Kingman Healthcare Center
Your Medical & Rx Snapshot

Insurance Administrator of America (IAA)

January thru December 2025

PIC
Professional Insurance Consultants
Benefit Services For Your Business Needs

Insurance Administrator of America
Important Contact Information

Welcome To Your Open Enrollment Period!

Insurance Administrator of America, Inc. (IAA) is your "Health Plan" administrator. IAA is responsible for customer service, quoting benefits, processing claims, appeals and other services related to your Medical and Prescription Plan. IAA has been providing health care solutions for private and public sector employer groups for over two decades.

Medical: ProviDRs Care PPO is your National Provider Network with access to quality care providers.

Prescription: trueRx is your Prescription Vendor.

IAA is your contact for Medical and Prescription benefits, questions, and concerns.

IAA Building
1934 Olney Avenue Cherry Hill, NJ 08003

IAA Hours of Operation EST
Monday—Thursday 8:30AM to 6:00PM
Friday 8:30AM to 4:30PM

IAA Customer Service	1-800-283-2524	Claims@iaatpa.com
IAA Portal	Register for 24/7 Account Access www.iaatpa.com	
Additional ID Cards	Angela Pino Ext. 8224 or Angelap@iaatpa.com	
COBRA **Point C Health**	Phone 856-484-5277, Fax 856-888-2855 Cobra@pointchealth.com	
trueRx	Register for Account Access www.trueRx.com or chat hello@truerx.com	
WB RX Express	1-855-391-0126	
Teladoc	1-800-Teladoc www.teladoc.com	

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Welcome to IAA!

Log in or Register at www.iaatpa.com for secure web access to
Eligibility, Claims, Temporary ID Card, Health Information, Provider Search

Clients Products Partners Forms Contact

Health Plan Portal Login
Flexible Benefit Portal Login
COBRA Portal Login
FSA Shop
HSA Shop

Start Taking Control of Your Healthcare Experience

ARE YOU NEW HERE?

Members and Healthcare Providers need to self-register a website account before they can login. Employers will need to contact Insurance Administrator of America for registration.

CREATE A NEW LOGIN ACCOUNT

RETURNING USER LOGIN

Username

This is typically your email address.

Password

☐ Show Password

Login

New Member Registration

1. Log onto www.iaatpa.com
2. Click "Login"
3. Select "Member"
4. Select " Member Health Plan Login"
5. Select "Create A New Login Account

If you have any questions please contact IAA @ 1-800-283-2524

INSURANCE ADMINISTRATOR OF AMERICA, INC.
P.O. Box 5082 • Mt. Laurel, NJ 08054 • 800-283-2524 • 800-220-7786 fax • www.iaatpa.com

Kingman Healthcare Center
Schedule of Benefits
January 1, 2025
Non-Grandfathered Plan

Benefits	**Option A PPO Plan**		
	***Domestic: Kingman Healthcare Center**	***Participating**	***Non-Participating**

***In-Network Services** *(Participating)*
Allowables are based on the Negotiated Rate established in a contractual arrangement with a Provider and/or Facility.

***Out-of-Network Services** *(Non-Participating)* **- Payments are subject to the "Maximum Allowable Charge"**
"Maximum Allowable Charge" shall mean the benefit payable for a specific coverage item or benefit under the Plan.
Maximum Allowable Charge(s) may be the lesser of:
1. The Usual and Customary amount;
2. The allowable charge specified under the terms of the Plan;
3. 125% of the Medicare Reimbursement Rate; or
4. The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.
The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Please see pre-certed services at the end of the schedule of benefits. Pre-cert does not apply to Domestic Tier

Benefits	Domestic: Kingman Healthcare Center	Participating	Non-Participating
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Plan Year Maximum	Unlimited	Unlimited	Unlimited
Deductible *(Per Calendar Year)*			
Individual	$0	$1,500	$2,500
Per Family Unit	$0	$3,000	$5,000
Deductible shares between Domestic and Participating; does not share between Non-Participating			
Charges tracking to the last quarter of the year (October, November, December) are applied to the following year's deductible. This does not apply to Non-Participating			
Coinsurance *(Per Calendar Year)*			
Individual	$1,000	$1,500	$2,500
Family Unit	$2,000	$3,000	$5,000
Medical Out of Pocket Maximum *(Shares between Domestic and Participating) (Includes Deductible and Coinsurance)*			
Individual	$1,000	$3,000	$5,000
Family Unit	$2,000	$6,000	$10,000
Total Out of Pocket Maximum *(Includes Copays, prescription drugs, deductible and coinsurance)*			
Individual	$5,000	$6,350	N/A
Family Unit	$10,000	$12,700	N/A
Deductible, Coinsurance, and Copayments are included in the Out of Pocket Maximum.			
Cost containment penalties do not apply toward the deductible and out-of-pocket maximum and are never paid at 100%,			
Out-of-Pocket Maximum shares between Domestic and Participating; does not share between Non-Participating			
The Plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered charges for the rest of the Plan Year unless otherwise stated.			
Services received at Non-Participating providers while traveling or Dependents living outside the Participating area will be covered at the participating Provider rate.			
Co-Payments			
Teladoc Medical and Mental Health	Covered 100%	Covered 100%	N/A
Physician Visits	Covered 100% after $15 copay	Covered 100% after $40 copay	Covered 30% after deductible
Specialist Visits	Covered 100% after $15 copay	Covered 100% after $50 copay	Covered 30% after deductible
Urgent Care Visits	Covered 100% after $15 copay	Covered 100% after $40 copay	Covered 30% after deductible
Emergency Services			
Ambulance Service	Covered 50% after Participating deductible		
Emergency Room Services	$75 copay then 80% coinsurance	$100 copay then 50% after deductible	Covered 30% after deductible
Non-Participating covered at Participating benefits for True Emergency only *The Emergency room co-payment is waived if the patient is admitted to the Hospital on an emergency basis.* *The utilization review administrator must be notified within 48 hours of the admission (please refer to your ID Card for telephone number), even if the patient is discharged within 48 hours of the admission.*			
Covered Services			
Accident Injury Services	Pays 100% up to $1,000 per person per Calendar Year then standard benefits apply.		
Initial treatment and follow-up care within ninety (90) days of an injury			
Allergy Injections/Testing	Covered 100% after $15 copay	Covered 100% after $40 copay	Covered 30% after deductible
Chiropractic Care	Covered 100% after $15 copay	Covered 100% after $40 copay	Covered 100% after $35 copay
Diabetic Self-Management Education	Covered 100% after $15 copay	Covered 100% after $40 copay	Covered 30% after deductible

Kingman Healthcare Center
Schedule of Benefits
January 1, 2025
Non-Grandfathered Plan

Benefits	Option A PPO Plan		
	*Domestic: Kingman Healthcare Center	*Participating	*Non-Participating
Dialysis Treatment *(Outpatient)*	N/A	Covered 50% after deductible	Covered 30% after deductible
Durable Medical Equipment	N/A	Covered 50% after deductible	Covered 30% after deductible
Hearing Aid	Not Covered	Not Covered	Not Covered
Home Health Care	N/A	Covered 50% after deductible	Covered 30% after deductible
Hospice Care *(Provided as part of Hospice Care Program)*	N/A	Covered 50% after deductible	Covered 30% after deductible
Hospital Inpatient Care *(Pre-certification Required)*			
Inpatient Admission	Covered 80%	Covered 50% after deductible	Covered 30% after deductible
Inpatient Physician Services	Covered 80%	Covered 50% after deductible	Covered 30% after deductible
Maternity Benefits			
Inpatient Hospital Charges *(Pre-certification Required)*	Covered 80%	Covered 50% after deductible	Covered 30% after deductible
Obstetric Care/Physician Charges	Covered 100%	Covered 100%	Covered 30% after deductible
Ultrasound	Covered 100%	Covered 100%	Covered 30% after deductible
Mental Health/Alcohol and Drug Abuse/Applied Behavioral Analysis (ABA) *(Pre-certification Required)*			
Inpatient	N/A	Covered 50% after deductible	Covered 30% after deductible
Outpatient	N/A	Covered 100% after $40 copay	Covered 30% after deductible
Office	N/A	Covered 100% after $40 copay	Covered 30% after deductible
ABA Only Home	N/A	Covered 50% after deductible	Covered 30% after deductible
Nutritional Counseling	Covered 100% after $15 copay	Covered 100% after $40 copay	Covered 30% after deductible
Organ & Corneal Transplants	N/A	Covered 50% after deductible	Covered 30% after deductible
Prosthetic Devices	N/A	Covered 50% after deductible	Covered 30% after deductible
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility *(Pre-certification Required)*	Covered 80%	Covered 50% after deductible	Covered 30% after deductible
Specialty Drugs	Not Covered	Not Covered	Not Covered
Preventive Well Care as defined by PPACA			
Breastfeeding Support, Supplies & Counseling	Covered 100%	Covered 100%	Covered 30% after deductible
Colonoscopy & Colorectal Screening/Cologuard	Covered 100%	Covered 100%	Covered 30% after deductible
Contraceptive Methods & Counseling	Covered 100%	Covered 100%	Covered 30% after deductible
GYN Exams/ PAP	Covered 100%	Covered 100%	Covered 30% after deductible
Immunization	Covered 100%	Covered 100%	Covered 30% after deductible
Mammograms	Covered 100%	Covered 100%	Covered 30% after deductible
Prostate Cancer Screening	Covered 100%	Covered 100%	Covered 30% after deductible
Routine Adult Physicals	Covered 100%	Covered 100%	Covered 30% after deductible
Tubal Ligation Services	N/A	Covered 100%	Covered 30% after deductible
Well Child Exams	Covered 100%	Covered 100%	Covered 30% after deductible
Well Child Immunizations and Lead Screening	N/A	Covered 100%	Covered 30% after deductible
Surgical Benefits			
Ambulatory Surgical Center/Free Standing Facility	N/A	Covered 50% after deductible	Covered 30% after deductible
Anesthesia at Ambulatory Surgical Center/Free Standing Facility	N/A	Covered 50% after deductible	Covered 30% after deductible
Physician Services at Ambulatory Surgical Center/Free Standing Facility	N/A	Covered 50% after deductible	Covered 30% after deductible
Physician Office	Covered 80%	Covered 50% after deductible	Covered 30% after deductible
Hospital Inpatient Surgery	Covered 80%	Covered 50% after deductible	Covered 30% after deductible
Anesthesia Hospital Inpatient	Covered 80%	Covered 50% after deductible	Covered 30% after deductible
Physician Services Hospital Inpatient	Covered 80%	Covered 50% after deductible	Covered 30% after deductible
Hospital Outpatient Surgery	Covered 80%	Covered 50% after deductible	Covered 30% after deductible
Anesthesia Hospital Outpatient	Covered 80%	Covered 50% after deductible	Covered 30% after deductible
Physician Services Hospital Outpatient	Covered 80%	Covered 50% after deductible	Covered 30% after deductible
Bariatric Surgery	Not Covered	Not Covered	Not Covered

Kingman Healthcare Center
Schedule of Benefits
January 1, 2025
Non-Grandfathered Plan

Benefits	Option A PPO Plan		
	*Domestic: Kingman Healthcare Center	*Participating	*Non-Participating
X-Rays, Ultrasound and Lab Tests - Charge By Place of Service			
Physicians Office/Independent Facility/Hospital - Outpatient Testing	Covered 100% up to a combined maximum of $300 for each covered person each Calendar Year, then covered 80%	Covered 100% up to a combined maximum of $300 for each covered person each Calendar Year, then covered 50% after deductible	Covered 30% after deductible
Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.) - Charge By Place of Service			
Physicians Office/Independent Facility/Hospital - Outpatient Testing	Covered 100% up to a combined maximum of $300 for each covered person each Calendar Year, then covered 80%	Covered 100% up to a combined maximum of $300 for each covered person each Calendar Year, then covered 50% after deductible	Covered 30% after deductible
Therapy Services			
Physical	Covered 80%	Covered 50% after deductible	Covered 30% after deductible
Occupational	Covered 80%	Covered 50% after deductible	Covered 30% after deductible
Speech	Covered 80%	Covered 50% after deductible	Covered 30% after deductible
Respiratory	Covered 80%	Covered 50% after deductible	Covered 30% after deductible
Cardiac Rehabilitation	Covered 80%	Covered 50% after deductible	Covered 30% after deductible
Chemotherapy	Covered 80%	Covered 50% after deductible	Covered 30% after deductible
Radiation Therapy	N/A	Covered 50% after deductible	Covered 30% after deductible
Infusion Therapy	Covered 80%	Covered 50% after deductible	Covered 30% after deductible
Vision Care Benefits			
Eye Exam, One in 12 Months *(Includes Refractions)* **:**	N/A	Covered 100% after $40 copay	Covered 30% after deductible
Screening exams for children under 5 (five) years of age are covered 100%			
Prescription Drug Benefit			
Rx Out of Pocket Maximum Combined with Medical			N/A
Retail *(Benefit limited to 34 day supply*)*			
Generic	$20		N/A
Brand	$55		N/A
Non-Preferred	$80		N/A
Specialty	Not Covered		N/A
Preventative Medications as defined by PPACA	$0		N/A
**The quantity per prescription shall be greater of a 34 day supply or 100 unit dosage, if defined as a maintenance drug*			
Mail Order *(90-Day Supply)*			
Generic	$40		N/A
Brand	$137.50		N/A
Non-Preferred	$200		N/A
Specialty	Not Covered		N/A
Preventative Medications as defined by PPACA	$0		N/A

Precertification List -This does not apply to Domestic Tier

The following services require Precertification

Inpatient hospitalization
Skilled nursing facility stays
Rehabilitation Facilities
Long Term Acute Care
Inpatient Mental/Nervous facility based programs
Inpatient Substance Abuse facility based programs
Transplant candidacy evaluation and transplant (organ and/or tissue)

Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

Kingman Healthcare Center
Schedule of Benefits
January 1, 2025
Non-Grandfathered Plan

Benefits	Option B HSA HDHP Plan		
	*Domestic: Kingman Healthcare Center	*Participating	*Non-Participating

***In-Network Services** *(Participating)*
Allowables are based on the Negotiated Rate established in a contractual arrangement with a Provider and/or Facility.

