This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling (866) 868-8541

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$6,850 Individual $13,700 Family**	This amount must be met prior to the plan paying for benefits.
Are there other deductibles for specific services?	**No**	
Is there an out–of–pocket limit on my expenses?	**$6,850 Individual $13,700 Family**	This amount must be met prior to the plan paying for benefits.
What is not included in the out–of–pocket limit?	**Prescription Drugs**	
Is there an overall annual limit on what the plan pays?	**No**	
Does this plan use a network of providers?	**Yes**	MultiPlan
Do I need a referral to see a specialist?	**Yes**	
Are there services this plan doesn't cover?	**Yes**	Please see the Summary Plan Description for a full list of benefits.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use MultiPlan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	100%	100%	
	Specialist visit	100%	100%	
	Other practitioner office visit	100%	100%	
	Preventive care/screening/immunization	0%	0%	
If you have a test	Diagnostic test (x-ray, blood work)	100%	100%	
	Imaging (CT/PET scans, MRIs)	100%	100%	Limit 5 per year.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** please call (866) 868-8541	Generic drugs	100%	100%	Subject to formulary.
	Preferred brand drugs	100%	100%	Subject to formulary.
	Non-preferred brand drugs	100%	100%	Subject to formulary.
	Specialty drugs	N/A	N/A	Benefit not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	100%	100%	Combined limit of 5 per year
	Physician/surgeon fees	100%	100%	
If you need immediate medical	Emergency room services	100%	100%	Limit 3 per year.
	Emergency medical transportation	N/A	N/A	Benefit not covered.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
attention	Urgent care	100%	100%	
If you have a hospital stay	Facility fee (e.g., hospital room)	100%	100%	Combined limit of 20 days per year.
	Physician/surgeon fee	100%	100%	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	100%	100%	
	Mental/Behavioral health inpatient services	100%	100%	
	Substance use disorder outpatient services	100%	100%	Combined limit of 25 days per year, including in- and outpatient services.
	Substance use disorder inpatient services	100%	100%	
If you are pregnant	Prenatal and postnatal care	100%	100%	
	Delivery and all inpatient services	100%	100%	
If you need help recovering or have other special health needs	Home health care	N/A	N/A	Benefit not covered.
	Rehabilitation services	100%	100%	Combined limit of 20 days per year.
	Habilitation services	100%	100%	
	Skilled nursing care	100%	100%	Limit 10 days per year.
	Durable medical equipment	N/A	N/A	Benefit not covered.
	Hospice service	N/A	N/A	Benefit not covered.
If your child needs dental or eye care	Eye exam	N/A	N/A	Benefit not covered.
	Glasses	N/A	N/A	Benefit not covered.
	Dental check-up	N/A	N/A	Benefit not covered.

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.)

- Durable Medical Equipment
- Children Dental or Vision
- Home Health 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.)

- Please see Summary Plan Description for a complete Schedule of Benefits.

Your Rights to Continue Coverage:

Standard COBRA Rights apply. Please see Summary Plan Description for more information.

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 questions about your rights, this notice, or assistance, you can contact: (866) 868-8541

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (866) 868-8541
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (866) 868-8541

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (866) 868-8541

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (866) 868-8541

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $690
- **Patient pays** $6,850

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$6,850
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$6,850**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $400
- **Patient pays** $5,000

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$5,000
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$5,000**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.