

# Insurance Company 1: Plan Option 1

Coverage Period: 01/01/2014 – 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Spouse | Plan Type: PPO



**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 at [www.\[insert\]](#) or by calling 1-800-[insert].

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	<b>\$500</b> person / <b>\$1,000</b> family Doesn't apply to preventive care	You must pay all the costs up to the <b><u>deductible</u></b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b><u>deductible</u></b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b><u>deductible</u></b> .
<b>Are there other <u>deductibles</u> for specific services?</b>	Yes. <b>\$300</b> for prescription drug coverage. There are no other specific <b><u>deductibles</u></b> .	You must pay all of the costs for these services up to the specific <b><u>deductible</u></b> amount before this plan begins to pay for these services.
<b>Is there an <u>out-of-pocket limit</u> on my expenses?</b>	Yes. For participating providers <b>\$2,500</b> person / <b>\$5,000</b> family For non-participating providers <b>\$4,000</b> person / <b>\$8,000</b> family	The <b><u>out-of-pocket limit</u></b> 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b> .
<b>Is there an overall annual limit on what the plan</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.

**Questions:** Call 1-800-[insert] or visit us at [www.\[insert\]](#).

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pays?		
Does this plan use a <u>network of providers</u> ?	Yes. See <a href="#">www.[insert].com</a> or call 1-800-[insert] for a list of participating providers.	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <b>specialist</b> you choose without permission from this plan.
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 <b>excluded services</b> .

OMB Control Numbers 1545-2229,  
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Released on April 23, 2013 (corrected)



- **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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

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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
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$35 copay/visit	40% coinsurance	_____none_____
	Specialist visit	\$50 copay/visit	40% coinsurance	_____none_____
	Other practitioner office visit	20% coinsurance for chiropractor and acupuncture	40% coinsurance for chiropractor and acupuncture	_____none_____
	Preventive care/screening/immunization	No charge	40% coinsurance	
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	\$10 copay/test	40% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	\$50 copay/test	40% coinsurance	_____none_____

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<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="#">www.[insert]</a> .	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)
	Preferred brand drugs	20% coinsurance (retail and mail order)	40% coinsurance	_____none_____
	Non-preferred brand drugs	40% coinsurance (retail and mail order)	60% coinsurance	_____none_____
	Specialty drugs	50% coinsurance	70% coinsurance	_____none_____
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	_____none_____
	Physician/surgeon fees	20% coinsurance	40% coinsurance	_____none_____
<b>If you need immediate medical attention</b>	Emergency room services	20% coinsurance	20% coinsurance	_____none_____
	Emergency medical transportation	20% coinsurance	20% coinsurance	_____none_____

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	Urgent care	20% coinsurance	40% coinsurance	_____none_____
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	_____none_____
	Physician/surgeon fee	20% coinsurance	40% coinsurance	_____none_____

**Questions:** Call 1-800-[insert] or visit us at [www.\[insert\]](http://www.[insert]).

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<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$35 copay/office visit and 20% coinsurance other outpatient services	40% coinsurance	_____none_____
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	_____none_____
	Substance use disorder outpatient services	\$35 copay/office visit and 20% coinsurance other outpatient services	40% coinsurance	_____none_____
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	_____none_____
<b>If you are pregnant</b>	Prenatal and postnatal care	20% coinsurance	40% coinsurance	_____none_____
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	_____none_____

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<b>If you need help recovering or have other special health needs</b>	Home health care	20% coinsurance	40% coinsurance	_____none_____
	Rehabilitation services	20% coinsurance	40% coinsurance	_____none_____
	Habilitation services	20% coinsurance	40% coinsurance	_____none_____
	Skilled nursing care	20% coinsurance	40% coinsurance	_____none_____
	Durable medical equipment	20% coinsurance	40% coinsurance	_____none_____
	Hospice service	20% coinsurance	40% coinsurance	_____none_____
<b>If your child needs dental or eye care</b>	Eye exam	\$35 copay/ visit	Not Covered	Limited to one exam per year
	Glasses	20% coinsurance	Not Covered	Limited to one pair of glasses per year
	Dental check-up	No Charge	Not Covered	Covers up to \$50 per year

**Questions:** Call 1-800-[insert] or visit us at [www.\[insert\]](http://www.[insert]).

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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

**Questions:** Call 1-800-[insert] or visit us at www.[insert].

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Your Rights to Continue Coverage:

## \*\* Individual health insurance sample –

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at [contact number]. You may also contact your state insurance department at [insert applicable State Department of Insurance contact information].

## \*\* Group health coverage sample –

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

OR

For more information on your rights to continue coverage, contact the plan at [contact number]. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://www.cciio.cms.gov).

**Questions:** Call 1-800-[insert] or visit us at [www.\[insert\]](http://www.[insert]).

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## 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: [insert applicable contact information from instructions].

## 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/ does not] 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/does not] meet the minimum value standard for the benefits it provides.**

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

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## Coverage Examples

Managing type 2 diabetes

(routine maintenance of

Coverage for: Individual + Spouse Plan Type: PPO

## 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

Costs: \$7,540

### Patient pays:

Deductibles	\$700
Copays	\$30
Coinsurance	\$1320
Limits or exclusions	\$0
<b>Total</b>	<b>\$2,050</b>

	\$2,700
	\$2,100
	\$900
	\$900
	\$500
	\$200
	\$200
	\$40
	<b>\$7,540</b>

- Amount owed to providers: \$5,400
- Plan pays \$3,520
- Patient pays \$1,880

### 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
<b>Total</b>	<b>\$5,400</b>

### Patient pays:

Deductibles	\$800
Copays	\$500
Coinsurance	\$500
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,880</b>

Note: These numbers assume the patient is participating in our 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].

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## Questions and answers about the Coverage Examples:

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### 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.

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### 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.

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### 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.

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### 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.

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### 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.

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### 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.