***Out-of-Network Services** *(Non-Participating)* **- Payments are subject to the "Maximum Allowable Charge"**
"Maximum Allowable Charge" shall mean the benefit payable for a specific coverage item or benefit under the Plan.
Maximum Allowable Charge(s) may be the lesser of:
1. The Usual and Customary amount;
2. The allowable charge specified under the terms of the Plan;
3. 125% of the Medicare Reimbursement Rate; or
4. The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.
The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Please see pre-certed services at the end of the schedule of benefits. Pre-cert does not apply to Domestic Tier

Benefits	*Domestic: Kingman Healthcare Center	*Participating	*Non-Participating
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Plan Year Maximum	Unlimited	Unlimited	Unlimited
Deductible *(Per Calendar Year)*			
Individual	$3,000	$3,000	$5,000
Per Family Unit	$6,000	$6,000	$10,000
Deductible shares between Domestic and Participating; does not share between Non-Participating			
Out of Pocket Maximum			
Individual	$6,350	$6,350	N/A
Family Unit	$12,700	$12,700	N/A
Deductible, Coinsurance, and Copayments are included in the Out of Pocket Maximum.			
Cost containment penalties do not apply toward the deductible and out-of-pocket maximum and are never paid at 100%,			
Out-of-Pocket Maximum shares between Domestic and Participating; does not share between Non-Participating			
The Plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered charges for the rest of the Plan Year unless otherwise stated.			
Services received at Non-Participating providers while traveling or Dependents living outside the Participating area will be covered at the participating Provider rate.			
Co-Payments			
Teladoc Medical and Mental Health	Covered 100% after deductible	Covered 100% after deductible	N/A
Physician Visits	Covered 100% after deductible and $15 copay	Covered 100% after deductible and $35 copay	Covered 30% after deductible
Specialist Visits	Covered 100% after deductible and $15 copay	Covered 100% after deductible and $35 copay	Covered 30% after deductible
Urgent Care Visits	Covered 100% after deductible and $15 copay	Covered 100% after deductible and $35 copay	Covered 30% after deductible
Emergency Services			
Ambulance Service	Covered 100% after deductible		
Emergency Room Services	Covered 100% after deductible and $75 copay	Covered 100% after deductible and $100 copay	Covered 30% after deductible
Non-Participating covered at Participating benefits for True Emergency only The Emergency room co-payment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator must be notified within 48 hours of the admission (please refer to your ID Card for telephone number), even if the patient is discharged within 48 hours of the admission.			
Covered Services			
Accident Injury Services	Covered 100% after deductible		Covered 30% after deductible
Initial treatment and follow-up care within ninety (90) days of an injury			
Allergy Injections/Testing	Covered 100% after deductible and $15 copay	Covered 100% after deductible and $35 copay	Covered 30% after deductible
Chiropractic Care	Covered 100% after deductible and $15 copay	Covered 100% after deductible and $35 copay	Covered 100% after deductible and $35 copay
Diabetic Self-Management Education	Covered 100% after deductible and $15 copay	Covered 100% after deductible and $35 copay	Covered 30% after deductible
Dialysis Treatment *(Outpatient)*	N/A	Covered 100% after deductible	Covered 30% after deductible
Durable Medical Equipment	N/A	Covered 100% after deductible	Covered 30% after deductible
Hearing Aid	Not Covered	Not Covered	Not Covered
Home Health Care	N/A	Covered 100% after deductible	Covered 30% after deductible
Hospice Care *(Provided as part of Hospice Care Program)*	N/A	Covered 100% after deductible	Covered 30% after deductible

Kingman Healthcare Center
Schedule of Benefits
January 1, 2025
Non-Grandfathered Plan

Benefits	Option B HSA HDHP Plan		
	*Domestic: Kingman Healthcare Center	*Participating	*Non-Participating
Hospital Inpatient Care *(Pre-certification Required)*			
Inpatient Admission	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Inpatient Physician Services	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Maternity Benefits			
Inpatient Hospital Charges *(Pre-certification Required)*	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Obstetric Care/Physician Charges	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Ultrasound	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Mental Health/Alcohol and Drug Abuse/Applied Behavioral Analysis (ABA) *(Pre-certification Required)*			
Inpatient	N/A	Covered 100% after deductible	Covered 30% after deductible
Outpatient	N/A	Covered 100% after deductible and $35 copay	Covered 30% after deductible
Office	N/A	Covered 100% after deductible and $35 copay	Covered 30% after deductible
ABA Only Home	N/A	Covered 100% after deductible	Covered 30% after deductible
Nutritional Counseling	Covered 100% after deductible and $15 copay	Covered 100% after deductible and $35 copay	Covered 30% after deductible
Organ & Corneal Transplants	N/A	Covered 100% after deductible	Covered 30% after deductible
Prosthetic Devices	N/A	Covered 100% after deductible	Covered 30% after deductible
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility *(Pre-certification Required)*	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Specialty Drugs	Not Covered	Not Covered	Not Covered
Preventive Well Care as defined by PPACA			
Breastfeeding Support, Supplies & Counseling	Covered 100%	Covered 100%	Covered 30% after deductible
Colonoscopy & Colorectal Screening/Cologuard	Covered 100%	Covered 100%	Covered 30% after deductible
Contraceptive Methods & Counseling	Covered 100%	Covered 100%	Covered 30% after deductible
GYN Exams/ PAP	Covered 100%	Covered 100%	Covered 30% after deductible
Immunization	Covered 100%	Covered 100%	Covered 30% after deductible
Mammograms	Covered 100%	Covered 100%	Covered 30% after deductible
Prostate Cancer Screening	Covered 100%	Covered 100%	Covered 30% after deductible
Routine Adult Physicals	Covered 100%	Covered 100%	Covered 30% after deductible
Tubal Ligation Services	N/A	Covered 100%	Covered 30% after deductible
Well Child Exams	Covered 100%	Covered 100%	Covered 30% after deductible
Well Child Immunizations and Lead Screening	N/A	Covered 100%	Covered 30% after deductible
Surgical Benefits			
Ambulatory Surgical Center/Free Standing Facility	N/A	Covered 100% after deductible	Covered 30% after deductible
Anesthesia at Ambulatory Surgical Center/Free Standing Facility	N/A	Covered 100% after deductible	Covered 30% after deductible
Physician Services at Ambulatory Surgical Center/Free Standing Facility	N/A	Covered 100% after deductible	Covered 30% after deductible
Physician Office	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Hospital Inpatient Surgery	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Anesthesia Hospital Inpatient	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Physician Services Hospital Inpatient	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Hospital Outpatient Surgery	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Anesthesia Hospital Outpatient	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Physician Services Hospital Outpatient	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Bariatric Surgery	Not Covered	Not Covered	Not Covered
X-Rays, Ultrasound and Lab Tests - Charge By Place of Service			
Physicians Office/Independent Facility/Hospital - Outpatient Testing	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.) - Charge By Place of Service			
Physicians Office/Independent Facility/Hospital - Outpatient Testing	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible

Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

Kingman Healthcare Center
Schedule of Benefits
January 1, 2025
Non-Grandfathered Plan

Benefits	Option B HSA HDHP Plan		
	*Domestic: Kingman Healthcare Center	*Participating	*Non-Participating
Therapy Services			
Physical	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Occupational	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Speech	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Respiratory	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Cardiac Rehabilitation	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Chemotherapy	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Radiation Therapy	N/A	Covered 100% after deductible	Covered 30% after deductible
Infusion Therapy	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Vision Care Benefits			
Eye Exam, One in 12 Months *(Includes Refractions)* **:**	N/A	Covered 100% after deductible and $35 copay	Covered 30% after deductible
Screening exams for children under 5 (five) years of age are covered 100%			
Prescription Drug Benefit			
Rx Deductible and Out of Pocket Maximum Combined with Medical			N/A
Retail *(Benefit limited to 34 day supply*)*			
Generic	$20 copay after deductible		N/A
Brand	$55 copay after deductible		N/A
Non-Preferred	$80 copay after deductible		N/A
Specialty	Not Covered		N/A
Preventative Medications as defined by PPACA	$0		N/A
**The quantity per prescription shall be greater of a 34 day supply or 100 unit dosage, if defined as a maintenance drug*			
Mail Order *(90-Day Supply)*			
Generic	$40 copay after deductible		N/A
Brand	$137.50 copay after deductible		N/A
Non-Preferred	$200 copay after deductible		N/A
Specialty	Not Covered		N/A
Preventative Medications as defined by PPACA	$0		N/A

Precertification List -this does not apply to Domestic Tier

The following services require Precertification

Inpatient hospitalization
Skilled nursing facility stays
Rehabilitation Facilities
Long Term Acute Care
Inpatient Mental/Nervous facility based programs
Inpatient Substance Abuse facility based programs
Transplant candidacy evaluation and transplant (organ and/or tissue)

KINGMAN HEALTHCARE CENTER
MEDICAL & RX, RATES 2X Per Month
JANUARY THRU DECEMBER 2025

Medical & RX PPO	Employee	Emp/Child	Emp/Spouse	Family
Employee Pays	$ 105.76	$ 259.91	$ 291.05	$ 427.04
Hospital Pays	$ 394.55	$ 586.27	$ 658.93	$ 976.25
Total Premium 2X Per Month	$ 500.31	$ 846.18	$ 949.98	$ 1,403.29

Medical & RX HDHP	Employee	Emp/Child	Emp/Spouse	Family
Employee Pays	$ 100.02	$ 273.89	$ 244.72	$ 401.27
Hospital Pays	$ 371.57	$ 521.67	$ 648.06	$ 916.11
Total Premium 2X Per Month	$ 471.59	$ 795.56	$ 892.78	$ 1,317.38

ProviDRs Care

Kingman HealthCare Center	Log Out	Main Menu	ProviDRs Care Network
Provider Name Search	Facility/Hospital Name Search	Provider Radius Search	Create a Custom Directory

Please Read and Select a Search Option from the Menu

Provider Name Search
Search for a specific physician by last name, practice name or specialty.

Facility & Ancillary Name Search
Search for a hospital, medical facility, or ancillary provider by name or type.

Provider Radius Search
Choose a specific provider specialty or facility type and search for providers or facilities within a certain mile radius of your zip code.

Create a Custom Directory
Generate a custom PDF Directory of providers or facilities within a certain distance radius of your zip code or select statewide by a specific specialty or for all specialties.

Coverage for services received from any provider is subject to the terms of your health care benefit plan, even if services are pre-certified. Please refer to your health care benefit plan for specific information on all terms, conditions, exclusions, and limitations.

Insurance Administrator of America, (IAA)

PPO Option A

Summary of Benefits and Coverage (SBC)

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, **www.iaatpa.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.iaatpa.com**or call **1-856-470-1200** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** Individual / **$0**Family for Domestic Providers and **$1,500** Individual / **$3,000** Family for Participating Providers and **N/A** Individual / **N/A** Family for Non-Participating Providers.	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. Preventative 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	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	**Medical Out of Pocket Maximum:** **$1,000** Individual / **$2,000** Family for Domestic Providers and **$3,000** Individual / **$6,000** Family for Participating Providers and **$5,000** Individual / **$10,000** Family for Non-Participating Providers. **Total Out of Pocket Maximum:** **$5,000** Individual / **$10,000** Family for Domestic Providers and **$6,350** Individual / **$12,700** Family for Participating Providers and **N/A** Individual / **N/A** Family for Non-	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.

Important Questions	Answers	Why This Matters:
	Participating Providers.	
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, cost containment penalties, and healthcare 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	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 permission from this plan.

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	$15 Copay for Domestic Providers and $40 Copay for Participating Providers	70% Coinsurance after the deductible	——————None——————
	Specialist visit	$15 Copay for Domestic Providers and $50 Copay for Participating Providers	70% Coinsurance after the deductible	——————None——————
	Preventive care/screening/ immunization	Covered 100%	70% Coinsurance after the deductible	——————None——————
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance for Domestic Providers and 50% Coinsurance after the deductible for Participating Providers	70% Coinsurance after the deductible	Domestic Providers and Participating Providers covered 100% up to a combined maximum of $300 for each covered person each calendar year.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance for Domestic Providers and 50% Coinsurance after	70% Coinsurance after the deductible	Domestic Providers and Participating Providers covered 100% up to a combined maximum of $300 for each covered person

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)	
		the deductible for Participating Providers		each calendar year.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.iaatpa.com**	Generic drugs	$20 Copay Retail / $40 Copay Mail Order	N/A	Covers up to a 34-day supply (retail prescription) and limited to 90-day supply (mail order prescription). Preventative medications as defined by the PPACA are covered at no cost.
	Preferred brand drugs	$55 Copay Retail / $137.50 Copay Mail Order	N/A	Covers up to a 34-day supply (retail prescription) and limited to 90-day supply (mail order prescription). Preventative medications as defined by the PPACA are covered at no cost.
	Non-preferred brand drugs	$80 Copay Retail / $200 Copay Mail Order		
	Specialty drugs	Contact IAA for Applicable Costs		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	N/A Domestic Providers / 50% Coinsurance after the deductible for Participating Providers	70% Coinsurance after the deductible	——————None——————
	Physician/surgeon fees	N/A Domestic Providers / 50% Coinsurance after the deductible for Participating Providers	70% Coinsurance after the deductible	——————None——————
If you need immediate medical attention	Emergency room care	$75 Copay then 20% Coinsurance for Domestic Providers and $100 Copay then 50% Coinsurance after the deductible for Participating Providers	70% Coinsurance after the deductible	The Emergency room co-payment is waived if the patient is admitted to the Hospital on an emergency basis. Non-Participating covered at Participating benefits for True Emergency only
	Emergency medical transportation	50% Coinsurance after Participating deductible		——————None——————

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

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)	
	Urgent care	$15 Copay for Domestic Providers and $40 Copay for Participating Providers	70% Coinsurance after the deductible	———None———
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance for Domestic Providers / 50% Coinsurance after the deductible for Participating Providers	70% Coinsurance after the deductible	Pre-certification Required
	Physician/surgeon fees	20% Coinsurance for Domestic Providers / 50% Coinsurance after the deductible for Participating Providers	70% Coinsurance after the deductible	———None———
If you need mental health, behavioral health, or substance abuse services	Outpatient services	N/A Domestic Providers and $40 Copay for Participating Providers	70% Coinsurance after the deductible	———None———
	Inpatient services	N/A for Domestic Providers / 50% Coinsurance after the deductible for Participating Providers	70% Coinsurance after the deductible	Pre-certification Required
If you are pregnant	Office visits	Covered 100%	70% Coinsurance after the deductible	———None———
	Childbirth/delivery professional services	20% Coinsurance for Domestic Providers / 50% Coinsurance after the deductible for Participating Providers	70% Coinsurance after the deductible	———None———
	Childbirth/delivery facility services	20% Coinsurance for Domestic Providers / 50% Coinsurance after the deductible for Participating Providers	70% Coinsurance after the deductible	Pre-certification Required
If you need help	Home health care	N/A Domestic Providers	70% Coinsurance after	———None———

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

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)	
recovering or have other special health needs		/ 50% Coinsurance after the deductible for Participating Providers	the deductible	
	Rehabilitation services	20% Coinsurance for Domestic Providers / 50% Coinsurance after the deductible for Participating Providers	70% Coinsurance after the deductible	———None———
	Habilitation services	20% Coinsurance for Domestic Providers / 50% Coinsurance after the deductible for Participating Providers	70% Coinsurance after the deductible	———None———
	Skilled nursing care	20% Coinsurance for Domestic Providers / 50% Coinsurance after the deductible for Participating Providers	70% Coinsurance after the deductible	Pre-certification Required
	Durable medical equipment	N/A Domestic Providers / 50% Coinsurance after the deductible for Participating Providers	70% Coinsurance after the deductible	———None———
	Hospice services	N/A Domestic Providers / 50% Coinsurance after the deductible for Participating Providers	70% Coinsurance after the deductible	———None———
If your child needs dental or eye care	Children's eye exam	N/A and $40 Copay for Participating Providers	70% Coinsurance after the deductible	One in 12 months. Screening exams for children under 5 (five) years of age are covered 100%
	Children's glasses	Not Covered		
	Children's dental check-up	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	• Long-term care	• Bariatric surgery

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Weight loss programs	• Dental Care (Adult)	• Non-emergency care when traveling outside the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Routine eye care (Adult)	• Chiropractic care	• Home Health 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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 800-283-2524.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-283-2524.
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码800-283-2524.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-283-2524.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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** — **$15 Copay**
- **Hospital (facility)** — **20% Coinsurance**
- **Other** — **20% Coinsurance**

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	$0
Copayments	$10
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,070**

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** — **$15 Copay**
- **Hospital (facility)** — **20% Coinsurance**
- **Other** — **20% Coinsurance**

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	$0
Copayments	$600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$820**

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

- **The plan's overall deductible** — **$0**
- **Specialist** — **$15 Copay**
- **Hospital (facility)** — **20% Coinsurance**
- **Other** — **20% Coinsurance**

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	$0
Copayments	$100
Coinsurance	$700
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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

Insurance Administrator of America, (IAA)

HDHP/HSA Option B

Summary of Benefits and Coverage (SBC)

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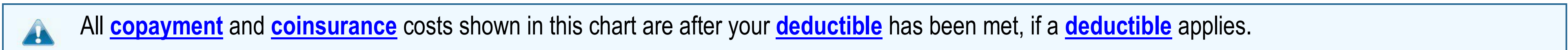
Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$3,000** Individual / **$6,000** Family for Domestic Providers and **$3,000** Individual / **$6,000** Family for Participating Providers and **$5,000** Individual / **$10,000** Family for Non-Participating Providers.	Generally, 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. Preventative 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	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	**$6,350** Individual / **$12,700** Family for Domestic Providers and **$6,350** Individual / **$12,700** Family for Participating Providers and **N/A** Individual / **N/A** Family for Non-Participating Providers.	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, cost containment penalties, and healthcare 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	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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.



