



This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other **bolded** terms see the **Glossary**. You can view the Glossary at [www.\[insert\].com](http://www.[insert].com) or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$500 /person or \$1,000 /family Doesn't apply to preventive care	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1). The Common Medical Events chart below shows how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	Yes. \$300 for prescription drug coverage . There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers \$2,500 /person or \$5,000 /family For non-participating providers \$4,000 /person or \$8,000 /family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Premiums , balance-billed charges, health care this plan doesn't cover, [and out-of-network services].	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Does this plan use a network of providers ?	Yes. See www.[insert].com or call 1-800-[insert] for a list of participating providers .	If you use an in-network health care provider , this plan will pay some or all of the costs of covered services. Lesser coverage, or no coverage, may be available for out-of-network providers . Be aware, your in-network doctor or hospital may use another out-of-network provider for some services (such as lab work).
Do I need a referral to see a specialist ?	No. To see a specialist , you don't need a referral from this plan .	You can see the specialist you choose without getting permission from this plan .

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$35 copay/visit	40% coinsurance	—————none—————
	Specialist visit	\$50 copay/visit	40% coinsurance	
	Other practitioner office visit	20% coinsurance for chiropractor and acupuncture	40% coinsurance for chiropractor and acupuncture	
	Preventive care/screening /immunization	No charge	40% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	\$10 copay/test	40% coinsurance	—————none—————
	Imaging (CT/PET scans, MRIs)	\$50 copay/test	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert] .	Generic drugs	\$10 copay/prescription (retail and mail order)	40% coinsurance	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription) —————none—————
	Preferred brand drugs	20% coinsurance (retail and mail order)	40% coinsurance	
	Non-preferred brand drugs	40% coinsurance (retail and mail order)	60% coinsurance	
	Specialty drugs	50% coinsurance	70% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	—————none—————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	—————none—————
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	—————none—————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$35 copay/office visit; 20% coinsurance/other outpatient services	40% coinsurance	_____none_____
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	
	Substance use disorder outpatient services	\$35 copay/office visit; 20% coinsurance/other outpatient services	40% coinsurance	
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Prenatal, postnatal care, delivery, and all inpatient services	20% coinsurance	40% coinsurance	_____none_____
If you need help recovering or have other special health needs	<u>Home health care</u>	20% coinsurance	40% coinsurance	_____none_____
	<u>Rehabilitation services</u>	20% coinsurance	40% coinsurance	
	<u>Habilitation services</u>	20% coinsurance	40% coinsurance	
	<u>Skilled nursing care</u>	20% coinsurance	40% coinsurance	
	<u>Durable medical equipment</u>	20% coinsurance	40% coinsurance	
	<u>Hospice services</u>	20% coinsurance	40% coinsurance	
If your child needs dental or eye care	Eye exam	\$35 copay/visit	Not Covered	Plan coverage limited to one exam/year
	Glasses	20% coinsurance	Not Covered	Plan coverage limited to one pair of glasses/year
	Dental check-up	No Charge	Not Covered	Plan covers up to \$50/year

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Most coverage provided outside the United States. See www.[insert]
- Weight loss programs

Your Rights to Continue Coverage: Federal and State laws may provide protections that allow you to continue health coverage after it would otherwise end. For more information, contact us at [insert contact information] or contact: [insert State, HHS, and/or DOL contact information, as applicable]. Other options to continue coverage are available to you too, including 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: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

Does this Coverage Satisfy the Individual Responsibility Requirement and Meet the Minimum Value Standard?

Yes. This coverage constitutes minimum essential coverage under the Affordable Care Act, so enrolling in this coverage satisfies your obligations under the individual responsibility requirement. In addition, this coverage provides a level of benefits specified in the Affordable Care Act as “minimum value.”

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

About these Coverage Examples:

These examples show how this **plan** might cover medical care in a few situations and show how **deductibles**, **copayments**, and **coinsurance** can add up. Use these examples to see, in general, how much financial protection a sample patient might get from coverage under this plan compared to other plans by comparing the “Patient Pays” section for the same example under each plan’s Summary of Benefits and Coverage.



This is not a cost estimator. Don’t use these examples to estimate your actual costs under this **plan**. Treatments shown are just examples and your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Also, costs don’t include **premiums** you pay to buy coverage under a plan.

Having a baby (normal delivery)

- **Cost of care** \$14,150
- **Plan pays** \$11,650
- **Patient pays** \$2,550

Sample care costs:

Hospital charges (mother)	\$6,700
Routine obstetric care	\$2,500
Hospital charges (baby)	\$2,100
Anesthesia	\$1,200
Laboratory tests	\$1,000
Prescriptions	\$200
Radiology	\$200
Education	\$200
Vaccines, other preventive	\$50
Total	\$14,150

Patient pays:

Deductibles	\$700
Copayments	\$140
Coinsurance	\$1660
Limits or exclusions	\$0
Total	\$2,500

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Cost of care** \$6,100
- **Plan pays** \$4,130
- **Patient pays** \$1,970

Sample care costs:

Prescriptions	\$3,300
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$800
Education	\$300
Laboratory tests	\$200
Vaccines, other preventive	\$200
Total	\$6,100

Patient pays:

Deductibles	\$800
Copayments	\$590
Coinsurance	\$500
Limits or exclusions	\$80
Total	\$1,970

Note: The numbers in “Managing type 2 diabetes” assume the patient is participating in the plan’s diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: [insert].

Simple fracture (with emergency room visit)

- **Cost of care** \$2,400
- **Plan pays** \$ 1,430
- **Patient pays** \$ 970

Sample care costs:

Emergency Services	\$1,400
Medical Equipment and Supplies	\$400
Office Visits and Procedures	\$300
Physical Therapy	\$200
Laboratory tests	\$90
Prescriptions	\$10
Total	\$2,400

Patient pays:

Deductibles	\$560
Copayments	\$100
Coinsurance	\$300
Limits or exclusions	\$10
Total	\$970