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?	In-Network $600.00 individual / $1,200.00 family Out-of-Network $5,000.00 individual / $10,000.00 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 preventive care telemedicine urgent care	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?	In-Network $2,000.00 individual / $4,000.00 family Out-of-Network $10,000.00 individual / $20,000.00 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.

Important Questions	Answers	Why This Matters:
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	10% coinsurance	30% coinsurance	• None
	Specialist visit	10% coinsurance	30% coinsurance	• None
	Preventive care/screening/ immunization	No Charge Deductible does not apply	30% 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)	10% coinsurance	30% coinsurance	• Precertification is required. Benefits are reduced by $500.00 for noncompliance. • All Out-of-Network non-emergency MRI & CAT scans must be set up and performed by a Care IQ facility or will be subject to a $200.00 copayment.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	

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: 20% copay/prescription ($7.50 minimum / $10.00 maximum. If prescription is less than $7.50, the copay is the cost of the prescription) Deductible does not apply Mail Order: 20% copay/prescription ($15.00 minimum / $20.00 maximum. If prescription is less than $15.00, the copay is the cost of the 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 medications may require prior authorization • If participant requests a preferred or non-preferred when a generic is available, the participant pays 100% of the cost. • Specialty medications must be ordered through Magellan Rx by calling 800-424-0472 • Specialty medications are limited to a 30- day supply
	Preferred brand drugs	Retail: 20% copay/prescription ($15.00 minimum / $25.00 maximum. If prescription is less than $15.00, the copay is the cost of the prescription) Deductible does not apply Mail Order: 20% copay/prescription ($30.00 minimum / $50.00 maximum. If prescription is less than $30.00, the copay is the cost of the prescription) Deductible does not apply	Not Covered	

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)	
	Non-preferred brand drugs	Retail: 20% copay/prescription ($30.00 minimum / $50.00 maximum. If prescription is less than $30.00, the copay is the cost of the prescription) Deductible does not apply Mail Order: 20% copay/prescription ($60.00 minimum / $100.00 maximum. If prescription is less than $60.00, the copay is the cost of the prescription) Deductible does not apply	Not Covered	
	Specialty drugs	Retail: 10% coinsurance Mail Order: 10% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	• Precertification is required. Benefits are reduced by $500.00 for noncompliance.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	$125.00 copay per visit then subject to 10% coinsurance	$125.00 copay per visit then subject to 10% coinsurance	• Refer to the Plan Document for the definition of Emergency Care & Emergency Medical Condition • Copay is waived if admitted
	Emergency medical transportation	10% coinsurance	30% coinsurance	• Refer to the Plan Document for the definition of Emergency Care & Emergency Medical Condition
	Urgent care	$40.00 copay/visit Deductible Waived	$40.00 copay/visit Deductible Waived	• Copay is waived if referred to a hospital emergency room

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)	10% coinsurance	30% coinsurance	• Precertification is required. Benefits are reduced by $500.00 for noncompliance.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	• None
	Inpatient services	10% coinsurance	30% coinsurance	• Precertification is required. Benefits are reduced by $500.00 for noncompliance.
If you are pregnant	Office visits	10% coinsurance	30% 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	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	0% coinsurance	• Limited to 100 visits per calendar year
	Rehabilitation services	10% coinsurance	30% coinsurance	• Limited to 60 visits per calendar year for any combination of services
	Habilitation services	Not Covered	Not Covered	• Not Covered
	Skilled nursing care	10% coinsurance	30% coinsurance	• Limited to 30 days per calendar year
	Durable medical equipment	10% coinsurance	30% coinsurance	• Rental up to purchase price
	Hospice services	0% coinsurance	0% coinsurance	• None
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	0% coinsurance	0% coinsurance	• Oral exams are limited to two per calendar year

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	• Hearing aids	• Private-duty nursing
• Bariatric surgery	• Infertility treatment	• Routine eye care (Adult)
• Cosmetic surgery	• Long-term care	• Routine foot care
• Habilitation services	• Non-emergency care when traveling outside the U.S.	• 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 – visit limitations. Please refer to Plan Document.	• Dental care (Adult) – oral exams are limited to two per calendar year

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** **$600**
- **Specialist *[cost sharing]*** **10%**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **10%**

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	$600
Copayments	$0
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$2,061**

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 *[cost sharing]*** **10%**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **10%**

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	$635
Coinsurance	$133
What isn't covered	
Limits or exclusions	$22
The total Joe would pay is	**$1,390**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$600**
- **Specialist *[cost sharing]*** **10%**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **10%**

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	$5
Coinsurance	$220
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$825**

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