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	Covered 100% after the deductible then $15 Copay for Domestic Providers and covered 100% after the deductible then $35 Copay for Participating Providers	70% Coinsurance after the deductible	———None———
	Specialist visit	Covered 100% after the deductible then $15 Copay for Domestic Providers and covered 100% after the deductible then $35 Copay for Participating Providers	70% Coinsurance after the deductible	———None———
	Preventive care/screening/ immunization	Covered 100%	70% Coinsurance after the deductible	———None———
If you have a test	Diagnostic test (x-ray, blood work)	Covered 100% after the deductible	70% Coinsurance after the deductible	———None———
	Imaging (CT/PET scans, MRIs)	Covered 100% after the deductible	70% Coinsurance after the deductible	———None———
If you need drugs to treat your illness or condition More information about **prescription drug**	Generic drugs	$20 Copay after the deductible Retail / $40 Copay after the deductible Mail Order	N/A	Covers up to a 34-day supply (retail prescription) and limited to 90-day supply (mail order prescription). Preventative medications as defined by the

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
coverage is available at www.iaatpa.com				PPACA are covered at no cost.
	Preferred brand drugs	$55 Copay after the deductible Retail / $137.50 Copay after the deductible Mail Order	N/A	Covers up to a 34-day supply (retail prescription) and limited to 90-day supply (mail order prescription). Preventative medications as defined by the PPACA are covered at no cost.
	Non-preferred brand drugs	$80 Copay after the deductible Retail / $200 Copay after the deductible Mail Order	N/A	Covers up to a 34-day supply (retail prescription) and limited to 90-day supply (mail order prescription). Preventative medications as defined by the PPACA are covered at no cost.
	Specialty drugs	Contact IAA for Applicable Costs		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Covered 100% after the deductible	70% Coinsurance after the deductible	N/A for Domestic Providers
	Physician/surgeon fees	Covered 100% after the deductible	70% Coinsurance after the deductible	N/A for Domestic Providers
If you need immediate medical attention	Emergency room care	Covered 100% after the deductible then $75 Copay for Domestic Providers and covered 100% after the deductible then $100 Copay for Participating Providers	70% Coinsurance after the deductible	The Emergency room co-payment is waived if the patient is admitted to the Hospital on an emergency basis. Non-Participating covered at Participating benefits for True Emergency only
	Emergency medical transportation	Covered 100% after deductible		————None————
	Urgent care	Covered 100% after the deductible then $15 Copay for Domestic Providers and covered 100% after the deductible then $35	70% Coinsurance after the deductible	————None————

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

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)	
		Copay for Participating Providers		
If you have a hospital stay	Facility fee (e.g., hospital room)	Covered 100% after the deductible	70% Coinsurance after the deductible	Pre-certification Required
	Physician/surgeon fees	Covered 100% after the deductible	70% Coinsurance after the deductible	————None————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Covered 100% after the deductible then $35 Copay for Participating Providers	70% Coinsurance after the deductible	N/A for Domestic Providers
	Inpatient services	Covered 100% after the deductible	70% Coinsurance after the deductible	N/A for Domestic Providers. Pre-certification Required
If you are pregnant	Office visits	Covered 100% after the deductible	70% Coinsurance after the deductible	————None————
	Childbirth/delivery professional services	Covered 100% after the deductible	70% Coinsurance after the deductible	————None————
	Childbirth/delivery facility services	Covered 100% after the deductible	70% Coinsurance after the deductible	Pre-certification Required
If you need help recovering or have other special health needs	Home health care	Covered 100% after the deductible	70% Coinsurance after the deductible	N/A for Domestic Providers
	Rehabilitation services	Covered 100% after the deductible	70% Coinsurance after the deductible	————None————
	Habilitation services	Covered 100% after the deductible	70% Coinsurance after the deductible	————None————
	Skilled nursing care	Covered 100% after the deductible	70% Coinsurance after the deductible	Pre-certification Required
	Durable medical equipment	Covered 100% after the deductible	70% Coinsurance after the deductible	N/A for Domestic Providers
	Hospice services	Covered 100% after the deductible	70% Coinsurance after the deductible	N/A for Domestic Providers
If your child needs dental or eye care	Children's eye exam	Covered 100% after the deductible then $15 Copay for Domestic	70% Coinsurance after the deductible	One in 12 months. Screening exams for children under 5 (five) years of age are covered 100%

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

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)	
		Providers and covered 100% after the deductible then $35 Copay for Participating Providers		
	Children's glasses	Not Covered		
	Children's dental check-up	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
- Weight loss programs
- Long-term care
- Dental Care (Adult)
- Bariatric surgery
- Non-emergency care when traveling outside the U.S.

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

- Routine eye care (Adult)
- Chiropractic care
- Home Health 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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

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

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Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 800-283-2524.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-283-2524.
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码800-283-2524.

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

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-283-2524.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$3,000**
- **Specialist** **$15 Copay then covered 100% after deductible**
- **Hospital (facility)** **Covered 100% after deductible**
- **Other** **Covered 100% after deductible**

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	$3,000
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,070**

Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **$3,000**
- **Specialist** **$15 Copay then covered 100% after deductible**
- **Hospital (facility)** **Covered 100% after deductible**
- **Other** **Covered 100% after deductible**

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	$3,000
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,320**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$3,000**
- **Specialist** **$15 Copay then covered 100% after deductible**
- **Hospital (facility)** **Covered 100% after deductible**
- **Other** **Covered 100% after deductible**

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	$2,800
Copayments	$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.

Insurance Administrator of America, (IAA)

Summary of Benefits and Coverage (SBC)

Glossary of Terms

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

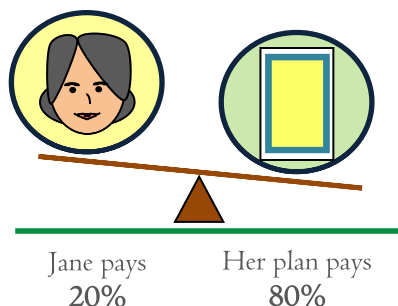
Allowed Amount
This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

Appeal
A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not balance bill you for covered services.

Claim
A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance
Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

Complications of Pregnancy
Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

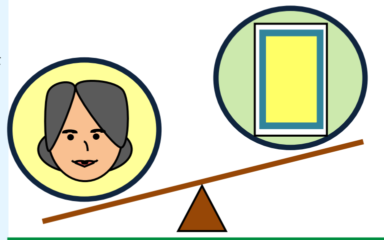
Copayment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.

Cost Sharing
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions
Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% Her plan pays 0%

(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services that your plan doesn't pay for or cover.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost-sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost-sharing amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or plan.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan."

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered health care services. Your share is usually lower for in-network covered services.

In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange." The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage
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.

Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost-sharing reductions to buy a plan from the Marketplace.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

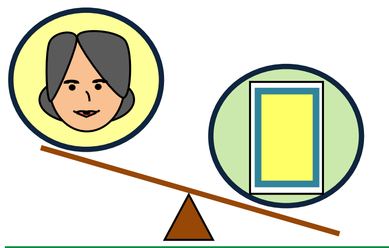
Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)
A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."

Out-of-pocket Limit



(See page 6 for a detailed example.)

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan," "policy," "health insurance policy," or "health insurance."

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called "prior authorization," "prior approval," or "precertification." Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

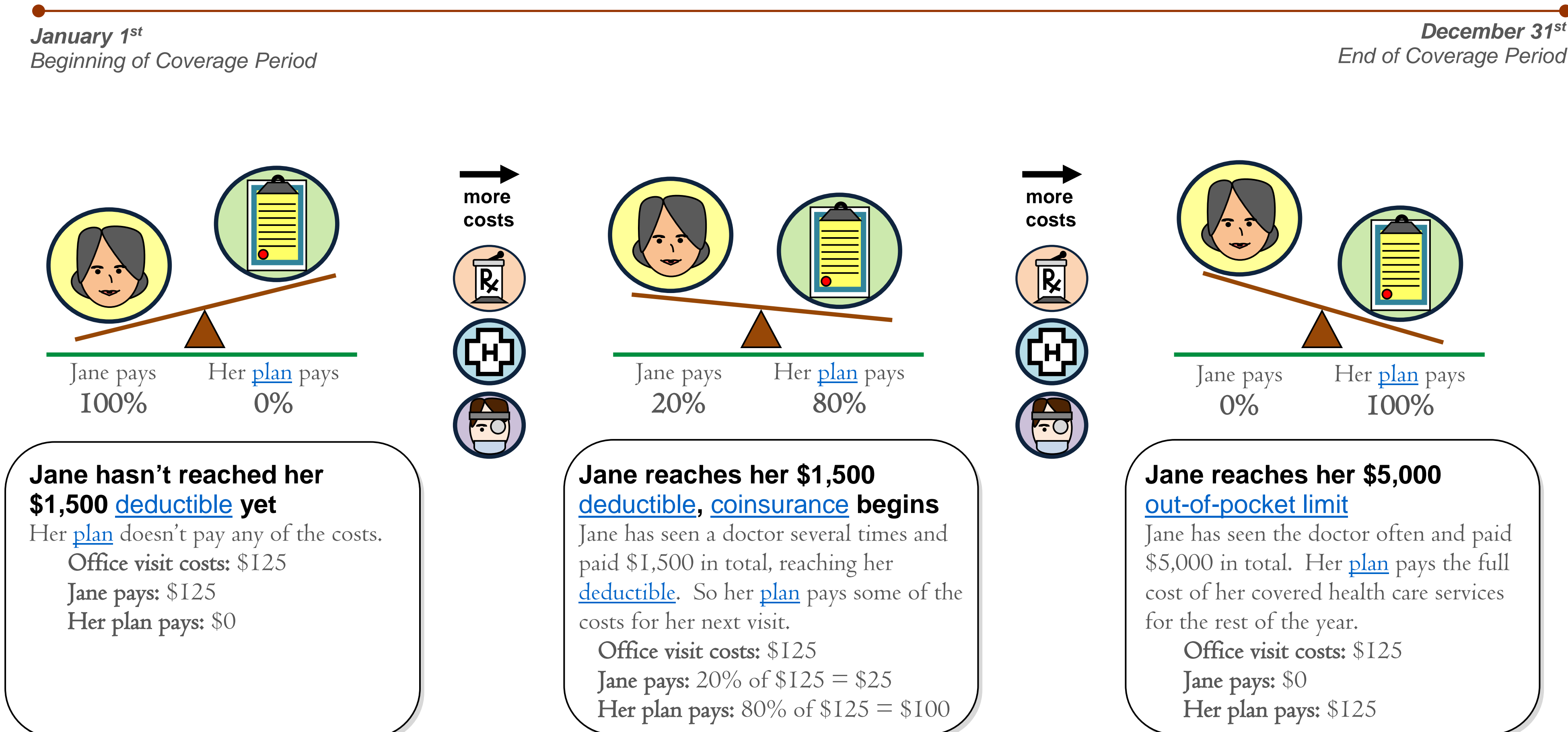
Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000



Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100

Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $125
Jane pays: $0
Her plan pays: $125

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Enjoy your day!

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620-227-6940

Kingman Healthcare Center – *Follow Your Benefit Path*

Kansas City Life
Delta Dental
EBCFlex
Vision Care Direct

January thru December 2025

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Professional Insurance Consultants
Benefit Services For Your Business Needs

Ninnescah Valley Health Systems, Inc. dba Kingman Healthcare Center

- Life & Dependent Life
- Long-Term Disability
- Voluntary Life

Life Insurance

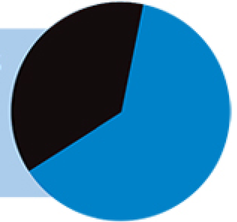
Kansas City Life
Insurance Company

Group Benefits

Do you have a spouse, dependent children or a parent in your life who relies on you for support? If the answer is "Yes," life insurance may be the choice for you.

Given the loss of the primary wage earner, 1 in 3 households would have immediate trouble paying living expenses.

Source: *2016 Insurance Barometer Study, Life Happens and LIMRA.*



93% of U.S. workers with employer-based life insurance benefits believe most people need life insurance.

Source: *2015 Life Insurance Awareness Month Fact Sheet, LIMRA.*

Life insurance continues to be an integral part of an employer's benefits package. Today, employees have come to recognize that having life insurance is a necessity. Stories of loved ones leaving behind families with no financial protection are becoming all too familiar. Kansas City Life Insurance Company's Group Life plan can help you get the protection and comfort you need.

Take this opportunity to review the life insurance benefits available to you on behalf of Ninnescah Valley Health Systems, Inc. dba Kingman Healthcare Center

Benefit Summary

All Full-time active employees working 30 hours per week year-round, who are U.S. Citizens or legal U.S. residents and are performing the duties of their occupation on their last scheduled working day immediately preceding the effective date of the plan are eligible for insurance on that effective date.

Your benefit coverage is $50,000.

Your depenendent benefits are: Spouse - $10,000 / Child – 0 days to 26 years *$5,000.

Coverage reduces 50 percent at age 70. Coverage terminates at retirement.

**May vary by state.*

	KHC Pays
ER paid Life	$4.50
ER paid AD&D	$1.00
Total Premium Per Month	$5.50
ER paid Dep Life per Family Unit	$2.50

Accidental Death & Dismemberment

The amount shown is paid if a covered loss occurs within 90 days after accidental bodily injury or death, on or off the job.

Loss of	Percentage of Amount Insured
Life	100%
Movement of both upper and lower limbs (Quadriplegia)	100%
Movement of three limbs (Triplegia)	75%
Movement of both lower limbs (Paraplegia)	75%
Movement of both upper and lower limbs on one side of the body (Hemiplegia)	50%
One hand, one foot or sight of one eye	50%
Speech or hearing	50%
Movement of one limb (Uniplegia)	25%
Thumb and index finger only	25%

Kansas City Life will not pay more than 100 percent of the amount insured for all losses sustained by an individual in one accident. Only the largest amount shown will be paid for injuries to the same limb resulting from any single accident.

Additional Benefits
Waiver of Premium
Conversion Privilege
Accelerated Death Benefit
Spouse Education Benefit
Child(ren) Education Benefit
AD&D Benefits include: Seat Belt/Air Bag Benefit, Repatriation Benefit

This outline is intended to be a summary of your benefits and does not include all plan provisions and limitations. Details of your benefits can be found in your certificate of coverage, provided to you at a later date. If there are any discrepancies between this outline and the group certificate, the group certificate governs.

This is a brief description only and is not a contract. The Group Master Policy will determine all rights and benefits. For costs and further details of the coverage, including exclusions, any reductions or limitations and the terms under which the policy may be continued in force or discontinued, see your agent or write to the Company. The policy is cancellable or renewable at the option of the Company. The Company has the right to increase the premium rates. Coverage is not available in all states

Policy and certificate referenced: PJ136/CJ136

Enroll today!

Complete, sign and turn in your enrollment form to Human Resources and know that you have taken an important step to help offset a financial burden in the event of an untimely death.

Dedicated to excellence.
Your partner in employee benefits.

KANSAS CITY LIFE

GROUP BENEFITS

Underwritten by:
Kansas City Life Insurance Company
3520 Broadway
Kansas City, MO 64111-2565
P.O. Box 219425
Kansas City, MO 64121-9425
Toll-free: 877-266-6767, ext. 8200
Fax: 816-531-4648
groupbenefits@kclife.com
www.kclgroupbenefits.com

2025 Plan Year

Long Term Disability (LTD)

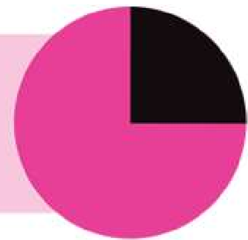
Kansas City Life
Insurance Company

Group
Benefits

Do you have a spouse, child or parent in your life who relies on you for financial support? If so, how would they obtain the finances needed for necessities such as food, utilities and other expenses if you became disabled and unable to work?

Just over 1 in 4 of today's 20-year-olds will become disabled before age 67.

Source: *Social Security Basic Facts, 2015.*



According to the Federal Reserve and the U.S. Census Bureau, only 38% of adults have an emergency fund to use in place of income to pay bills.

Source: *CDA 2014 Consumer Disability Awareness Study.*

Long Term Disability is one of the coverages people think they can go without. Unfortunately, anyone can suffer a disability. In the event of an accident or illness that leaves you unable to work, disability coverage is a way to help secure your future financially, by maintaining an income that otherwise would cease if you stop working.

LTD BENEFIT SUMMARY FOR

Ninnescah Valley Health Systems, Inc. dba Kingman Healthcare Center

All Full-time active employees working 30 hours per week year-round, who are U.S. Citizens or legal U.S. residents and are performing the duties of their occupation on their last scheduled working day immediately preceding the effective date of the plan are eligible for insurance on that effective date.

Plan of Benefits	
Monthly Benefit:	66.67% of Monthly Earnings
Minimum Monthly Payment:	The greater of $100 or 10% of your Gross Monthly Payment
Maximum Monthly Benefit:	$12500 per month
Elimination Period (the number of days you must be continuously disabled due to injury or sickness before benefits begin):	90 consecutive days
Accumulation of Elimination Period (if you return to work while satisfying the elimination period, you may satisfy your elimination period within the accumulation period):	180 consecutive days
Pre-Existing Condition Limitation: Benefits will not be paid if disability begins in the first 12 months following effective date of coverage and is caused by, contributed to by, or the result of a condition for which:	You received medical treatment, consultation, care or services, including diagnostic measures, or took or were prescribed drugs or medicines in the 3 months just prior to effective date of coverage

Note: Includes Employee Assistance Program, up to five face-to-face visits per member, per issue, per year.

