




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 you can go to www.HealtheAtCerner.com or call 1-877-765-1033. 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.HealtheAtCerner.com or call 1-877-765-1033 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes.	This plan covers some items and service if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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 ?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit ?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider ?	Not Applicable.	This plan does not use a provider network . You can receive services from any provider .
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
		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	No Charge	Not Covered	—————N/A—————
	Specialist visit	No Charge	Not Covered	Chiropractic treatment is limited to a maximum of 52 visits per plan year per participant.
	Preventive care/screening/immunization	No Charge	Not Covered	—————N/A—————
If you have a test	Diagnostic test (x-ray, blood work)	Not Covered	Not Covered	Rapid result labs may be covered with no charge.
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	—————N/A—————
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at 1-877-765-1033.	Generic drugs	Not Covered	Not Covered	—————N/A—————
	Preferred brand drugs	Not Covered	Not Covered	—————N/A—————
	Non-preferred brand drugs	Not Covered	Not Covered	—————N/A—————
	Specialty drugs	Not Covered	Not Covered	—————N/A—————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	—————N/A—————
	Physician/surgeon fees	Not Covered	Not Covered	—————N/A—————
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	—————N/A—————
	Emergency medical transportation	Not Covered	Not Covered	—————N/A—————
	Urgent care	Not Covered	Not Covered	—————N/A—————
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	—————N/A—————
	Physician/surgeon fees	Not Covered	Not Covered	—————N/A—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	Not Covered	Age limit – must be age 18 or older
	Inpatient services	Not Covered	Not Covered	—————N/A—————
If you are pregnant	Office visits	Not Covered	Not Covered	—————N/A—————
	Childbirth/delivery professional	Not Covered	Not Covered	—————N/A—————

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)	
	services			
	Childbirth/delivery facility services	Not Covered	Not Covered	_____N/A_____
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	_____N/A_____
	Rehabilitation services	Not Covered	Not Covered	_____N/A_____
	Habilitation services	Not Covered	Not Covered	_____N/A_____
	Skilled nursing care	Not Covered	Not Covered	_____N/A_____
	Durable medical equipment	Not Covered	Not Covered	_____N/A_____
	Hospice services	Not Covered	Not Covered	_____N/A_____
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	_____N/A_____
	Children's glasses	Not Covered	Not Covered	_____N/A_____
	Children's dental check-up	Not Covered	Not Covered	_____N/A_____

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](#).)

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|-----------------------|--|----------------------------|
| • Acupuncture | • Infertility treatment | • Weight loss programs |
| • Bariatric surgery | • Long-term care | • Routine eye care (Adult) |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Routine foot care |
| • Dental care (Adult) | • Private-duty nursing | |
| • Hearing aids | | |

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

- Chiropractic care

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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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 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 Cerner Health Plan Services at 1-877-765-1033. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? No.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? No.

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 816.982.7547.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 816.982.7547.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 816.982.7547.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 816.982.7547.

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	\$0
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$12,800
The total Peg would pay is	\$12,800

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$7,000
The total Joe would pay is	\$7,000

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	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	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$1,900
The total Mia would pay is	\$1,900