



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.LifetimeBenefitSolutions.com or by calling 1-800-251-5077.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$100 Individual / \$200 Family	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 1st). See the chart starting 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 don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. \$400 Individual The out-of-pocket limit is waived for certain "grandfathered" participants.	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 ?	The deductible, premiums, balanced-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 .
Does this plan use a network of providers ?	No.	This plan treats providers the same in determining payment for the same services.
Do I need a referral to see a specialist ?	No. You don't need a referral to see a specialist.	You can see the specialist 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 5. See your policy or plan document for additional information about excluded services .

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.

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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**.)

Common Medical Event	Services You May Need	Your cost if you use an	Limitations & Exceptions
		In-network or Out-of-network Provider	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	—————none—————
	Specialist visit	20% Coinsurance	—————none—————
	Other practitioner office visit	Chiropractor: 20% Coinsurance Acupuncture Therapy: Not Covered	—————none—————
	Preventive care/screening/immunization	No Charge up to allowed amount	Adult exam limit: One exam per calendar year
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: No Charge up to allowed amount Lab: No Charge up to \$100 per calendar year, then 20% Coinsurance after deductible	—————none—————
	Imaging (CT/PET scans, MRIs)	No Charge up to allowed amount	—————none—————

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Common Medical Event	Services You May Need	Your cost if you use an	Limitations & Exceptions
		In-network or Out-of-network Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.proactpharmacy.com .	Generic drugs	20% Coinsurance	—————none—————
	Preferred brand drugs	20% Coinsurance	
	Non-preferred brand drugs	20% Coinsurance	
	Specialty drugs	20% Coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge up to allowed amount	—————none—————
	Physician/surgeon fees	No Charge up to allowed amount	—————none—————
If you need immediate medical attention	Emergency room services	No Charge up to allowed amount	—————none—————
	Emergency medical transportation	20% Coinsurance	—————none—————
	Urgent care	20% Coinsurance	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge up to allowed amount	Limit: 365 days per admission
	Physician/surgeon fee	No Charge up to allowed amount	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% Coinsurance	—————none—————
	Mental/Behavioral health inpatient services	No Charge up to allowed amount	Limit: 365 days per admission
	Substance use disorder outpatient services	20% Coinsurance	—————none—————
	Substance use disorder inpatient services	No Charge up to allowed amount	Limit: 365 days per admission

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Common Medical Event	Services You May Need	Your cost if you use an	Limitations & Exceptions
		In-network or Out-of-network Provider	
If you are pregnant	Prenatal and postnatal care	No Charge up to allowed amount	—————none—————
	Delivery and all inpatient services	No Charge up to allowed amount	—————none—————
If you need help recovering or have other special health needs	Home health care	No Charge up to allowed amount for 40 visits per calendar year, then 20% Coinsurance after deductible	—————none—————
	Rehabilitation services	Physical, Occupational and Speech Therapy: 20% Coinsurance Rehabilitation Facility: No Charge up to allowed amount	Rehabilitation Facility limit: 45 days per calendar year combined with Silled nursing care
	Habilitation services	See Rehabilitation Services	See Rehabilitation Services
	Skilled nursing care	No Charge up to allowed amount	Limit: 45 days per calendar year combined with Rehabilitation Facility
	Durable medical equipment	20% Coinsurance	—————none—————
	Hospice service	No Charge up to allowed amount	Limit: 210 days/visits per lifetime
If your child needs dental or eye care	Eye exam	No Charge for up to \$35 per calendar year, member responsible for balance	Limit: One exam per calendar year
	Glasses	No Charge for up to Fee Schedule amount per calendar year, member responsible for balance	Limit: One pair of glasses per calendar year/one pair of frames every two calendar years
	Dental check-up	20% Coinsurance	—————none—————

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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.)

- | | | |
|---|-------------------------|------------------------|
| • Acupuncture (if prescribed for rehabilitation purposes) | • Infertility Treatment | • Routine Foot Care |
| • Cosmetic Surgery | • Long-term Care | • Weight Loss Programs |

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.)

- | | | |
|-----------------------|--|----------------------------|
| • Bariatric Surgery | • Most coverage provided outside the United States. | • Private-duty Nursing |
| • Dental Care (Adult) | • Non-emergency care when traveling outside the U.S. | • Routine Eye Care (Adult) |
| • Chiropractic Care | | |
| • Hearing Aids | | |

Your Rights to Continue Coverage:

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.

For more information on your rights to continue coverage, contact the plan using the contact information in your Summary Plan Description or Plan Document. 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 or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 your plan using the contact information in your Summary Plan Description or Plan Document. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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.

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

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 \$7,340
- Patient pays \$200

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	\$100
Copays	\$0
Coinsurance	\$100
Limits or exclusions	\$0
Total	\$200

*These examples assume that you have not met your **out-of-pocket limit**.

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

- Amount owed to providers: \$5,400
- Plan pays \$4,900
- Patient pays \$500

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	\$100
Copays	\$0
Coinsurance	\$400
Limits or exclusions	\$0
Total	\$500

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-251-5077.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-251-5077.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-251-5077.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-251-5077.

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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.
- 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.

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