Employer Paid LTD Rate: Per $100 Covered Payroll is 0.44.

This outline is intended to be a summary of your benefits and does not include all plan provisions and limitations. Details of your benefits can be found in your certificate of coverage, provided to you at a later date. If there are any discrepancies between this outline and the group certificate, the group certificate governs. This is a brief description only and is not a contract. The Group Master Policy will determine all rights and benefits. For costs and further details of the coverage, including exclusions, any reductions or limitations and the terms under which the policy may be continued in force or discontinued, see your agent or write to the Company. The policy is cancellable or renewable at the option of the Company. The Company has the right to increase the premium rates. Coverage is not available in all states.

Policy and certificate referenced: PJ140/CJ140

KANSAS CITY LIFE

GROUP BENEFITS

Underwritten by:
Kansas City Life Insurance Company
3520 Broadway
Kansas City, MO 64111-2565
P.O. Box 219425
Kansas City, MO 64121-9425
Toll-free: 877-266-6767, ext. 8200
Fax: 816-531-4648
groupbenefits@kclife.com
www.kclgroupbenefits.com

2025 Plan Year

Voluntary Life Insurance

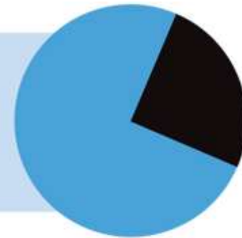
Kansas City Life
Insurance Company

Group Benefits

Determining how much life insurance you need requires a careful evaluation of your current and future financial obligations. Ask yourself: How much money will my family need after my death to meet immediate expenses, such as funeral expenses and debts? How much money will my family need to maintain its standard of living over the long run?

Nearly 1 in 4 people with only group insurance feel they need more.

Source: *2016 Insurance Barometer Study, Life Happens and LIMRA.*



If you are one of those four individuals, now is the time to consider purchasing additional coverage. Typically, voluntary life insurance coverage offered through an employer is more affordable than purchasing an individual policy. Insurance premiums will be automatically deducted from your paycheck, and if you enroll in a timely manner, you may select a benefit in which you are not required to supply evidence of good health.

In order to evaluate how much life insurance you need, review your family's circumstances. In order to make this process easier for you, and to get a general sense of your needs, look at the calculator below. It will walk you through the process and provide you with an estimate of your insurance needs in a matter of minutes.

Most individuals are surprised to find out they are underinsured. How much life insurance do you need to protect your family? This simple worksheet can give you an idea.

1) Your current annual income:	$______________
2) Years spouse will need your income (do not exceed seven years):	______________
Simply multiply line 1 by line 2 and put total here.	$______________
3) Mortgage and other outstanding debts:	$______________
4) College costs for each child, in today's dollars:	$______________
Add lines 3 and 4 and put total here.	$______________
Now add your two totals and put total here.	$______________
5) Other life insurance	$______________
6) Subtract line 5 from the total	$______________
Estimated life insurance needed	$______________

Based on the amounts listed above, this is an estimate of the life insurance you need.

VOLUNTARY LIFE BENEFIT SUMMARY FOR
Ninnescah Valley Health System, Inc. dba Kingman H

All Full-time active employees working 30 hours per week year-round, who are U.S. Citizens or legal U.S. residents and are performing the duties of their occupation on their last scheduled working day immediately preceding the effective date of the plan are eligible for insurance on that effective date.

Your benefit coverage is in increments of $10,000, minimum of $10,000, to a maximum of $500,000, not to exceed 5 times annual earnings, whichever is less. Amounts in excess of the guaranteed issue amount of $100,000 will require evidence of insurability. If the employee is age 70 or over, the amount is $25,000.

Your spouse’s benefit is in increments of $5,000, minimum of $5,000, to a maximum of $250,000, or one half of the employee’s elected amount, whichever is less. Amounts in excess of the guaranteed issue amount of $30,000 will require evidence of insurability. The spouse’s premiums are based on the employee’s age.

The benefit amount for your children is in increments of $2,500 to a maximum of $10,000, or one-half of the employee's elected amount, whichever is less.

*May vary by state.

Employee & Spouse Age/Rates per $1,000					
Age 29 and under	$0.114	45-49	$0.224	65-69	$1.104
30-34	$0.124	50-54	$0.314	70-74	$2.820
35-39	$0.124	55-59	$0.494	75+	$4.630
40-44	$0.164	60-64	$0.684	Child rates per $2,500	$0.404

Coverage reduces 50 percent at age 70. Coverage terminates at retirement.

Additional Benefits
Waiver of Premium
Conversion
Portability
Accelerated Death Benefit
Accidental Death and Dismemberment including** - Seat Belt / Airbag - Repatriation - Day Care - Spouse and Child Education - Common Disaster

**Subject to state approval

Enroll today!

Complete, sign and turn in your enrollment form to Human Resources.

Coverage Limitation*

If a Covered Person dies by suicide, while sane or insane, within two years of the policy effective date, the amount payable by Us will be equal to the total premiums paid. If a Covered Person dies by suicide, while sane or insane, within two years after the effective date of any increase in the specified amount, the amount payable by Us associated with such increase will be limited to the cost of insurance associated with the increase.

**May vary by state.*

This outline is intended to be a summary of your benefits and does not include all plan provisions and limitations. Details of your benefits can be found in your certificate of coverage, provided to you at a later date. If there are any discrepancies between this outline and the group certificate, the group certificate governs.

This is a brief description only and is not a contract. The Group Master Policy will determine all rights and benefits. For costs and further details of the coverage, including exclusions, any reductions or limitations and the terms under which the policy may be continued in force or discontinued, see your agent or write to the Company. The policy is cancellable or renewable at the option of the Company. The Company has the right to increase the premium rates. Coverage is not available in all states.

Policy and certificate referenced: PJ136/CJ136

KANSAS CITY LIFE

GROUP BENEFITS

Underwritten by:
Kansas City Life Insurance Company
Toll-free: 877-266-6767, ext. 8200
Fax: 816-531-4648
groupbenefits@kclife.com
www.kclgroupbenefits.com

Ninnescah Valley Health Systems, Inc. dba Kingman Healthcare Center
Employee Voluntary Life with AD&D Semi-monthly Premium Calculator 2025 Plan Year

You are eligible to enroll for Voluntary Life with AD&D in increments of$10,000 with a minimum of$10,000 and a maximum of$500,000, not to exceed 5 times annual earnings, whichever is less.

		Benefit	10,000	20,000	30,000	40,000	50,000	60,000	70,000	80,000	90,000	100,000
Age	Rate per											
0- 29	$0.11		$0.57	$1.14	$1.71	$2.28	$2.85	$3.42	$3.99	$4.56	$5.13	$5.70
30 - 34	$0.12		$0.62	$1.24	$1.86	$2.48	$3.10	$3.72	$4.34	$4.96	$5.58	$6.20
35 - 39	$0.12		$0.62	$1.24	$1.86	$2.48	$3.10	$3.72	$4.34	$4.96	$5.58	$6.20
40 - 44	$0.16		$0.82	$1.64	$2.46	$3.28	$4.10	$4.92	$5.74	$6.56	$7.38	$8.20
45 - 49	$0.22		$1.12	$2.24	$3.36	$4.48	$5.60	$6.72	$7.84	$8.96	$10.08	$11.20
50 - 54	$0.31		$1.57	$3.14	$4.71	$6.28	$7.85	$9.42	$10.99	$12.56	$14.13	$15.70
55 - 59	$0.49		$2.47	$4.94	$7.41	$9.88	$12.35	$14.82	$17.29	$19.76	$22.23	$24.70
60 - 64	$0.68		$3.42	$6.84	$10.26	$13.68	$17.10	$20.52	$23.94	$27.36	$30.78	$34.20
65 - 69	$1.10		$5.52	$11.04	$16.56	$22.08	$27.60	$33.12	$38.64	$44.16	$49.68	$55.20
70 - 74	$2.82		$14.10	$28.20	$42.30	$56.40	$70.50	$84.60	$98.70	$112.80	$126.90	$141.00
75 +	$4.63		$23.15	$46.30	$69.45	$92.60	$115.75	$138.90	$162.05	$185.20	$208.35	$231.50

		Benefit	110,000	120,000	130,000	140,000	150,000	160,000	170,000	180,000	190,000	200,000
Age	Rate per											
0- 29	$0.11		$6.27	$6.84	$7.41	$7.98	$8.55	$9.12	$9.69	$10.26	$10.83	$11.40
30 - 34	$0.12		$6.82	$7.44	$8.06	$8.68	$9.30	$9.92	$10.54	$11.16	$11.78	$12.40
35 - 39	$0.12		$6.82	$7.44	$8.06	$8.68	$9.30	$9.92	$10.54	$11.16	$11.78	$12.40
40 - 44	$0.16		$9.02	$9.84	$10.66	$11.48	$12.30	$13.12	$13.94	$14.76	$15.58	$16.40
45 - 49	$0.22		$12.32	$13.44	$14.56	$15.68	$16.80	$17.92	$19.04	$20.16	$21.28	$22.40
50 - 54	$0.31		$17.27	$18.84	$20.41	$21.98	$23.55	$25.12	$26.69	$28.26	$29.83	$31.40
55 - 59	$0.49		$27.17	$29.64	$32.11	$34.58	$37.05	$39.52	$41.99	$44.46	$46.93	$49.40
60 - 64	$0.68		$37.62	$41.04	$44.46	$47.88	$51.30	$54.72	$58.14	$61.56	$64.98	$68.40
65 - 69	$I.I04		$60.72	$66.24	$71.76	$77.28	$82.80	$88.32	$93.84	$99.36	$104.88	$110.40
70 - 74	$2.82		$155.10	$169.20	$183.30	$197.40	$211.50	$225.60	$239.70	$253.80	$267.90	$282.00
75 +	$4.63		$254.65	$277.80	$300.95	$324.10	$347.25	$370.40	$393.55	$416.70	$439.85	$463.00

		Benefit	210,000	220,000	230,000	240,000	250,000	260,000	270,000	280,000	290,000	300,000
Age	Rate per											
0- 29	$0.11		$11.97	$12.54	$13.11	$13.68	$14.25	$14.82	$15.39	$15.96	$16.53	$17.10
30 - 34	$0.12		$13.02	$13.64	$14.26	$14.88	$15.50	$16.12	$16.74	$17.36	$17.98	$18.60
35 - 39	$0.12		$13.02	$13.64	$14.26	$14.88	$15.50	$16.12	$16.74	$17.36	$17.98	$18.60
40 - 44	$0.16		$17.22	$18.04	$18.86	$19.68	$20.50	$21.32	$22.14	$22.96	$23.78	$24.60
45 - 49	$0.22		$23.52	$24.64	$25.76	$26.88	$28.00	$29.12	$30.24	$31.36	$32.48	$33.60
50 - 54	$0.31		$32.97	$34.54	$36.11	$37.68	$39.25	$40.82	$42.39	$43.96	$45.53	$47.10
55 - 59	$0.49		$51.87	$54.34	$56.81	$59.28	$61.75	$64.22	$66.69	$69.16	$71.63	$74.10
60 - 64	$0.68		$71.82	$75.24	$78.66	$82.08	$85.50	$88.92	$92.34	$95.76	$99.18	$102.60
65 - 69	$1.10		$115.92	$121.44	$126.96	$132.48	$138.00	$143.52	$149.04	$154.56	$160.08	$165.60
70 - 74	$2.82		$296.10	$310.20	$324.30	$338.40	$352.50	$366.60	$380.70	$394.80	$408.90	$423.00
75 +	$4.63		$486.15	$509.30	$532.45	$555.60	$578.75	$601.90	$625.05	$648.20	$671.35	$694.50

		Benefit	310,000	320,000	330,000	340,000	350,000	360,000	370,000	380,000	390,000	400,000
Age 0- 29	Rate per $1,000:		$17.67	$18.24	$18.81	$19.38	$19.95	$20.52	$21.09	$21.66	$22.23	$22.80
30 - 34	$0.12		$19.22	$19.84	$20.46	$21.08	$21.70	$22.32	$22.94	$23.56	$24.18	$24.80
35 - 39	$0.12		$19.22	$19.84	$20.46	$21.08	$21.70	$22.32	$22.94	$23.56	$24.18	$24.80
40 - 44	$0.16		$25.42	$26.24	$27.06	$27.88	$28.70	$29.52	$30.34	$31.16	$31.98	$32.80
45 - 49	$0.22		$34.72	$35.84	$36.96	$38.08	$39.20	$40.32	$41.44	$42.56	$43.68	$44.80
50 - 54	$0.31		$48.67	$50.24	$51.81	$53.38	$54.95	$56.52	$58.09	$59.66	$61.23	$62.80
55 - 59	$0.49		$76.57	$79.04	$81.51	$83.98	$86.45	$88.92	$91.39	$93.86	$96.33	$98.80
60 - 64	$0.68		$106.02	$109.44	$112.86	$116.28	$119.70	$123.12	$126.54	$129.96	$133.38	$136.80
65 - 69	$1.10		$171.12	$176.64	$182.16	$187.68	$193.20	$198.72	$204.24	$209.76	$215.28	$220.80
70 - 74	$2.82		$437.10	$451.20	$465.30	$479.40	$493.50	$507.60	$521.70	$535.80	$549.90	$564.00
75 +	$4.63		$717.65	$740.80	$763.95	$787.10	$810.25	$833.40	$856.55	$879.70	$902.85	$926.00

Age	Rate per	Benefit	410,000	420,000	430,000	440,000	450,000	460,000	470,000	480,000	490,000	500,000
0- 29	$0.11		$23.37	$23.94	$24.51	$25.08	$25.65	$26.22	$26.79	$27.36	$27.93	$28.50
30 - 34	$0.12		$25.42	$26.04	$26.66	$27.28	$27.90	$28.52	$29.14	$29.76	$30.38	$31.00
35 - 39	$0.12		$25.42	$26.04	$26.66	$27.28	$27.90	$28.52	$29.14	$29.76	$30.38	$31.00
40 - 44	$0.16		$33.62	$34.44	$35.26	$36.08	$36.90	$37.72	$38.54	$39.36	$40.18	$41.00
45 - 49	$0.22		$45.92	$47.04	$48.16	$49.28	$50.40	$51.52	$52.64	$53.76	$54.88	$56.00
50 - 54	$0.31		$64.37	$65.94	$67.51	$69.08	$70.65	$72.22	$73.79	$75.36	$76.93	$78.50
55 - 59	$0.49		$101.27	$103.74	$106.21	$108.68	$111.15	$113.62	$116.09	$118.56	$121.03	$123.50
60 - 64	$0.68		$140.22	$143.64	$147.06	$150.48	$153.90	$157.32	$160.74	$164.16	$167.58	$171.00
65 - 69	$1.10		$226.32	$231.84	$237.36	$242.88	$248.40	$253.92	$259.44	$264.96	$270.48	$276.00
70 - 74	$2.82		$578.10	$592.20	$606.30	$620.40	$634.50	$648.60	$662.70	$676.80	$690.90	$705.00
75 +	$4.63		$949.15	$972.30	$995.45	$1018.60	$1041.75	$1064.90	$1088.05	$1111.20	$1134.35	$1157.50

Payroll deductions are a11 approximation. Please see your paystub for actual deductions.

