**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 1-888-423-8203.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$7,150** Person<br>**$14,300** Family | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you us. Check your policy or plan documents to see when the **deductible** starts over (usually, but not always, January 1st). See chart on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | You do not have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services his plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. For participating providers<br>**$7,150** Person<br>**$14,300** Family | This amount must be met prior to the plan paying for benefits. |
| **What is not included in the out–of–pocket limit?** | Premiums, balance-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of preferred providers, see www.MultiPlan.com,or call 1-888-423-8203. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**, See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | Yes. | This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services. |

**Questions:** Call 1-888-423-8203.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can request a copy by calling 1-888-423-8203.

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- **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 **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 | 0% Coinsurance after deductible | Not Covered | |
| | Specialist visit | 0% Coinsurance after deductible | Not Covered | Refer to Summary Plan Description for exclusions and limitations. |
| | Other practitioner office visit | 0% Coinsurance after deductible | Not Covered | |
| | Preventive care/screening/immunization | 0% Not subject to deductible | Not Covered | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 0% Coinsurance after deductible | Not Covered | |
| | Imaging (CT/PET scans, MRIs) | 0% Coinsurance after deductible | Not Covered | Limit 5 per year. |

| 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 need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage**, by calling 1-888-423-8203. | Generic drugs | 0% Coinsurance after deductible | Not Covered | Subject to formulary. |
| | Preferred brand drugs | 0% Coinsurance after deductible | Not Covered | Subject to formulary. |
| | Non-preferred brand drugs | 0% Coinsurance after deductible | Not Covered | Subject to formulary. |
| | Specialty drugs | Not Covered | Not Covered | Includes biotech prescriptions. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% Coinsurance after deductible | Not Covered | Limit of 5 per year |
| | Physician/surgeon fees | 0% Coinsurance after deductible | Not Covered | |
| **If you need immediate medical attention** | Emergency room services | 0% Coinsurance after deductible | Not Covered | Limit 3 per year. |
| | Emergency medical transportation | Not Covered | Not Covered | |
| | Urgent care | 0% Coinsurance after deductible | Not Covered | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% Coinsurance after deductible | Not Covered | Combined limit of 20 days per year for all Inpatient Hospitalization Services. |
| | Physician/surgeon fee | 0% Coinsurance after deductible | 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 |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services | 0% Coinsurance after deductible | Not Covered | |
| | Mental/Behavioral Health and Substance Abuse Disorder Inpatient Services | 0% Coinsurance after deductible | Not Covered | Combined limit of 20 days per year, For all Inpatient Hospitalization Services. |
| **If you are pregnant** | Prenatal and postnatal care | 0% Coinsurance after deductible | Not Covered | |
| | Delivery and all inpatient services | 0% Coinsurance after deductible | Not Covered | |
| **If you need help recovering or have other special health needs** | Home health care | Not Covered | Not Covered | |
| | Rehabilitation services (Speech/Occupational/Physical Therapy) | 0% Coinsurance after deductible | Not Covered | Combined limit of 20 days per year. |
| | Habilitation services (Speech/Occupational/Physical Therapy) | 0% Coinsurance after deductible | Not Covered | |
| | Skilled nursing care | Not Covered | Not Covered | |
| | Durable medical equipment | Not Covered | Not Covered | |
| | Hospice service | Not Covered | Not Covered | |
| **If your child needs dental or eye care** | Eye exam | Not Covered | Not Covered | |
| | Glasses | Not Covered | Not Covered | |
| | Dental check-up | Not Covered | 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.)**

- Diabetic Supplies
- Podiatry
- Acupuncture
- Children Dental or Vision
- Chiropractic Care
- Massage Therapy
- Dialysis
- Alternative Medicine/Homeopathy
- Sports-Related Therapy or Medicine of Any Kind

**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.)**

- Breast Cancer Screening
- Colorectal Cancer Screening
- Lung Cancer Screening
- Diabetes Screening
- Osteoporosis Screening
- Obesity Screening
- Healthy Diet Counseling
- Tobacco Use Counseling
- Contraception

## 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: 1-888-423-8203

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-423-8203

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-423-8203

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-423-8203

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-423-8203

*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.