specialty drugs (Tier 4)	$250 copay/prescription	40% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	40% coinsurance	Out-of-Network Providers will be covered at In-Network levels for Emergency Services and Air Ambulance Services.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Out-of-Network Providers will be covered at In-Network levels for Inpatient Services.

* For more information about limitations and exceptions, request the plan document from your Human Resource Department.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	$25 copay/office visit	40% coinsurance	
	Childbirth/delivery professional and facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	
	Rehabilitation services	20% coinsurance	40% coinsurance	
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	
	Durable medical equipment	20% coinsurance	40% coinsurance	
	Hospice services	20% coinsurance	40% coinsurance	
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Coverage limited to one exam/year.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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.)

- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Growth Hormone Treatment

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care
- Physical Therapy
- Genetic Testing

* For more information about limitations and exceptions, request the plan document from your Human Resource Department.

Your Rights to Continue Coverage: The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus BudgetReconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participants family who are covered under the Plan when they would otherwise lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the Participant. Coverage will end in certain instances, including if the Participant or their covered dependents fail to make timely payment of premiums. Participants should check with their employer to see if COBRA applies to them and their covered dependents. The Participant must provide notice to the Human Resource Department of certain qualifying events, such as divorce or cessation of dependent status within 30 days of the event. The Employer must provide notice to CPM within 14 days of such qualifying event. It is the responsibility of the qualified individuals, who are receiving COBRA benefits, to notify CPM of a second qualifying event, such as divorce, death of covered employee, or determination of disability by Social Security, via written notice within 30 days of the second qualifying event. Qualified individuals should keep CPM informed of their current address. This notice does not fully describe continuation coverage under this plan. Complete information regarding COBRA rights is available from CPM upon request and/or in the Summary Plan Description. Please contact CPM at 1-800-999-1781 with additional questions. 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.

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 the 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.

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, request the plan document from your Human Resource Department.

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	**$1200**
Specialist copayment	**$25**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1200
Copayments	$100
Coinsurance	$1000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,300**

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

The plan's overall deductible	**$600**
Specialist copayment	**$25**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$600
Copayments	$365
Coinsurance	$927
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1892**

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

The plan's overall deductible	**$600**
Specialist copayment	**$25**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$600
Copayments	$150
Coinsurance	$410
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1160**

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