Age	Rate per $1,000:	Benefit	5,000	10,000	15,000	20,000	25,000	30,000	35,000	40,000	45,000	50,000
0- 29			$0.29	$0.57	$0.86	$1.14	$1.43	$1.71	$2.00	$2.28	$2.57	$2.85
30 - 34	$0.12		$0.31	$0.62	$0.93	$1.24	$1.55	$1.86	$2.17	$2.48	$2.79	$3.10
35 - 39	$0.12		$0.31	$0.62	$0.93	$1.24	$1.55	$1.86	$2.17	$2.48	$2.79	$3.10
40 - 44	$0.16		$0.41	$0.82	$1.23	$1.64	$2.05	$2.46	$2.87	$3.28	$3.69	$4.10
45 - 49	$0.22		$0.56	$1.12	$1.68	$2.24	$2.80	$3.36	$3.92	$4.48	$5.04	$5.60
50 - 54	$0.31		$0.79	$1.57	$2.36	$3.14	$3.93	$4.71	$5.50	$6.28	$7.07	$7.85
55 - 59	$0.49		$1.24	$2.47	$3.71	$4.94	$6.18	$7.41	$8.65	$9.88	$11.12	$12.35
60 - 64	$0.68		$1.71	$3.42	$5.13	$6.84	$8.55	$10.26	$11.97	$13.68	$15.39	$17.10
65 - 69	$1.10		$2.76	$5.52	$8.28	$11.04	$13.80	$16.56	$19.32	$22.08	$24.84	$27.60
70 - 74	$2.82		$7.05	$14.10	$21.15	$28.20	$35.25	$42.30	$49.35	$56.40	$63.45	$70.50
75 +	$4.63		$11.58	$23.15	$34.73	$46.30	$57.88	$69.45	$81.03	$92.60	$104.18	$115.75

Age	Rate per $1,000:	Benefit	55,000	60,000	65,000	70,000	75,000	80,000	85,000	90,000	95,000	100,000
0- 29			$3.14	$3.42	$3.71	$3.99	$4.28	$4.56	$4.85	$5.13	$5.42	$5.70
30 - 34	$0.12		$3.41	$3.72	$4.03	$4.34	$4.65	$4.96	$5.27	$5.58	$5.89	$6.20
35 - 39	$0.12		$3.41	$3.72	$4.03	$4.34	$4.65	$4.96	$5.27	$5.58	$5.89	$6.20
40 - 44	$0.16		$4.51	$4.92	$5.33	$5.74	$6.15	$6.56	$6.97	$7.38	$7.79	$8.20
45 - 49	$0.22		$6.16	$6.72	$7.28	$7.84	$8.40	$8.96	$9.52	$10.08	$10.64	$11.20
50 - 54	$0.31		$8.64	$9.42	$10.21	$10.99	$ I 1.78	$12.56	$13.35	$14.13	$14.92	$15.70
55 - 59	$0.49		$13.59	$14.82	$16.06	$17.29	$18.53	$19.76	$21.00	$22.23	$23.47	$24.70
60 - 64	$0.68		$18.81	$20.52	$22.23	$23.94	$25.65	$27.36	$29.07	$30.78	$32.49	$34.20
65 - 69	$1.10		$30.36	$33.12	$35.88	$38.64	$41.40	$44.16	$46.92	$49.68	$52.44	$55.20
70 - 74	$2.82		$77.55	$84.60	$91.65	$98.70	$105.75	$112.80	$119.85	$126.90	$133.95	$141.00
75 +	$4.63		$127.33	$138.90	$150.48	$162.05	$173.63	$185.20	$196.78	$208.35	$219.93	$231.50

Age	Rate per $1,000:	Benefit	105,000	110,000	115,000	120,000	125,000	130,000	135,000	140,000	145,000	150,000
0- 29			$5.99	$6.27	$6.56	$6.84	$7.13	$7.41	$7.70	$7.98	$8.27	$8.55
30 - 34	$0.12		$6.51	$6.82	$7.13	$7.44	$7.75	$8.06	$8.37	$8.68	$8.99	$9.30
35 - 39	$0.12		$6.51	$6.82	$7.13	$7.44	$7.75	$8.06	$8.37	$8.68	$8.99	$9.30
40 - 44	$0.16		$8.61	$9.02	$9.43	$9.84	$10.25	$10.66	$11.07	$ I 1.48	$11.89	$12.30
45 - 49	$0.22		$11.76	$12.32	$12.88	$13.44	$14.00	$14.56	$15.12	$15.68	$16.24	$16.80
50 - 54	$0.31		$16.49	$17.27	$18.06	$18.84	$19.63	$20.41	$21.20	$21.98	$22.77	$23.55
55 - 59	$0.49		$25.94	$27.17	$28.41	$29.64	$30.88	$32.11	$33.35	$34.58	$35.82	$37.05
60 - 64	$0.68		$35.91	$37.62	$39.33	$41.04	$42.75	$44.46	$46.17	$47.88	$49.59	$51.30
65 - 69	$1.10		$57.96	$60.72	$63.48	$66.24	$69.00	$71.76	$74.52	$77.28	$80.04	$82.80
70 - 74	$2.82		$148.05	$155.10	$162.15	$169.20	$176.25	$183.30	$190.35	$197.40	$204.45	$211.50
75 +	$4.63		$243.08	$254.65	$266.23	$277.80	$289.38	$300.95	$312.53	$324.10	$335.68	$347.25

Age	Rate per $1,000:	Benefit	155,000	160,000	165,000	170,000	175,000	180,000	185,000	190,000	195,000	200,000
0- 29			$8.84	$9.12	$9.41	$9.69	$9.98	$10.26	$10.55	$10.83	$11.12	$11.40
30 - 34	$0.12		$9.61	$9.92	$10.23	$10.54	$10.85	$11.16	$11.47	$11.78	$12.09	$12.40
35 - 39	$0.12		$9.61	$9.92	$10.23	$10.54	$10.85	$11.16	$11.47	$11.78	$12.09	$12.40
40 - 44	$0.16		$12.71	$13.12	$13.53	$13.94	$14.35	$14.76	$15.17	$15.58	$15.99	$ I6.40
45 - 49	$0.22		$17.36	$17.92	$18.48	$19.04	$19.60	$20.16	$20.72	$21.28	$21.84	$22.40
50 - 54	$0.31		$24.34	$25.12	$25.91	$26.69	$27.48	$28.26	$29.05	$29.83	$30.62	$31.40
55 - 59	$0.49		$38.29	$39.52	$40.76	$41.99	$43.23	$44.46	$45.70	$46.93	$48.17	$49.40
60 - 64	$0.68		$53.01	$54.72	$56.43	$58.14	$59.85	$61.56	$63.27	$64.98	$66.69	$68.40
65 - 69	$1.10		$85.56	$88.32	$91.08	$93.84	$96.60	$99.36	$102.12	$104.88	$107.64	$110.40
70 - 74	$2.82		$218.55	$225.60	$232.65	$239.70	$246.75	$253.80	$260.85	$267.90	$274.95	$282.00
75 +	$4.63		$358.83	$370.40	$381.98	$393.55	$405.13	$416.70	$428.28	$439.85	$451.43	$463.00

Ninnescah Valley Health System, Inc. dba Kingman H
Spouse Voluntary Life with AD&D Semi-monthly Premium Calculator

You are eligible to enroll your spouse for Voluntary Life with AD&D in increments of$5,000 with a minimum of$5,000 and a maximum of$250,000, not to exceed 50% of the employee amount. The spouse premiu

Age	Rate per	Benefit	205,000	210,000	215,000	220,000	225,000	230,000	235,000	240,000	245,000	250,000
0- 29	$0.11		$11.69	$11.97	$12.26	$12.54	$12.83	$13.11	$ I3.40	$13.68	$13.97	$14.25
30 - 34	$0.12		$12.71	$13.02	$13.33	$13.64	$13.95	$14.26	$14.57	$14.88	$15.19	$15.50
35 - 39	$0.12		$12.71	$13.02	$13.33	$13.64	$13.95	$14.26	$14.57	$14.88	$15.19	$15.50
40 - 44	$0.16		$16.81	$17.22	$17.63	$18.04	$18.45	$18.86	$19.27	$19.68	$20.09	$20.50
45 - 49	$0.22		$22.96	$23.52	$24.08	$24.64	$25.20	$25.76	$26.32	$26.88	$27.44	$28.00
50 - 54	$0.31		$32.19	$32.97	$33.76	$34.54	$35.33	$36.11	$36.90	$37.68	$38.47	$39.25
55 - 59	$0.49		$50.64	$51.87	$53.11	$54.34	$55.58	$56.81	$58.05	$59.28	$60.52	$61.75
60 - 64	$0.68		$70.11	$71.82	$73.53	$75.24	$76.95	$78.66	$80.37	$82.08	$83.79	$85.50
65 - 69	$1.10		$113.16	$115.92	$118.68	$121.44	$124.20	$126.96	$129.72	$132.48	$135.24	$138.00
70 - 74	$2.82		$289.05	$296.10	$303.15	$310.20	$317.25	$324.30	$331.35	$338.40	$345.45	$352.50
75 +	$4.63		$474.58	$486.15	$497.73	$509.30	$520.88	$532.45	$544.03	$555.60	$567.18	$578.75

Payroll deductions are an approximation. Please see your paystub for actual deductions.

Ninnescah Valley Health System, Inc. dba Kingman H
Dependent Child Voluntary Life with AD&D Semi-monthly Premium Calculator

You are eligible to enroll your eligible dependents for Voluntary Life with AD&D in increments of$2,500 to a maximum of$10,000. lnfants aged 14 days to 6 months will be covered for a flat $1,500.

	Benefit	2,500	5,000	7,500	10,000
Rate per increment: $0.404		$0.20	$0.40	$0.61	$0.81

Payroll deductions are an approximation. Please see your paystub for actual deductions.

GET TO KNOW YOUR

Employee Assistance Program

Administered by

Acentra HEALTH

Your Employee Assistance Program (EAP) is a complimentary service available to you through your employer. The EAP provides counseling sessions at no cost to you, as well as offering a wide variety of services to enhance overall wellbeing and support healthy work/life balance. Services and commonly addresses issues are described below. The program is completely confidential and available to you, your household family members, and dependents.

EAP SERVICES & RESOURCES

IMMEDIATE 24/7 SUPPORT AND GUIDANCE

Master's level counselors and work/life specialists are standing by twenty-four hours a day, seven days a week, 365 days a year to answer any questions about the program, provide in-the-moment guidance, and connect you to any of the resources described below.

COUNSELING & SUPPORT

Whether you are dealing with stress, anxiety, depression, relationship issues, substance abuse issues, work issues, or other challenges, we can help. Let us connect you with a highly qualified counselor for in-person, phone, or video counseling sessions. You, your household family members, and dependents are eligible for free confidential counseling sessions.

ONLINE TOOLS & RESOURCES

The EAP website listed below is your one-stop resource for tools and information designed to address life's pressing concerns. You will find webinars, self-assessments, soft skills trainings, podcasts, articles, and more. Additionally, you can access calculators, childcare and eldercare resources, download legal and financial forms, and more.

MANAGEMENT & ORGANIZATIONAL SERVICES

Unlimited telephonic consultations are available to leadership to provide solutions to complex individual and team issues, including ways to reduce conflict and address performance and behavioral issues. The EAP also provides immediate guidance and support following a traumatic or critical incident that impacts the workplace, including coordination of critical incident debriefings.

LEGAL CONSULTATION

Legal concerns can be stressful, costly and often result in lost work time. Reach out to the EAP for a referral for a free 30-minute consultation with a lawyer for any issue (excluding work related issues). After the 30-minutes, you will receive a 25% discount for additional time and services. General legal information and forms, including a simple will form, can be found on the website.

FINANCIAL CONSULTATON

Sometimes we don't know where to start when we are having financial issues or need help budgeting, saving, or have other financial questions. Contact the EAP for a free 30-minute phone consultation with a financial expert. Additional information on budgeting, debt management, and getting ready for retirement can be found on the website.

WORK/LIFE SUPPORT & REFERRAL SERVICES

Let us do the leg work when it comes to researching fitness centers, colleges, adoption services, relocation services, volunteer opportunities, pet care, entertainment, doctors, home repair services, and so much more. Your time is too valuable; our research team is standing by to do the work for you.

CAREGIVER SUPPORT SERVICES

Are you looking for childcare, summer camps, afterschool activities, or back-up care? Need help finding referrals for assisted living facilities or in-home care for an older parent? We can help. Reach out to speak to one of our Child or Elder Specialists, available 24/7. In addition to referrals, they can offer expert advice and guidance tailored to your area of need.

VALUE ADDED SERVICES FROM A COMPANY YOU CAN TRUST

Beneficiary

Travel

Identity

Value Added Services from Generali Global Assistance

The benefits of doing business with Kansas City Life Insurance Company go beyond our exceptional Group coverage. By selecting Kansas City Life to provide your coverage, employees will have access to outstanding services from our partner, Generali Global Assistance (GGA). Value Added Services – just one of many benefits of choosing Kansas City Life.

Beneficiary Companion

Travel Assistance

Identity Theft

You can count on Generali Global Assistance 24/7/365. Take a look at the benefits.

Available 24 hours a day
866-409-4690
+1-240-330-1462 (Collect outside the U.S.)
ops@us.generaliglobalassistance.com

Beneficiary Companion

A service with survivors in mind

At a time of loss, the last thing survivors want to do is make phone calls and handle paperwork. With Kansas City Life's Group Benefit's Beneficiary Companion, they don't have to. Generali Global Assistance will take care of the administrative details involved in closing a loved one's affairs, relieving the stress of paperwork and allowing beneficiaries to focus on the healing process.

Guidance

Kansas City Life Group Benefit's Beneficiary Companion service offers the following types of support:

- Guidance on how to obtain death certificate copies (necessary for performing final notifications)
- 24/7 live support and counsel from a dedicated Beneficiary Assistance Coordinator
- The Beneficiary Companion Guidebook that serves as a handy reference tool for beneficiaries navigating the aftermath of a loved one's death

Assistance

Dedicated Beneficiary Assistance Coordinators manage the assistance process which includes notification to the following:

- Social Security Administration
- Credit reporting agencies
- Credit card companies
- Banks and other financial institutions
- Third-party vendors
- Government agencies

Social media shut down

In an increasingly digital world, it's more common than ever for loved ones to have an active social media presence. However, it can be an emotionally painful and time-consuming process to bring closure to those accounts. Our coordinators can work with the beneficiary to:

- Discontinue access to loved one's social media accounts
- Assist with memorialization of eligible accounts to preserve a loved one's digital profile

Identity protection and fraud resolution

Every year the identities of nearly 2.5 million deceased Americans are stolen to fraudulently open accounts, obtain loans, tax refunds, and other services, according to the IRS[1]. Studies have shown that a deceased person's identity is an attractive target for criminals, especially given the relative ease of obtaining their personally identifiable information. GGA's Identity Protection services give beneficiaries additional peace of mind by providing guidance on how to protect their loved one's identity and resolution assistance in the event of identity theft. Services include:

- Review of credit report with the beneficiary
- Suppression of the deceased person's credit report or a freeze/closure of the account with credit bureaus
- Full-service resolution assistance should there be an incident of identity theft, including affidavit assistance, credit bureaus and fraud department notification, help filing police report, creditor follow-up, and other services

[1] *https://hrhcpa.com/ghosting-exploits-the-stolen-identities-of-the-dead*

Travel Assistance

Safe travels with travel assistance services

With Generali Global Assistance (GGA), one quick phone call can take the hassle out of a traveling emergency. When you travel 100 miles or more away from home on trips of 90 days or less, you have access to travel medical and personal assistance services.

With a local presence in 200 countries and territories worldwide and 24/7/365 assistance centers staffed with multilingual assistance coordinators and case managers as well as medical staff, GGA is here to help you obtain the care and attention you need in case of an emergency while traveling.

In the event of a life-threatening emergency, call the local emergency authorities first to receive immediate assistance, and then contact GGA.

Available travel assistance services

Emergency medical payment

GGA will advance on-site emergency inpatient medical payments to you, up to $10,000 USD upon receipt of satisfactory guarantee of reimbursement from you. The cost of medical services is your responsibility.

Medical search and referral

GGA will assist you in finding physicians, dentists and medical facilities.

Replacement of medication and eyeglasses

GGA will arrange to fill a prescription that has been lost, forgotten or requires a refill, subject to local law, whenever possible. GGA will also arrange for shipment of replacement eyeglasses. Costs for shipping of medication or eyeglasses, or a prescription refill, etc. are your responsibility.

Medical monitoring

During the course of a medical emergency resulting from an accident or sickness, professional case managers, including physicians and nurses, GGA will monitor your case to determine whether the care is appropriate.

Visit by family member/friend

If you are traveling alone and must be or are likely to be hospitalized for seven or more days or are in life-threatening condition, GGA will arrange and coordinate payment for the round-trip transportation for one family member or friend, designated by you from his or her home to the place where you are hospitalized. Transportation costs are the responsibility of you, your family member or friend.

Dependent children assistance

If any dependent children under the age of 19 traveling with you are left unattended because you are hospitalized, GGA will coordinate and arrange payment for their economy class transportation home. Should transportation with an attendant be necessary, GGA will arrange for a qualified escort to accompany the child(ren). Transportation cost is your responsibility.

Traveling companion assistance

If a travel companion loses previously made travel arrangements due to your medical emergency, GGA will arrange for your traveling companion's return home. Transportation costs are the responsibility of you or your traveling companion.

Emergency evacuation/medically necessary repatriation

In the event of a medical emergency, when a physician designated by GGA determines that it is medically necessary for you to be transported under medical supervision to the nearest hospital or treatment facility or be returned to your place of residence for treatment, GGA will coordinate and arrange payment for the transport under proper medical supervision.

