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 your employer or Mid-American Benefits, LLC at 402-571-6224 or 800-364-9505. 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 402-571-6224 or 800-364-9505 to request a copy.

This document contains only a partial description of the benefits, limitations, exclusions and other provision of this health care plan. It is not a Plan document. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and Plan limitations. In the event there are discrepancies between this document and the Plan document, the terms and conditions of the Plan document will govern.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Medical: In-Network $1,500.00 individual / $3,000.00 family Out-of-Network $4,000.00 individual / $8,000.00 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 Chiropractic Services (in-network) Curaquick Clinic (Hy-Vee stores only) Emergency room services Physician Office Visit (includes visit charge, injections, lab, and x-ray for in-network) Pregnancy initial visit (in-network) Preventive care Urgent Care (in-network)	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.

Important Questions	Answers	Why This Matters:
What is the out-of-pocket limit for this plan?	Medical: In-Network $2,500.00 individual / $5,000.00 family Out-of-Network $4,400.00 individual / $8,800.00 family Prescription: In-Network: $5,950.00 individual / $11,900.00 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on 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, penalties	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 your medical ID card or www.mid-americanbenefits.com (Resources Tab) or call 402-571-6224 / 800-364-9505 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 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	You can see the specialist you choose without a referral.

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
		In-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	$30.00 copay/visit for office visit, injections, lab and x-ray Deductible does not apply 20% coinsurance for office surgery & all other services outside physician's office	40% coinsurance	• None
	Specialist visit	$30.00 copay/visit for office visit, injections, lab and x-ray Deductible does not apply 20% coinsurance for office surgery & all other services outside physician's office	40% coinsurance	• Chiropractic Care – limited to 24 visits per calendar year
	Preventive care/screening/ Immunization	No Charge Deductible does not apply	40% coinsurance	• You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	• None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	• None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com	Generic drugs	Retail: $10.00 copay/prescription Deductible does not apply Mail Order: $20.00 copay/prescription Deductible does not apply	Not Covered	• Retail Pharmacy – limited to a 30-day supply • Mail Order – limited to a 90-day supply • Some over the counter medications are also covered under this plan. • Certain prescription drugs may require prior authorization • High Dollar Prescription Drugs (up to a 30-day supply of a prescription costing over $500.00) are limited to $20,000.00 maximum paid benefit per calendar year • High Dollar Prescription Drugs (up to a 30-day supply of a prescription costing over $500.00) - the cost to the participant is 20% of the prescription cost
	Preferred brand drugs	Retail: $25.00 copay/prescription Deductible does not apply Mail Order: $50.00 copay/prescription Deductible does not apply	Not Covered	
	Non-preferred brand drugs	Retail: $45.00 copay/prescription Deductible does not apply Mail Order: $90.00 copay/prescription Deductible does not apply	Not Covered	
	Specialty drugs	N/A	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	• Precertification is required. Benefits are reduced by $500.00 for noncompliance.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$150.00 copay/visit Deductible does not apply	$150.00 copay/visit Deductible does not apply	• Refer to the Plan Document for the definition of Emergency Care & Emergency Medical Condition
	Emergency medical transportation	20% coinsurance	40% coinsurance	
	Urgent care	$30.00 copay/visit Deductible does not apply Curaquick Clinics (Hy-Vee stores only) $15.00 copay/visit Deductible does not apply	40% coinsurance	• None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	• Precertification is required. Benefits are reduced by $500.00 for noncompliance.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30.00 copay/visit Deductible does not apply	40% coinsurance	• None
	Inpatient services	20% coinsurance	40% coinsurance	• Inpatient and partial: Precertification is required. Benefits are reduced by $500.00 for noncompliance. • Substance abuse services are not covered
If you are pregnant	Office visits	$30.00 copay/initial visit Deductible does not apply Additional visits: 20% coinsurance	40% coinsurance	• Cost sharing does not apply for preventive services. • Depending on the type of services, a deductible, copayment, or coinsurance may apply. • Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	• Limited to 100 visits per calendar year
	Rehabilitation services	20% coinsurance	40% coinsurance	• Physical Therapy – limited to 24 visits per calendar year • Physical Therapy – out-of-network limited to $20.00 maximum per visit
	Habilitation services	20% coinsurance	40% coinsurance	• None
	Skilled nursing care	20% coinsurance	40% coinsurance	• Limited to 100 days per calendar year
	Durable medical equipment	20% coinsurance	40% coinsurance	• Rental up to purchase price
	Hospice services	20% coinsurance	40% coinsurance	• Limited to 180 days per occurrence or 360 days per lifetime

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	• Visual acuity screenings are covered under preventive care • Eye exams are not covered
	Children's glasses	Not Covered	Not Covered	• Not Covered
	Children's dental check-up	Not Covered	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 (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Substance abuse services
- Weight loss programs

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

- Acupuncture - must be administered by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.)
- Bariatric surgery – covered in conjunction with surgical treatment of morbid obesity and/or panniculectomy. Subject to additional conditions. Refer to Plan Document.
- Chiropractic care – limited to 24 visits per calendar year
- Habilitation services
- Private-duty nursing

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 Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x-61565 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 your employer or Mid-American Benefits, LLC at 402-571-6224 or 1-800-364-9505 or visit us at www.mid-americanbenefits.com.

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.

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**	**$1,500**
■ **Specialist *[cost sharing]***	**$30**
■ **Hospital (facility) *[cost sharing]***	**20%**
■ **Other *[cost sharing]***	**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	$1,500
Copayments	$72
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,632**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	**$1,500**
■ **Specialist *[cost sharing]***	**$30**
■ **Hospital (facility) *[cost sharing]***	**20%**
■ **Other *[cost sharing]***	**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	$122
Copayments	$1,445
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Joe would pay is	**$1,637**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	**$1,500**
■ **Specialist *[cost sharing]***	**$30**
■ **Hospital (facility) *[cost sharing]***	**20%**
■ **Other *[cost sharing]***	**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	$1,500
Copayments	$250
Coinsurance	$164
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,914**

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