**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 plan year: Platinum and Bronze Route network providers $5,000/individual, $10,000/family; Platinum Route Deductibles can be waived with coordination from your DPC provider | 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. Network Office visits, preventive care and 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. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Per plan year: Platinum and Bronze Route network providers $9,100/individual, $18,200/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?** | Yes. First Primary Care (FPC) & **HealthSmart**<br>See www.healthsmart.com for a list of network providers.<br>**If you see a Provider Out of Network, you will be subject to a Reference Based Price with No support of balance billing and a 50% coinsurance** | This plan uses a DPC and a provider network. You pay the least if you use a provider in the DPC network via the Platinum Route. You will pay the most if you use a Bronze Route Tier 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 for the Bronze Route, Yes for the Platinum Route. | You can see the specialist you choose without a referral. |

Bronze Route **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 |
|---|---|---|---|---|
| | | Platinum Route (You will pay the least) | Bronze Route (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 | $0 copay/visit – when coordinated or treated by DPC | 50% coinsurance | Chiropractic care limited to 20 visits/calendar year, subject to applicable deductible & coinsurance. Pre-certification required for Infusion therapy or any drug above $1,500/dose, Biologic drugs, and Chemotherapeutic drugs. Pre-certification required for Dialysis and On-going wound care. |
| | Specialist visit | $25 copay/visit – when coordinated by DPC | 50% coinsurance | |
| | Preventive care/ screening/ Immunization | No charge | 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 |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $0 copay/visit – when coordinated by DPC | 50% coinsurance | **Lab & Xray - Hospital outpatient facility:** After deductible - $150 copay<br>Pre-certification required for Genetic Testing, radiation treatments and endoscopic procedures.<br><br>Pre-certification required for EBCT, MRI, CT, PET scans (bone density studies are exempt). |
| | Imaging (CT/PET scans, MRIs) | $0 copay/visit – when coordinated by DPC | 50% coinsurance | |
| **If you need drugs to treat your illness or condition.** More information about **prescription drug coverage** | Generic drugs Magic Pill (MP)/ Non-Magic Pill (NMP) | Drugs on MP- MP/30/60/90 Day: $0. NMP/30-Day: $25 copay<br>Drugs Not available on MP- $10 copay | | **Diabetic Supplies**: Diabetic Solutions, Inc. – No Charge; OR if received through Pharmacy - 50% coinsurance<br><br>Experimental & investigational drugs are not covered.<br>No coverage for Non-Network Pharmacies.<br>All copays are listed per prescription.<br>Step-therapy required for certain medications.<br>Magic Pill Drugs are Internationally sourced. |
| | Formulary (MP/NMP) | Drugs on MP- MP/30/60/90 Day: $0 NMP- 30 Day: $80 copay | | |
| | Non-Formulary Specialty drugs (MP/NMP) | Drugs on MP- MP/30/60/90 Day: $0 30-Day: $100 copay | | |

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

| | | | | |
|---|---|---|---|---|
| **If you have outpatient surgery±** | Facility fee (e.g., ambulatory surgery center)± | $0 copay if coordinated by your DPC doctor | 50% coinsurance | Male elective sterilization limited to $1,000/lifetime. **Anesthesia services** subject to applicable deductible & coinsurance.<br><br>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 | $0 copay if coordinated by your DPC doctor | 50% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | $500 copay/visit, $0 copay/visit if coordinated by your DPC doctor | 50% coinsurance | Copay waived if admitted inpatient or confined under observation hours. Pre-certification required for observation stays that exceed 48 hours |
| | Emergency medical transportation | $0 if requested by your DPC doctor | 50% coinsurance | Transportation limited to the nearest hospital or skilled nursing facility that can provide the necessary medical treatment. |
| | Urgent care | $50 copay (re-imbursed) if coordinated coordinated by your DPC Doctor | 50% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $0 if coordinated by your DPC doctor | 50% coinsurance | Pre-certification required. |
| | Physician/ surgeon fees | $0 if coordinated by your DPC doctor | 50% coinsurance | Anesthesia services subject to applicable deductible & coinsurance |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay/visit if coordinated by your DPC doctor | 50% coinsurance | None |
| | Inpatient services | $0 copay/visit – if coordinated by your DPC doctor | 50% coinsurance | Pre-certification required for Inpatient, Intensive Outpatient, Residential or Partial Hospitalization Treatment Programs |
| **If you are pregnant** | Office visits | No Charge | 50% coinsurance | 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 | Same as Hospital Inpatient Professional Services | 50% coinsurance | |
| | Childbirth/delivery facility services | Same as Hospital Inpatient Stays | 50% coinsurance | |