Repatriation of mortal remains

In the event of your death while traveling, GGA will coordinate and arrange payment for all necessary government authorizations, including a container appropriate for transportation and for the return of the remains to place of residence for burial.

Trip interruption

If you or an immediate family member is critically injured, sick or dies while traveling, GGA shall arrange for you or your immediate family member's return to the preferred place of hospitalization or burial via the most direct route on economy class airfare. Transportation cost is your responsibility.

Additional travel assistance services

Pre-trip information – Know what you need from currency exchange to consulate referrals before heading out.

Language translation – Get assistance from an interpreter on the phone or on site.

Lost/stolen items – Retrieve lost or stolen luggage, ticket documentation or personal items.

Emergency cash – Emergency advances of up to $500 USD are available in a time of need. (Transfer/deliver fees are your responsibility.)

Emergency travel – Airline, hotel and/or car rental reservations are made during an emergency.

Legal assistance – Legal assistance and bail are available if you're arrested. (Service costs are your responsibilities.)

Emergency messaging – Urgent messages will be sent to your family, friends or associates during an emergency.

Vehicle return – If you're unable, GGA will arrange payment and return of your rental during an emergency. (Service costs are your responsibility.)

Pet return – Hospitalized? GGA will arrange to return your pets home. (Service costs are your responsibility.)

Identity Theft

Protect yourself against identity theft

While the means to detect and prevent identity theft continue to evolve, the crime continues to impact millions of Americans every single year. As criminals continue to search for new ways to commit identity theft, with social networks and healthcare records becoming growing areas to exploit, identity theft is an ever-increasing problem.

Comprehensive protection

Generali Global Assistance (GGA) basic identity theft protection program provides consumers with the information to protect themselves and guidance to help them resolve identity theft. This cost-effective solution offers:

Prevention

- Identity theft prevention kit
- Expertise available 24/7 (support available immediately upon enrollment)

Detection

- Three bureau fraud alert placement assistance

Resolution

- Credit information review
- ID theft affidavit assistance
- Wallet protection
- Translation service
- Emergency cash advance

Generali Global Assistance (GGA) Conditions and Exclusions

Generali Global Assistance (GGA) is not responsible for the validity of the documents presented by the Beneficiary Representative or by the Executor of the Estate, the accuracy of the contents of the Covered Member's credit report nor is GGA responsible for accounts that have been closed by a Covered Member's relative without the Beneficiary Representative's knowledge.

GGA is not responsible for the provision of probate or governmental agency services or proceedings relating to the Estate of the deceased Covered Member. GGA does not guarantee that its intervention on behalf of the Covered Member duly enrolled in the Beneficiary Companion Program will result in a particular outcome or that its efforts on behalf of the Covered Member will lead to a result satisfactory to the Covered Member. GGA services do not include, and GGA cannot assist the Covered Member, for thefts involving non-U.S. bank accounts. GGA is neither an insurer nor provider of insurance and nothing in this program is intended to provide a policy of insurance or insurance benefits to any Covered Member. GGA reserves the right, in its sole and exclusive discretion, to refuse to provide any Services to a Covered Member for a cause of action that occurred prior to his or her enrollment in the Identity Theft program and/or in the Beneficiary Companion program.

GGA shall provide services to all members. On any expenditure for which the member is responsible, GGA shall not be obligated to provide services without first securing funds from the member in payment of such expenditure. If the member pays for covered expenses without receiving an approval or authorization in writing from GGA, then GGA shall not be obligated to reimburse the member for any such expenditure. In the event a member requests a service not included in a program, GGA may, in its sole and absolute discretion, provide such benefits or services at the sole expense of the member, including a reasonable fee to GGA for its efforts on behalf of the member.

GGA provides the services under this program in all countries of the world. However, conditions such as war, natural disaster or political instability may exist in some countries that render assistance services difficult or impossible to provide. In such instances services cannot always be assured. GGA shall attempt to assist a member consistent with the limitations presented by the prevailing situation in the area. GGA reserves the right to suspend, curtail or limit its services in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strikes, nuclear accidents, acts of God or refusal of authorities to permit GGA to fully provide services. In the event a member travels in any area in which such conditions exist, GGA nonetheless shall endeavor to provide services consistent, however, with the risks and conditions then prevailing. GGA shall not be responsible for failure to provide, or for delay in providing services when such failure or delay is caused by conditions beyond GGA's control, including but not limited to flight conditions, labor disturbance and strike, rebellion, riot, civil commotion, war or uprising, nuclear accidents, natural disasters, acts of God or where rendering a service is prohibited by local law or regulations.

Decisions by physicians or other health care professionals employed by, or under contract to, or designated by GGA as to the medical necessity for providing any of the medical services covered by this program are medical decisions based on medical factors and shall be conclusive in determining the need for such services. GGA shall not evacuate or repatriate a member if an GGA designated physician determines that such transport is not medically advisable or necessary or if the injury or illness can be treated locally. In all cases, the medical professionals, medical facilities or legal counsel suggested by GGA to provide direct services to the eligible person pursuant to this program are not employees or agents of GGA, and the final selection of any such medical professional, medical facility, or legal counsel is your choice alone. GGA assumes no responsibility for the quality or content of any such medical or legal advice or services. GGA shall not be liable for the negligence or other wrongful acts or omissions of any of the healthcare or legal professionals providing direct services arising out of or pursuant to this program. The member shall not have any recourse against GGA by reason of its suggestion of, or contract with, any medical professional or attorney.

Dedicated to excellence.
Your partner in employee benefits.

KANSAS CITY LIFE

GROUP BENEFITS

Underwritten by: Kansas City Life Insurance Company
3520 Broadway • Kansas City, MO 64111-2565
P.O. Box 219425 • Kansas City, MO 64121-9425
877-266-6767, ext. 8200
Fax: 816-531-4648
groupbenefits@kclife.com
www.kclgroupbenefits.com

DELTA DENTAL

Summary of Dental Plan Benefits

Kingman Healthcare Center

Account Benefit Plan ID# 54661-01

Effective for January 1, 2025

MAXIMUM BENEFIT(S) PER PERSON:
The Maximum Benefit for all Covered Services, including Implant Services, for each Enrollee in any one Calendar Year is **Two Thousand Dollars ($2,000.00)**.

DEDUCTIBLE LIMITATIONS:
Coverage for Diagnostic and Preventive Services are not subject to the Deductible. For all other Covered Services, the Calendar Year Deductible is: **$50x3**.

RIGHT START 4 KIDS℠ (RS4K):
Children 12 and under receive their Claims paid at 100% for all Covered Services. Deductibles will not apply, but the annual maximum, frequencies, and limitations will apply. Orthodontics Services will not change. If a Child visits an Out-of-Network Dentist, normal waiting periods, Deductibles, and Coinsurance will apply.

ELIGIBLE CHILDREN AGES:
Children are eligible for coverage to age **26**.

Benefit % Paid

Delta Dental PPO	Delta Dental Premier	Out-of-Network		
			DIAGNOSTIC & PREVENTIVE (Not Subject to Deductible)	
100%	**100%**	**100%**	**Diagnostic:**	Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: • Oral evaluations – 2 times each Calendar Year. • Bitewing x-rays – 2 times each Calendar Year for Dependents under age 18 and once each 12 months for adults age 18 and over. • Full mouth or panoramic x-rays – once each 5 years.
100%	**100%**	**100%**	**Preventive:**	Provides for the following: • Routine Cleanings – unlimited. • Topical Fluoride – 2 times each Calendar Year for Dependent Children under age 19. • Space Maintainers – for Dependent Children under age 14 and only for early loss of baby molars. • Sealants – once (1) each tooth per lifetime for Dependent Children under age 16 when applied only to adult molars with no decay or fillings on the chewing surface and intact.
			BASIC (Subject to Deductible)	
80%	**80%**	**80%**	**Ancillary:**	Provides for one emergency/limited exam per Calendar Year by the Dentist for the relief of pain.
80%	**80%**	**80%**	**Oral Surgery:**	Provides for removal of teeth including pre and post-operative care, preparation of the mouth for dentures, removal of the vertical band of thin tissue that connects the tongue to the bottom of the mouth, removal of the tissue that attaches the lips to the gum above the top front two teeth, removal of tissue that connects the gums to the insides of the cheeks, and removal of a piece of tissue from a lesion and sent to the lab for testing.
80%	**80%**	**80%**	**Regular Restorative:**	Provides silver fillings; resin (white) fillings on all teeth; and stainless-steel crowns for Dependents under age 12.
80%	**80%**	**80%**	**Endodontics:**	Includes root canal treatments. When covered, payment for the initial root canal therapy is limited to one per lifetime, per tooth; payment for the retreatment of a root canal is limited to once per 24 months, per tooth.
80%	**80%**	**80%**	**Periodontics:**	a. Includes procedures for the treatment of diseases of the gums and bones. Periodontal cleaning is unlimited if diagnosed with periodontal treatment history.
80%	**80%**	**80%**		b. Surgical periodontal procedures.
			MAJOR (Subject to Deductible)	
50%	**50%**	**50%**	**Special Restorative:**	When teeth cannot be restored with a filling, provides for individual crowns.
50%	**50%**	**50%**	**Prosthodontics:**	a. Includes bridges, partial and complete dentures.
50%	**50%**	**50%**		b. Repairs and adjustments of bridges and dentures.
50%	**50%**	**50%**		c. Implants.
			ORTHODONTICS (Subject to Deductible)	
0%	**0%**	**0%**	**Orthodontics (Braces):**	Orthodontic appliances and treatment.

This is a summary of benefits only and does not bind Delta Dental of Kansas to any coverage. Subscribers are encouraged to familiarize themselves with the details of their individual plan benefits. Subscribers are responsible for any required copayments, deductibles, or fees for services not covered by their plan at the time services are performed. Please refer to the Description of Dental Care Coverage ("Benefits Booklet") for complete coverage information, including but not limited to any applicable exclusions and limitations. Coverage as described in the employer group's dental benefits contract with Delta Dental of Kansas is binding on all parties and supersedes all other written or oral communications.

DELTA DENTAL®

Welcome to Delta Dental of Kansas

With Delta Dental of Kansas you receive the expertise of the largest, most experienced dental benefits carrier in the nation, paired with our unparalleled customer service. With your employer, we have designed a dental benefit plan to help protect you and your family's oral health. Regular, preventive dental care is fundamental to making your smile last, and a healthy mouth contributes to your overall wellbeing.

CHOOSING A DENTIST

You are free to go to any dentist of your choice, but there may be a difference in the amount you pay if the dentist is not a Delta Dental in-network dentist. It is to your advantage to choose a **Delta Dental PPO™** or **Delta Dental Premier®** network dentist. Nearly 4 out of 5 dentists nationwide participate with Delta Dental, so chances are excellent your dentist is already in-network. You can search for an in-network dentist at **DeltaDentalKS.com**, on the Delta Dental mobile app or by contacting our customer service team at 800.234.3375.

MANAGING MY BENEFITS

At **DeltaDentalKS.com**, you can log in to your member account to:

- Print your member ID card
- Review your eligibility and benefit information
- See how your claims paid
- Estimate your out-of-pocket costs*
- Sign-up to receive your Explanation of Benefits (EOBs) electronically
- And more!

Through Delta Dental's mobile app, you can:

- Use your mobile ID card
- Find a dentist
- Estimate your out-of-pocket costs*
- Review your coverage and claims
- And more!

SCAN TO DOWNLOAD
DELTA DENTAL MOBILE APP

**The Dental Care Cost Estimator provides an estimate and does not guarantee the exact fees for dental procedures, what your dental benefits plan will cover or your out-of-pocket costs. Estimates should not be construed as financial or medical advice. For more detailed information on your actual dental care costs, please consult your dentist and call Delta Dental of Kansas at 800-234-3375.*

Dental	Employee	Emp/Child	Emp/Spouse	Family
Employee Pays Per Pay Period	$ 9.62	$ 28.08	$ 28.48	$ 54.57
Hospital Pays Per Pay Period	$ 9.62	$ 9.62	$ 9.62	$ 9.62
Total Premium Per Pay Period	$ 19.25	$ 37.70	$ 38.10	$ 64.19
Total Monthly Premium	$ 38.49	$ 75.40	$ 76.19	$ 128.37

2025 Plan Year

Employee
Benefits
Corporation

The BESTflex℠ Plan

FSA HSA

Kingman Healthcare Center

Flexible Spending Accounts
Dependent Care Accounts
Health Savings Accounts

January thru December 2025

My Company Plan

Appendix to the BESTflex Plan Summary Plan Description
This document outlines all of the options included in your company's BESTflex Plan. It may include options you have chosen not to participate in. For further information about your plan, refer to your BESTflex Plan Summary Plan Description.

My Plan

Organization Name	Ninnescah Valley Health Systems, Inc (N13997)
Cafeteria Plan Name	Ninnescah Valley Health Systems, Inc. Medical Flexible Spending Account Plan
Plan Year	January 1 - December 31

My Plan Eligibility

Benefit Type	Eligibility
Dependent Care FSA	The employee is eligible the first of the month following 60 days of employment. Only employees who are regularly scheduled to work at least 30 hours weekly can participate.
Health Care FSA - Limited	The employee is eligible the first of the month following 60 days of employment. Only employees who are regularly scheduled to work at least 30 hours weekly can participate.
Health Care FSA - Standard	The employee is eligible the first of the month following 60 days of employment. Only employees who are regularly scheduled to work at least 30 hours weekly can participate.
HSA Contributions	Employees must participate in a qualified High Deductible Health Plan. See your Summary Plan Description (SPD) for more information.
Insurance Premiums	Employees otherwise eligible for certain insurance coverages (listed in the My Other Pretax Benefits section) are eligible to pay for those premiums before taxes.

My FSA Options

You may choose to participate in and contribute to the following flexible spending account (FSA) options.

Dependent Care FSA

Used for daycare expenses incurred for the care of your child(ren) or other eligible dependents. You (and your spouse, if you are married) must be working, looking for work, or be a full-time student to use this account.

Minimum Plan Year Contribution:	None for this plan year
Maximum Plan Year Contribution:	$5,000

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Health Care FSA - Limited (with Rollover)

Used for eligible vision and dental expenses incurred by you, your spouse, your eligible child(ren) or your eligible dependent(s). This plan is compatible with making health savings account (HSA) contributions in the same plan year. You may only enroll in one Health Care FSA for the plan year – the limited or the standard.

Minimum Plan Year Contribution:	None for this plan year
Maximum Plan Year Contribution:	$3,300
Rollover Details:	Your Health Care FSA - Limited option includes rollover, which allows unused balances of up to $660 to roll into the next plan year. Please refer to Health Care FSA Details in your BESTflex Plan Summary Plan Description (SPD) for more information about how rollover works.

Health Care FSA - Standard (with Rollover)

Used for eligible medical, vision, and dental expenses incurred by you, your spouse, your eligible child(ren) or your eligible dependent(s). This plan is not compatible with making health savings account (HSA) contributions in the same plan year. You may only enroll in one Health Care FSA for the plan year – the limited or the standard.

Minimum Plan Year Contribution:	None for this plan year
Maximum Plan Year Contribution:	$3,300
Rollover Details:	Your Health Care FSA - Standard option includes rollover, which allows unused balances of up to $660 to roll into the next plan year. Please refer to Health Care FSA Details in your BESTflex Plan Summary Plan Description (SPD) for more information about how rollover works.

Submitting FSA Claims

The Accessing Your Funds section in your BESTflex Plan Summary Description includes more information about the following.

Submitting FSA Claims for Reimbursement Online, through the Mobile App, or on a Claim Form

You may submit claims for reimbursement online at www.ebcflex.com, through the mobile app, or by filling out and submitting a claim form. Reimbursement is made in the order claims are received. The first claim received and processed is the first one paid from the FSA.

Paying for Eligible Health Care Expenses with the Benefits Card

Your employer's Health Care FSA includes a Benefits Card. The Benefits Card is a prepaid debit card you can use to pay for eligible expenses with funds directly from your Health Care FSA balance.

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The Benefits Card debits your Health Care FSA when you use the card at approved service providers and retailers to pay for eligible expenses. Remember to save your receipts and purchase documentation when using the Benefits Card. If your transaction cannot be automatically substantiated at the point of sale, you will be sent a Documentation Request to verify the expense is eligible for payment from your Health Care FSA.

You can only use your Benefits Card for an expense incurred in the same plan year it is paid. To be reimbursed during your runout period for prior plan year expenses, submit a claim for reimbursement online, through the mobile app, or on a claim form.

