

**Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services**  
**SASNAK Management Corporation Employee Benefits Plan: MEC Care Plus Plan**

**Coverage Period: 01/01/2026-12/31/2026**  
**Coverage for: Individual/Family | Plan Type: PPO**



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, call 1-312-906-8080 or go to [www.alliedbenefit.com](http://www.alliedbenefit.com). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. [www.alliedbenefit.com](http://www.alliedbenefit.com) or call 1-312-906-8080 to request a copy.

| Important Questions                                                             | Answers         | Why This Matters:                                                                                                                                |
|---------------------------------------------------------------------------------|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$0             | See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.                                          |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Not applicable. | This <a href="#">plan</a> does not have a <a href="#">deductible</a> .                                                                           |
| Are there other <a href="#">deductibles</a> for specific services?              | No.             | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                        |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | Unlimited.      | This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.                                                 |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Not applicable. | This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.                                                 |
| Will you pay less if you use a <a href="#">network provider</a> ?               | No.             | This <a href="#">plan</a> does not use a <a href="#">provider network</a> . You can receive covered services from any <a href="#">provider</a> . |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.             | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                       |

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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                         |
| If you visit a health care <a href="#">provider's office</a> or clinic | Primary care visit to treat an injury or illness | 0% <a href="#">coinsurance</a>               | Not covered                                        | Limited to a combined maximum (Primary care visits and other practitioner visits) of 6 visits per person per Plan Year. |
|                                                                        | <a href="#">Specialist</a> visit                 | 0% <a href="#">coinsurance</a>               | Not covered                                        |                                                                                                                         |





| Common Medical Event                                                  | Services You May Need                     | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information |
|-----------------------------------------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
|                                                                       |                                           | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                        |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | Not covered                                  |                                                    | None.                                                  |
|                                                                       | <a href="#">Rehabilitation services</a>   | Not covered                                  |                                                    | None.                                                  |
|                                                                       | <a href="#">Habilitation services</a>     | Not covered                                  |                                                    | None.                                                  |
|                                                                       | <a href="#">Skilled nursing care</a>      | Not covered                                  |                                                    | None.                                                  |
|                                                                       | <a href="#">Durable medical equipment</a> | Not covered                                  |                                                    | None.                                                  |
|                                                                       | <a href="#">Hospice services</a>          | Not covered                                  |                                                    | None.                                                  |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | 0% <a href="#">coinsurance</a>               | Not covered                                        | Applies from birth through age 5.                      |
|                                                                       | Children's glasses                        | Not covered                                  | Not covered                                        | Not covered.                                           |
|                                                                       | Children's dental check-up                | Not covered                                  | Not covered                                        | Not covered.                                           |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)                                                                                                                                                                                         |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                           |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Chiropractic care</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> <li>Dental check-up</li> <li>Diagnostic imaging (CT/PET scans, MRIs)</li> <li>Durable medical equipment</li> <li>Emergency medical transportation</li> <li>Facility fees (e.g. ambulatory surgery center)</li> </ul> | <ul style="list-style-type: none"> <li>Facility fees (e.g. hospital room)</li> <li>Glasses (Child)</li> <li>Habilitative services</li> <li>Hearing aids</li> <li>Home health care</li> <li>Hospice services</li> <li>Infertility treatment</li> <li>Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Non-preferred brand drugs</li> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</li> <li>Routine foot care</li> <li>Specialty drugs</li> <li>Weight loss programs</li> </ul> |  |

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

- Mental/Behavioral health inpatient services
- Mental/Behavioral health outpatient services
- Substance use disorder inpatient services
- Substance use disorder outpatient services

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://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: the Plan Administrator at (316) 683-2611 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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? No.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

*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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0 |
| ■ <a href="#">Specialist coinsurance</a>                        | 0%  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%  |
| ■ Other <a href="#">coinsurance</a>                             | 0%  |

This EXAMPLE event includes services like:

[Specialist](#) office visits (prenatal care)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (ultrasounds and blood work)  
[Specialist](#) visit (anesthesia)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$2,900        |
| <b>The total Peg would pay is</b> | <b>\$2,900</b> |

### Managing Joe's Type 2 Diabetes

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

|                                                                 |     |
|-----------------------------------------------------------------|-----|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0 |
| ■ <a href="#">Specialist coinsurance</a>                        | 0%  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%  |
| ■ Other <a href="#">coinsurance</a>                             | 0%  |

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (including disease education)  
[Diagnostic tests](#) (blood work)  
[Prescription drugs](#)  
[Durable medical equipment](#) (glucose meter)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$4,600        |
| <b>The total Joe would pay is</b> | <b>\$4,600</b> |

### Mia's Simple Fracture

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

|                                                                 |     |
|-----------------------------------------------------------------|-----|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0 |
| ■ <a href="#">Specialist coinsurance</a>                        | 0%  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%  |
| ■ Other <a href="#">coinsurance</a>                             | 0%  |

This EXAMPLE event includes services like:

[Emergency room care](#) (including medical supplies)  
[Diagnostic test](#) (x-ray)  
[Durable medical equipment](#) (crutches)  
[Rehabilitation services](#) (physical therapy)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$1,200        |
| <b>The total Mia would pay is</b> | <b>\$1,200</b> |

Note: The Coverage Examples above assume the patient received all care from [providers](#) accepting reimbursement in full based on the Maximum Allowable Amount. Otherwise, costs would have been higher.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.