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	

Table of Contents

IAA Medical & Rx Benefit Summary, Option A PPO Plan……1

IAA Medical & Rx Benefit Summary, Option B HDHP Plan……4

IAA Rate Summary……7

ProviDrs Care Network, How to Find a Provider……..…...8

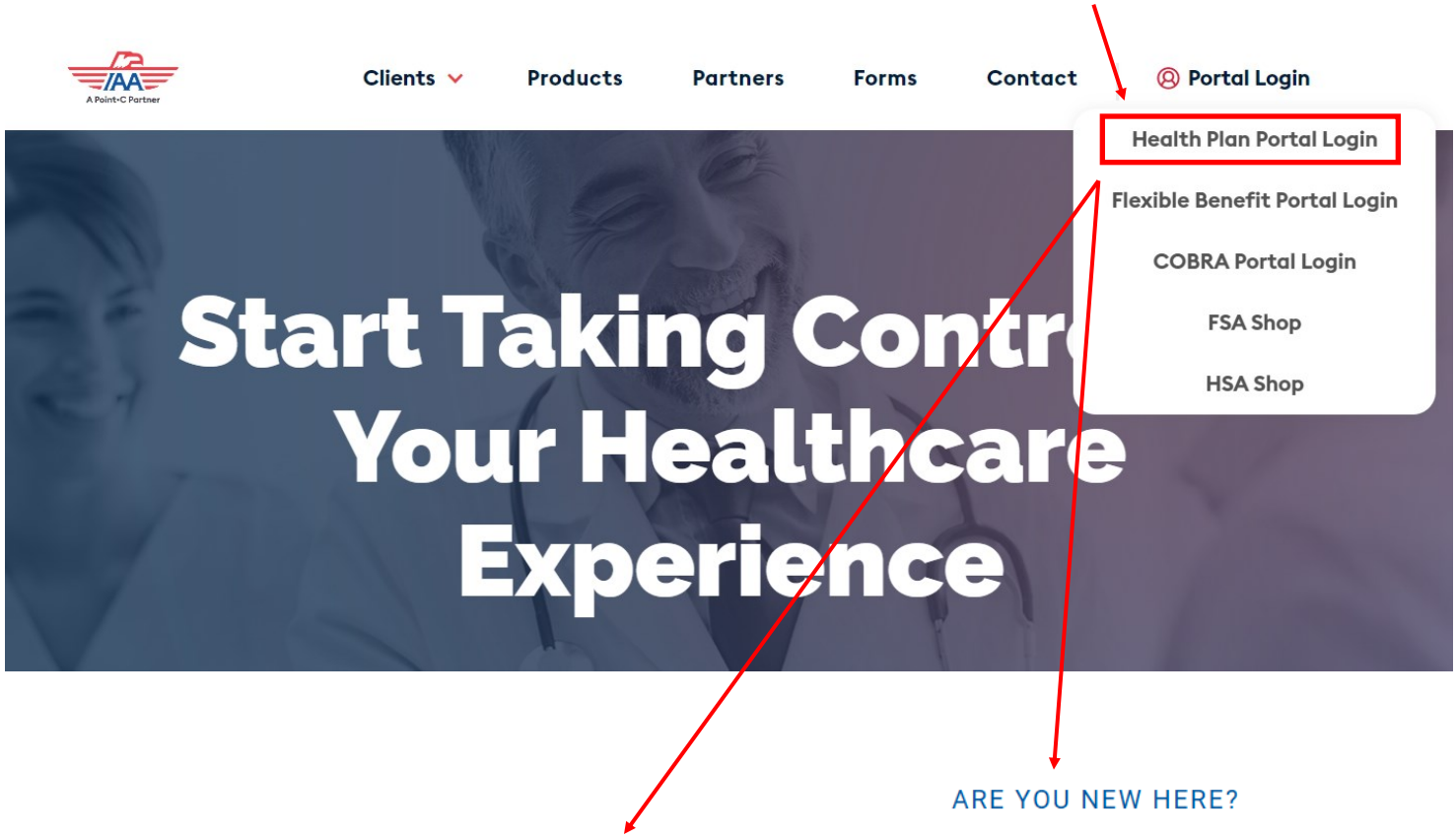
Summary of Benefits & Coverage (SBC) Option A PPO Plan…….9

Summary of Benefits & Coverage (SBC) Option B HDHP Plan……17

SBC, Glossary of Terms……...25

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



RETURNING USER LOGIN

Username

This is typically your email address.

Password

Show Password

Login

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

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			
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)

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			
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

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 Provider Directory https://providrscare.net/contact-us/

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.comor 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————————

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——————

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

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

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.

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)

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.comor call **1-856-470-1200** to request a copy.

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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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——————

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%

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

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.

* 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.

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 $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

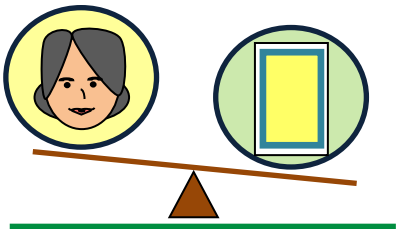
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $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

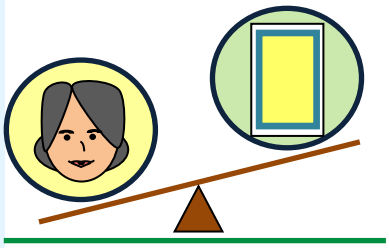
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your 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.

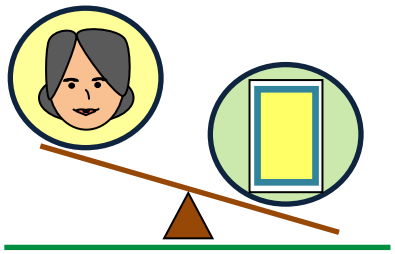
Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

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

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.



Jane pays 0% | Her plan pays 100%

(See page 6 for a detailed example.)

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.

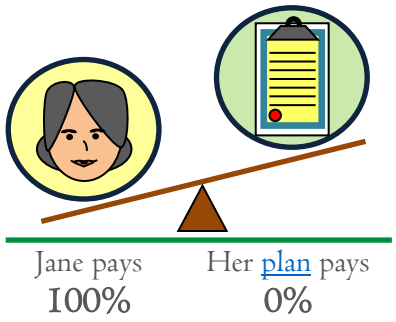
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

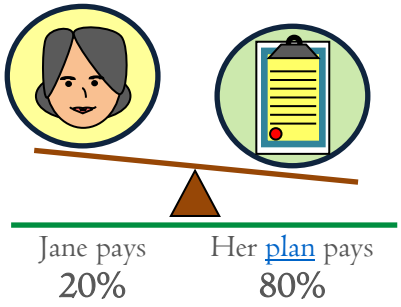
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

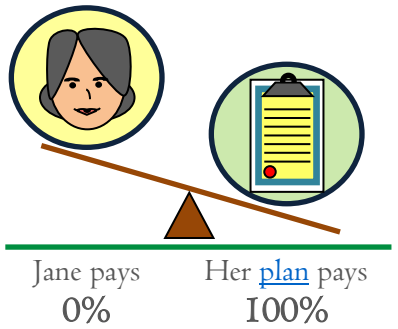
December 31st
End of Coverage Period



more costs



more costs



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

Enjoy your day!

www.picbenefitservices.com

rhonda@picbenefitservices.com

620-227-6940