If you use your Benefits Card while you have pending claims for reimbursement that you previously submitted, your Benefits Card transaction may be processed before the pending claims. As a reminder, the first claim processed is the first one paid from the Health Care FSA.

Runout Period

Your runout period is 3 months long and you may submit claims for eligible expenses incurred during the plan year until March 31, 2026.

Health Care FSA Termination:

If you end your employment, lose eligibility, or revoke your Health Care FSA mid-plan year, your FSA terminates. Your Benefits Card is not available for use after your FSA termination date; however, you have 3 months from the date your FSA terminates to submit Health Care FSA claims for eligible expenses incurred prior to your FSA termination date.

If you are eligible for and choose to elect COBRA continuation coverage on your Health Care FSA, your FSA is reactivated and you have access to your entire election as long as you remain on COBRA.

My Other Pretax Benefits

The BESTflex Plan allows your employer to withhold certain pretax benefit contributions from your payroll before taxes, which saves you money.

Group Insurance Premiums	Renewal Date
Accident	January 1
Dental Insurance	January 1
Hospital Indemnity	January 1
Medical Insurance	January 1
Vision Care	January 1

Health Savings Account (HSA) Contributions

If you are an eligible HSA accountholder, your BESTflex Plan allows you to contribute to your HSA on a pre-tax basis by making a salary reduction election.

Additional Details

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Employer Contributions	The Employer will contribute monthly the following amounts into the Employee's Health Savings Account (HSA) based on their coverage type: $50 Single, $50 Family.
Administration Fees	Your employer is paying all fees for this plan.

My Health Care FSA ERISA Information

ERISA Status	The Plan is governed by ERISA
Contact	Human Resources Representative
Plan Administrator	Ninnescah Valley Health Systems, Inc
Address	750 West D Avenue Kingman, KS 67068
Telephone	(620)532-0200
Federal ID Number	48-0761700
Legal Plan Name	Kingman Healthcare Center Flexible Compensation Plan
Plan Number	501
Original Effective Date	1/1/2019
Agent for Service of Process	Christine Jennings
Collectively Bargained	No

Your company, Ninnescah Valley Health Systems, Inc, has adopted the BESTflex Plan (the Plan) and has engaged Employee Benefits Corporation, P.O. Box 44347, Madison, WI, 53744 (telephone: 608 831 8445; toll free: 800 346 2126), to provide services related to the Plan. For purposes of federal law, the Employer is the Plan Sponsor and the Plan Administrator.

Employee Benefits Corporation Contact Information

Web Address	www.ebcflex.com
E-mail Address	participantservices@ebcflex.com
Fax Number	(608) 831-4790
Mailing Address	Employee Benefits Corporation PO Box 44347 Madison, WI 53744-4347
Phone Number	(800) 346-2126 (608) 831-8445

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Employee Benefits Corporation

Standard Health FSA Eligible Expenses

There are two types of Health Care FSAs: a standard health FSA and a limited health FSA. Your **standard health FSA** allows you to pay for eligible medical, vision, and dental expenses that are not covered by another health plan.

Examples of Eligible Expenses for Standard Health FSAs:

Dental Expenses

- Dental X-Rays
- Exams/Teeth Cleanings, Gum Treatments
- Fillings, Crowns/Bridges
- Oral Surgery, Extractions, Dentures
- Orthodontia/Braces

Vision Expenses

- Contact Lenses, Contact Lens Solution and Cleaners
- Eye Examinations
- Eyeglasses, Reading Glasses, Prescription Sunglasses
- Laser Eye Surgeries, Radial Keratotomy/LASIK

Out-of-Pocket Uncovered Medical Care Expenses

- Copays, Coinsurance, Deductible Expenses
- Prescribed Medication *(including insulin and birth control)*
- Prescribed Vitamins

Lab Exams/Tests

- Blood Tests, Spinal Fluid Tests, Urine/Stool Analyses
- Cardiographs
- Diagnostic Fees, Laboratory Fees
- X-Rays
- At-Home COVID-19 Testing

Medical Treatments/Procedures

- Acupuncture, Chiropractor
- Hearing Exams, Hearing Aids and Batteries
- Individual Behavioral or Mental Health
- Infertility, In-vitro Fertilization
- Inpatient treatment for addiction to alcohol/drugs
- Physical Therapy, Speech Therapy
- Sterilization, Vasectomy and Vasectomy Reversals
- Vaccinations and Immunizations
- Well Baby Care

Medical Supplies and Services

- Abdominal/Back Supports, Arch Supports/Orthopedic Insoles *(not for general comfort)* or Diabetic Shoes
- Blood Pressure Monitors
- Breast Pumps and Lactation Supplies
- Compression Hosiery above 30 mmHg
- Contraceptives, Norplant Insertion or Removal
- Counseling *(except for Marriage and Family)*
- Crutches, Wheelchair, Oxygen Equipment, Splints/Casts
- Medic Alert Bracelet or Necklace
- Hospital and Ambulance Services
- Insulin Supplies, Syringes
- Guide Dog *(for visually/hearing impaired person)*
- Mastectomy Bras, Prosthesis
- Medical Miles, Tolls, Parking, or Transportation Expenses *(essential to medical care)*
- Pregnancy Tests, Pre-Natal Vitamins

Contact Us www.ebcflex.com (800) 346-2126 participantservices@ebcflex.com |

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Over the Counter (OTC) Products

- Allergy, Anti-Itch, Antihistamine Medicines, Eye Drops
- Digestive Tract Relief Medications, Antacids, Anti-Diarrhea Medications, Laxatives
- Anti-Nausea Medications, Motion Sickness Pills
- Cold and Flu Medications, Cough Drops & Syrups, Decongestants, Nasal Sinus Sprays, Sore Throat Spray, Sinus Medications, Throat Lozenges, Vapor Rubs
- First Aid Creams, Diaper Rash Ointments, Calamine Lotion, Bug Bite Medication, Wart Remover Treatments, Special Ointments/Burn Ointments, Rubbing Alcohol
- Menstrual Pain and Cramp Relief Medication
- Menstrual Products, including Tampons and Pads
- Pain Relievers, Analgesics, Aspirin, Fever Reducers, Muscle/Joint Pain Relievers
- Smoking Cessation Products, Nicotine Gum/Patches
- Sunscreen with at least SPF 15
- Athletes Foot Creams and Powders, Cold Sore Remedies, Hemorrhoid Medications, Lice and Scabies Treatments, Yeast Infection Treatments

Personal Protective Equipment (PPE) to Prevent Spread of COVID-19

- Face masks (disposable or cloth), with multiple layers of material and with nose wire
- Hand sanitizer rubs and hand sanitizing wipes with at least 60% alcohol content

This list is not meant to be all inclusive. Other expenses not listed may also qualify. Please contact us if you have any questions.

Examples of Ineligible Expenses for Standard Health FSAs:

We're commonly asked which expenses are not eligible for payment. Here are some examples, but the list is not all inclusive.

- Canceled Appointment Fees
- Drugs or treatments that are illegal under Federal law
- Cosmetic Surgery, Treatments, or Procedures
- Toiletries or Sundry Items
- Vitamins or Supplements for General Health
- Food and meals that replace regular nutritional requirements
- Household cleaning products, including surface cleaning wipes
- Face shields, neck gaiters, or face masks with vents/valves
- Fitness expenses such as gym memberships, athletic gear, and exercise equipment when used for an individual's general health

Personal care items or services for general health are not usually eligible, but if your health care provider recommends an otherwise personal product or service to treat a specific diagnosis, you can submit the expense for reimbursement with a *Letter of Medical Necessity*.

This is a letter from your health care provider that includes a recommendation of the item or service to treat your diagnosis, and the duration of the recommendation. Depending on the expense, you may have to provide additional documentation to show the expense would not have been incurred "but for" the medical condition.

Sometimes a personal or general use item may be specialized for the specific purpose of treating or alleviating a medical condition. In this case, only the excess cost of the specialized item over the non-specialized item can be reimbursed. A Letter of Medical Necessity may be requested for these items as well.

Where can I shop?

Visit www.ebcflex.com/WhereToShop

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Health Savings Account

The benefit that helps you save and invest in your health care.

A health savings account (HSA) is a savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses. With an HSA, you save approximately 30%* on your eligible expenses, making a $1,000 expense cost you about $700. You get these savings because the contributions you make to your HSA are exempt from Federal, State, and FICA payroll taxes.

*This tax example is a broad approximation of tax liability. Your specific savings depend on your tax bracket. Further, your contributions may be subject to state income tax in some states. You should consult a tax advisor for help with your own situation. Current IRS tax laws control all pre-tax payment and contribution matters and are subject to change.

HSA Options

HSAs offer flexibility and planning beyond what you get with other benefits. Spend your HSA dollars when you need them, save your HSA dollars when you don't have an immediate need, and invest some of your savings as your balance grows to see your money grow even faster.

Spend

Use funds on a tax-free basis to pay for **eligible purchases** as they come up. For more information on where you can spend your HSA funds, visit **www.ebcflex.com/WheretoShop**.

Save

Put funds away for future expenses. Take advantage of a **high-yield HSA**, which gives you the potential of a higher interest rate.

Invest

Help support your financial wellness by **investing funds** for health emergencies or health costs incurred during retirement.

1. Consider Your Interest Options

There are two interest options for your HSA—a **traditional interest option** or a **high-yield interest option**. When you first enroll in your HSA, your HSA cash balance will automatically start with the traditional HSA interest option, but you can transition your HSA cash balance to a high-yield HSA option at any time. The high-yield HSA gives you the opportunity to earn higher interest on your HSA funds by having your HSA held in a non-FDIC-insured account that is backed by a highly rated insurance company, Pacific Life. You can change your interest option preference anytime through your online account. Learn more at **www.ebcflex.com/highyieldhsa**.

2. Learn More About Investing

Once your HSA reaches a $1,001 cash balance, you can start investing your HSA funds. There are three investment models to choose from based on your expertise—Managed, Self-Directed, and Brokerage. Whether you're new to investing and are looking for a guided experience **or** are a seasoned investor looking to research and trade stocks and ETFs, you will have an investment model that best fits your needs. If your investment needs ever change, you can switch your investment model at any time.
You can also transfer funds between your HSA cash balance and investment balance at any time.

3. View Eligible Expenses

Consider which eligible expenses you can use your HSA funds on to help inform your contribution amount. For a full list of eligible HSA expenses, visit **www.ebcflex.com/eligibleexpenses**.

4. Choose Your Contribution Amount

After considering the eligible expenses, decide how much you would like to contribute to the HSA.
For 2024, you can elect to contribute up to the established limit:

Self-Only Health Plan | **$4,300***   Family Health Plan | **$8,550***

*Limits are based on the assumption that an individual is HSA eligible for the full plan year. Limits may be prorated based on the duration of HSA eligibility.

6. Complete the Enrollment Process

After determining that an HSA is right for you, if you are eligible for an HSA, and determining your election amount, you should be prepared to complete the enrollment process.

7. Spend Your HSA Funds

Use your Benefits Card to pay for eligible expenses directly from your HSA. You can also use the Bill Pay feature in your online account to pay a provider directly or pay yourself back for an eligible expense you made without your Benefits Card. For more information on where you can spend your HSA funds, visit **www.ebcflex.com/WheretoShop**.

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Maximizing your contributions

As you decide how much to contribute, it's important to note that contributing the maximum allowable amount helps you to get the most from your HSA. At the very least, you'll want to contribute enough to cover anticipated health care expenses. Because your balance rolls over year to year, there is no penalty for contributing more than you're able to use in one year. The tax advantages of an HSA make it a powerful long-term savings vehicle.

The maximum annual contribution can be made even if you become HSA-eligible after your tax year begins, as long as you are covered under a qualified High Deductible Health Plan (HDHP) on the first day of the last month of your tax year (December 1 for most taxpayers) and remain in a qualified HDHP for the following 12 months. See IRS publication 969 for details. Contributions are allowed until the tax filing deadline for the previous calendar year, typically this is April 15th. Additionally, if you are 55 or older, you are allowed to make a $1,000 catch up contribution.

Keep in mind that HSA contribution limits, established by the IRS, may change each year and you must not over contribute to avoid adverse tax consequences.

	2025 Contribution Limit	Catch-Up Contribution*
Single	$4,300	$1,000
Family	$8,550	$1,000

*Participants age 55 or older may make additional contributions above the set HSA maximum. Catch-up contributions can be made any time during the year in which the HSA participant turns 55.

Catch-up contributions for account holders 55 and older

If you are age 55 or older, you may be able to make a catch-up contribution above the annual limit. Even if you join a qualified HDHP after the start of the year, you can contribute the maximum amount, as long as you have qualified HDHP coverage for the last month of the taxable year and for the following 12 months. Catch-up contributions for the partial year of HDHP coverage must be pro-rated.

High-Yield interest option

Unlike an FSA, unused funds stay in your account from year to year and earn interest tax-free. You can choose the interest rate option that best meets your needs: High-Yield or Traditional. The High-Yield interest option can help you earn higher interest on your HSA cash balance, making it a great way to maximize the savings potential of your HSA cash balance.

Simply log in to your online account and select the HSA tile. Click on your account balance and select *interest options* to make your selection or change it at any time.

Does this sound complicated? Don't worry. There are tools within the online account that will help you monitor your contributions and help prevent over contributing. Contact us if you have questions at participantservices@ebcflex.com.

COMPLIANCE OVERVIEW

HSA Limits for 2025

The following chart shows the health savings account (HSA) limits that will apply for 2025, along with the 2024 limits for comparison purposes. The IRS limits for HSA contributions, as well as the minimum deductible and out-of-pocket maximum limits for high deductible health plans (HDHPs), will increase in 2025.

Type of Limit		2024	2025	Change
HSA Contribution Limit	***Self-only***	$4,150	$4,300	**Up $150**
	Family	$8,300	$8,550	**Up $250**
HSA Catch-up Contributions *(not subject to adjustment for inflation)*	***Age 55 or older***	$1,000	$1,000	No change
HDHP Minimum Deductible	***Self-only***	$1,600	$1,650	**Up $50**
	Family	$3,200	$3,300	**Up $100**
HDHP Maximum Out-of-Pocket Expense Limit *(deductibles, copayments and other amounts, but not premiums)*	***Self-only***	$8,050	$8,300	**Up $250**
	Family	$16,100	$16,600	**Up $500**

LINKS AND RESOURCES

- IRS Revenue Procedure 2023-23—HSA limits for 2024
- IRS Revenue Procedure 2024-25—HSA limits for 2025

Provided to you by **PIC Benefit Services**

PIC
Professional Insurance Consultants
Benefit Services For Your Business Needs

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Employee Benefits Corporation

EBC Account

MENU HOME LOGOUT

My Account Summary

Plans

FSA
Limited Health Care FSA
01/01/2023 - 12/31/2023
Available Balance $2,600.00

FSA A
Dependent Care FSA
01/01/2023 - 12/31/2023
Available Balance $0.00

HRA
Health Reimbursement Arrangement
01/01/2023 - 12/31/2023
Available Balance $4,000.00

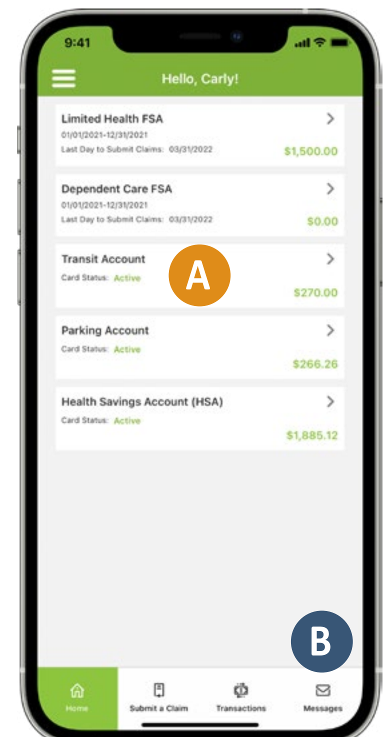
HSA
Health Savings Account
01/01/2022 - No End Date
View Balance >

Quick Links

Message Center C
Manage Direct Deposit
Submit a New Claim
Download Forms and Materials
Track Upcoming Payments
Track Processed Claims
Track Payment Details

Any device, any time.

You can access your EBC account by logging in online or on our mobile app, EBC Mobile.



Accessing Your Account

Online

To log in to your online account, go to www.ebcflex.com and log in as a participant.

Mobile

To log in to EBC Mobile, download the app from the App Store or Google Play and enter your login information.