| | | | | |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | $25 copay/visit if coordinated by your DPC doctor | 50% coinsurance | Limited to 60 visits/calendar year. Pre-certification required. |
| | Rehabilitation services | $25 copay/visit if coordinated by your DPC doctor | 50% coinsurance | Limited to 60 visits/calendar year combined for physical therapy, speech therapy, & occupational therapy. Pre-certification required for Physical, Occupational & Speech therapies and Inpatient Rehabilitation. |
| | Habilitation services | $25 copay/visit if coordinated by your DPC doctor | 50% coinsurance | |
| | Skilled nursing care | $25 copay/visit if coordinated by your DPC doctor | 50% coinsurance | Limited to 30 days/calendar year. Pre-certification required. |
| | Durable medical equipment | $25 copay/visit if coordinated by your DPC doctor | 50% coinsurance | Pre-certification required over $2,500 or from a non-network provider. |
| | Hospice services | $25 copay/visit if coordinated by your DPC doctor | 50% coinsurance | Inpatient: Pre-certification required. |
| **If your child needs dental or eye care** | Children's eye exam | No charge – Birth up to 19 years | No charge – Birth up to 19 years | Limited to one exam w/refractions/calendar year. |
| | Children's glasses | Not covered | Not covered | |
| | Children's dental check-up | No charge – Birth up to 19 years | No charge – Birth up to 19 years | Limited to one exam, cleaning & scaling/calendar year. X-rays excluded. |

±Contact a Care Navigator at (316) 683-4111 Option 5, Text (316) 669-4399, Email CareNavigator@ProviDrsCare.net, live chat at www.providrscare.net/members for information about **"Centers of Value" (COV Program)** for certain surgeries, joint replacements & cardiology services. This is a free voluntary program. If eligible for the program and receive services under the COV Program, you will have $0 out-of-pocket costs AFTER Deductible when utilizing a designated provider.

## 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
- Bariatric Surgery subject to Medical Necessity
- 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.)**

- Routine Eye Care
- Chiropractic Care limited to 20 visits/calendar year
- Hearing Aids (Limit $1,500/ear every 3 years)
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing (Home Health only)

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

**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; the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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. 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)- **DPC Initiated**

| | |
|---|---|
| ■ **The plan's deductible Waived** | **$0** |
| ■ **Primary care cost sharing** | **see above** |
| ■ **Hospital (facility) cost sharing** | **see above** |
| ■ **Other cost sharing** | **see above** |

**This EXAMPLE event includes services like:**
Primary care office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic test (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost of Care** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayment | $250 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$310** |

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

| | |
|---|---|
| ■ **The plan's deductible Waived** | **$0** |
| ■ **Specialist cost sharing** | **see above** |
| ■ **Hospital (facility) cost sharing** | **see above** |
| ■ **Other cost sharing** | **see above** |

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

| **Total Example Cost of Care** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayment | $75 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$95** |

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

| | |
|---|---|
| ■ **The plan's deductible Waived** | **$0** |
| ■ **Specialist cost sharing** | **see above** |
| ■ **Hospital (facility) cost sharing** | **see above** |
| ■ **Other cost sharing** | **see above** |

**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 of Care** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayment | $200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$200** |

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

## Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)- **NO DPC ENGAGEMENT**

| | |
|---|---|
| ■ **The plan's overall deductible** | **$5,000** |
| ■ **Primary care cost sharing** | **see above** |
| ■ **Hospital (facility) cost sharing** | **see above** |
| ■ **Other cost sharing** | **see above** |

**This EXAMPLE event includes services like:**
Primary care office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic test (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost of Care** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $5,000 |
| Copayment | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$5,460** |

## Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)- **NO DPC ENGAGEMENT**

| | |
|---|---|
| ■ **The plan's overall deductible** | **$5,000** |
| ■ **Specialist cost sharing** | **see above** |
| ■ **Hospital (facility) cost sharing** | **see above** |
| ■ **Other cost sharing** | **see above** |

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

| **Total Example Cost of Care** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $5,000 |
| Copayment | $100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$5,120** |

## Mia's Simple Fracture

(in-network emergency room visit and follow up care)- **NO DPC ENGAGEMENT**

| | |
|---|---|
| ■ **The plan's overall deductible** | **$5,000** |
| ■ **Specialist cost sharing** | **see above** |
| ■ **Hospital (facility) cost sharing** | **see above** |
| ■ **Other cost sharing** | **see above** |

**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 of Care** | **$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.