If you don't have an account set up, you can create your account online or on EBC Mobile by selecting ***Register*** on the login screen.

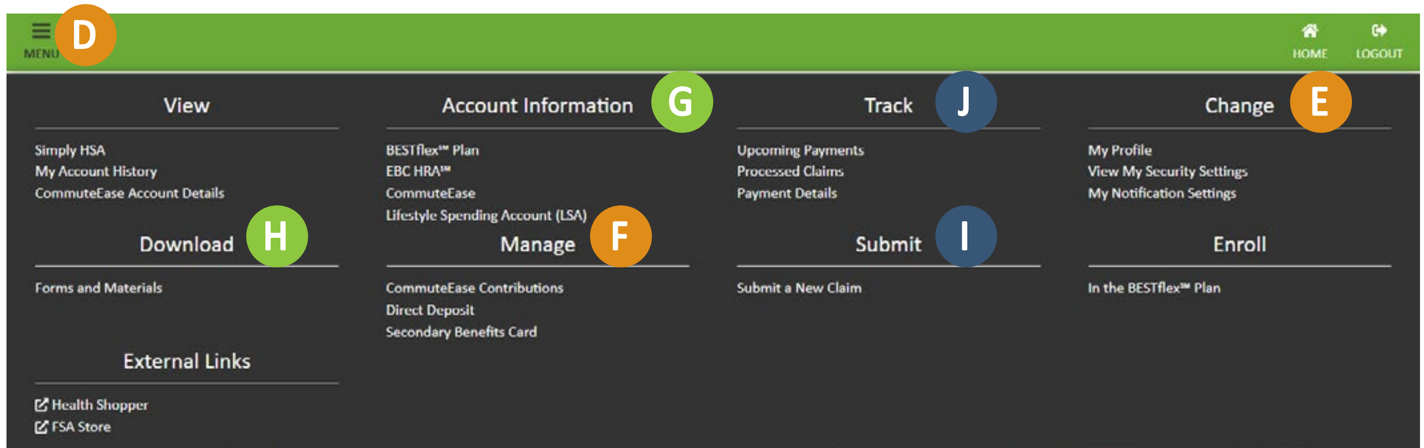
Account Overview

Home

When you log in to your EBC account, you will be taken to the home screen where you can find an overview of your EBC accounts. Click each account tile [A] to access your account details.

Account Notifications

You can access important messages by selecting ***Messages*** [B] in the app or ***Message Center*** [C] in your online account.



Account Settings

Navigate to the ***Menu*** **[D]** to see the following account settings.

My Profile

It's important to keep your contact information up-to-date to receive important messages from us. You can view and/or update your contact information under ***Change*** **[E]** **>** ***My Profile***.

Username and Password Management*

If you have forgotten your password and would like to reset it, you can do so from the login screen. If you'd like to update your username and password, go to ***Change*** **[E]** **>** ***View My Security Settings*** in your online account and navigate to ***User Security Settings***.

Direct Deposit*

You can sign up for direct deposit in your online account. When you sign up for direct deposit, you get your money faster because your reimbursement funds will be deposited electronically and securely in your checking or savings account. Go to ***Manage*** **[F]** **>** ***Direct Deposit***.

Resources

Navigate to the menu to see the following resources.

Account Information*

Find additional information in the online main menu under ***Account Information*** **[G]**.

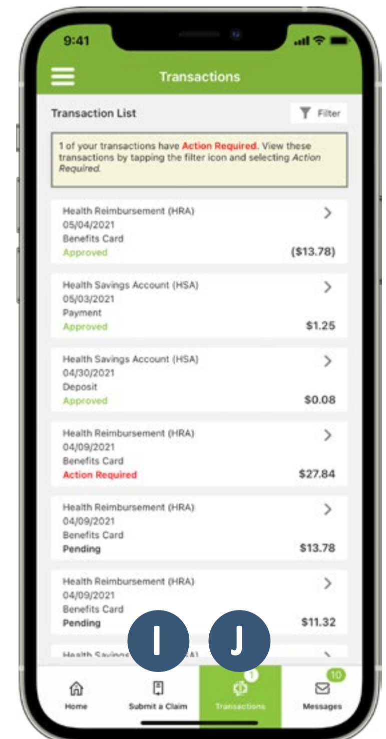
Forms and Materials*

Forms and additional materials can be found under ***Download*** **[H]** **>** ***Forms and Materials*** in your online account. Once you navigate to ***Forms and Materials***, you will have to choose which account you'd like to see materials for.

Some commonly accessed materials include the *Participant Authorization Form*, *Letter of Medical Necessity*, *Contract on File*, and *Eligible Expense List*. *Note that these documents are examples and are not available for all accounts.*

Claim Submission and Tracking

You can submit **[I]** and track **[J]** the status of your claims. Select each claim to view the full details. If you experience a denied claim, selecting the claim will provide the reason for the claim denial.



*The following is not available on EBC Mobile.

In the states of Arizona, California, Florida, Kentucky, Massachusetts, Montana, North Carolina, Nebraska, New York, Ohio, Rhode Island, Tennessee, Virginia, and Washington, Employee Benefits Corporation is registered under the "doing business as" (DBA) name EBC Benefits Administration Corporation. In the state of New Hampshire, Employee Benefits Corporation is registered under the DBA name Employee Benefits Administrators of WI. In the state of Vermont, Employee Benefits Corporation is registered under the DBA name EBC Benefits Administration.

Employee Benefits Corporation

An employee-owned company
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VISION BENEFIT PROPOSAL

PREPARED FOR KINGMAN HEALTHCARE CENTER

www.visioncaredirect.com
(877) 488-8900

Kingman Healthcare Center
Renewal Date: 1/1/2025

	Platinum Materials 130	Platinum Materials 200	Platinum Complete 130	Platinum Complete 200
Benefit Frequency				
Eye Exam	N/A	N/A	12 Months	12 Months
Frames	12 Months	12 Months	12 Months	12 Months
Lenses	12 Months	12 Months	12 Months	12 Months
In Network Allowance				
Frames	$130	$200	$130	$200
Single Vision Lenses	Included	Included	Included	Included
Bifocal Lenses	Included	Included	Included	Included
Trifocal Lenses	Included	Included	Included	Included
Progressive Lenses	Included*	Included*	Included*	Included*
Anti-reflective Coating	Included*	Included*	Included*	Included*
Polycarbonate for Kids	Included	Included	Included	Included
Elective Contact Lenses	$130	$200	$130	$200
Member Fees				
Eye Exam	N/A	N/A	$15	$15
Glasses	$15	$15	$15	$15
Polycarbonate for Kids	$25	$25	$25	$25
Monthly Rates				
Primary Only	$12.28	$17.84	$16.74	$22.30
Primary + 1	$19.66	$28.56	$26.80	$35.70
Primary + Children	$22.68	$32.96	$30.92	$41.18
Whole Family	$38.56	$56.04	$52.58	$70.04
Semi-Monthly Payroll Rate				
Primary Only	$6.14	$8.92	$8.37	$11.15
Primary + 1	$9.83	$14.28	$13.40	$17.85
Primary + Children	$11.34	$16.48	$15.46	$20.59
Whole Family	$19.28	$28.02	$26.29	$35.02

ADDITIONAL SAVINGS

Flexible Exam Benefit	In the event that a member has an eye exam included with another plan, Vision Care Direct allows you to use your exam benefit for other services or materials. A $65 credit will be applied to your bill at time of service toward non-covered items.
Lasik Vision Correction	Get $200 toward your Lasik procedure through your VCD materials benefit. Lasik is in lieu of glasses and contacts. To file for your Lasik reimbursement, go to members.visioncaredirect.com/lasik.

* Standard digital progressive lenses and anti-reflective coatings are included at no additional charge through any of our VCD PLUS providers. The progressive lens allowance through a Standard VCD provider is equal to the doctor's retail cost of standard trifocal lenses. There is no benefit for anti-reflective coatings through Standard VCD providers.

Thank you for your business!

KADEN JAMES
Senior Account Executive

Vision Care Direct is a membership plan, not insurance. Minimum participation requirement for the plans offered above is 2 employees. Contact lens allowance amount is in lieu of glasses. For a complete listing of allowances, exclusions and limitations, please reference the enclosed Allowance Summary.
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Vision Care Direct OF KANSAS

Platinum Materials Only 130

Allowance Summary

Kingman Healthcare Center

	VCD Standard Network	VCD PLUS Network	Out of Network
Benefit Frequency			
Eye Exam	N/A	N/A	N/A
Frames	12 Months	12 Months	12 Months
Lenses	12 Months	12 Months	12 Months
Contacts	12 Months	12 Months	12 Months
Member Fees			
Eye Exam	N/A	N/A	N/A
Glasses	$15	$15	$0
Polycarbonate for Kids	$25	$25	$0
Contacts	$0	$0	$0
Lasik	$0	$0	$0
Eye Exam (amount included after exam fee listed above)			
Comprehensive eye health examination including refraction and dilation	N/A	N/A	N/A
Flexible Exam Benefit			
In the event you have an eye exam included with another plan, Vision Care Direct allows you to use your exam benefit for other services or materials. A credit will be applied to your bill at time of service toward non-covered items.	N/A	N/A	N/A
Frames			
Frame allowance toward retail price of any frame in provider's office.	$130	$130	$60
Lenses (amount included after glasses fee listed above)			
Single Vision: CR-39 in glass or plastic	100%	100%	$50
Bifocal: CR-39 in glass or plastic	100%	100%	$75
Trifocal: CR-39 in glass or plastic	100%	100%	$100
Standard Progressive Lenses	Up to retail price of lined trifocal	100%	$100
Premium Progressive Lenses	Up to retail price of lined trifocal	Up to retail price of standard progressive	$100
Lens Options			
Scratch Resistant Coating	Not Included	100%	$0
Ultraviolet Coating	Not Included	100%	$0
Anti-Reflective Coating	Not Included	100%	$0
Oil & Water Resistant Coating	Not Included	100%	$0
Polycarbonate for Kids (after PK fee listed above)	100%	100%	$0
Polycarbonate for Adults	Not Included	Not Included	$0
Contacts			
Elective Contact Lenses: In lieu of glasses. Can be used toward multi-focal contacts and contact lens fitting fees.	$130	$130	$80
Medically Necessary Contact Lenses: Requires prior authorization from your doctor to the Vision Care Direct Medical Director. Medically necessary is defined as 1) Keratoconus; or 2) monocular and/or binocular aphakia	$750	$750	$80

Lasik

In lieu of glasses and contacts. Allowance of $200 toward Lasik procedure in the form of a reimbursement directly to the member. To file for Lasik reimbursement, go to members.visioncaredirect.com/lasik

GENERAL LIMITATIONS AND EXCLUSIONS:

Vision Care Direct guarantees benefits only for the products/services listed above. Any charges incurred for items not detailed here, or that are incurred after the membership ends, are the sole responsibility of the member. Out of network benefits are provided in the form of a reimbursement directly to the member. To file for an out of network reimbursement, visit members.visioncaredirect.com/oon.

Get more for your money! To access enhanced benefits through the VCD PLUS Network, look for locations on the VCD Provider Directory at www.visioncaredirect.com with this logo:

Vision Care Direct OF KANSAS

Platinum Materials Only 200

Allowance Summary

Kingman Healthcare Center

	VCD Standard Network	VCD PLUS Network	Out of Network
Benefit Frequency			
Eye Exam	N/A	N/A	N/A
Frames	12 Months	12 Months	12 Months
Lenses	12 Months	12 Months	12 Months
Contacts	12 Months	12 Months	12 Months
Member Fees			
Eye Exam	N/A	N/A	N/A
Glasses	$15	$15	$0
Polycarbonate for Kids	$25	$25	$0
Contacts	$0	$0	$0
Lasik	$0	$0	$0
Eye Exam (amount included after exam fee listed above)			
Comprehensive eye health examination including refraction and dilation	N/A	N/A	N/A
Flexible Exam Benefit			
In the event you have an eye exam included with another plan, Vision Care Direct allows you to use your exam benefit for other services or materials. A credit will be applied to your bill at time of service toward non-covered items.	N/A	N/A	N/A
Frames			
Frame allowance toward retail price of any frame in provider's office.	$200	$200	$60
Lenses (amount included after glasses fee listed above)			
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Platinum Complete 130

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Ultraviolet Coating	Not Included	100%	$0
Anti-Reflective Coating	Not Included	100%	$0
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Frames	12 Months	12 Months	12 Months
Lenses	12 Months	12 Months	12 Months
Contacts	12 Months	12 Months	12 Months
Member Fees			
Eye Exam	$15	$15	$0
Glasses	$15	$15	$0
Polycarbonate for Kids	$25	$25	$0
Contacts	$0	$0	$0
Lasik	$0	$0	$0
Eye Exam (amount included after exam fee listed above)			
Comprehensive eye health examination including refraction and dilation	100%	100%	$50
Flexible Exam Benefit			
In the event you have an eye exam included with another plan, Vision Care Direct allows you to use your exam benefit for other services or materials. A credit will be applied to your bill at time of service toward non-covered items.	$65	$65	$0
Frames			
Frame allowance toward retail price of any frame in provider's office.	$200	$200	$60
Lenses (amount included after glasses fee listed above)			
Single Vision: CR-39 in glass or plastic	100%	100%	$50
Bifocal: CR-39 in glass or plastic	100%	100%	$75
Trifocal: CR-39 in glass or plastic	100%	100%	$100
Standard Progressive Lenses	Up to retail price of lined trifocal	100%	$100
Premium Progressive Lenses	Up to retail price of lined trifocal	Up to retail price of standard progressive	$100
Lens Options			
Scratch Resistant Coating	Not Included	100%	$0
Ultraviolet Coating	Not Included	100%	$0
Anti-Reflective Coating	Not Included	100%	$0
Oil & Water Resistant Coating	Not Included	100%	$0
Polycarbonate for Kids (after PK fee listed above)	100%	100%	$0
Polycarbonate for Adults	Not Included	Not Included	$0
Contacts			
Elective Contact Lenses: In lieu of glasses. Can be used toward multi-focal contacts and contact lens fitting fees.	$200	$200	$80
Medically Necessary Contact Lenses: Requires prior authorization from your doctor to the Vision Care Direct Medical Director. Medically necessary is defined as 1) Keratoconus; or 2) monocular and/or binocular aphakia	$750	$750	$80

Lasik

In lieu of glasses and contacts. Allowance of $200 toward Lasik procedure in the form of a reimbursement directly to the member. To file for Lasik reimbursement, go to members.visioncaredirect.com/lasik

GENERAL LIMITATIONS AND EXCLUSIONS:

Vision Care Direct guarantees benefits only for the products/services listed above. Any charges incurred for items not detailed here, or that are incurred after the membership ends, are the sole responsibility of the member. Out of network benefits are provided in the form of a reimbursement directly to the member. To file for an out of network reimbursement, visit members.visioncaredirect.com/oon.

Get more for your money! To access enhanced benefits through the VCD PLUS Network, look for locations on the VCD Provider Directory at www.visioncaredirect.com with this logo:

Vision Care Direct OF KANSAS

CALL US TODAY
(877) 488-8900

SIMPLE.
FLEXIBLE.
AFFORDABLE.

	BENEFITS	INCLUDED
FRAMES	Up to $200	✓
CONTACTS	Up to $200	✓
LENSES	Single Vision	✓
	Bifocal	✓
	Trifocal	✓
VCD PLUS EXTRAS*	HD Progressive	✓
	Anti-Reflective Coating	✓
	Scratch Resistance	✓
	UV Protection	✓
	Oil & Water Resistance	✓

*Benefits available exclusively at VCD PLUS participating providers.
Contact lens benefit is in lieu of glasses.

COMPLETE PAIR OF GLASSES STARTING AT JUST $15

At last, you finally have the freedom to use your materials allowance the way you want without all the surprise out of pocket expenses. With VCD PLUS providers in your area, you'll have access to high definition (single vision, bifocal, trifocal or premium progressive) lenses, premium anti-reflection coating, scratch resistant coating and UV protection all for one low price!

OWNED BY KANSANS, FOR KANSANS

Vision Care Direct is proudly owned by private practice optometrists right here in the great state of Kansas. Revenue and tax dollars stay in Kansas to support your local communities and schools.

Vision Care Direct is a membership plan, not insurance. Minimum participation requirement for the plans offered above is 2 employees. Contact lens allowance amount is in lieu of glasses. For a complete listing of allowances, exclusions and limitations, please reference the enclosed Allowance Summary.

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VCD PLUS

Enjoy your day!

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