



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call Imagine360 at 1-800-903-4360. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-903-4360 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                                                                                                                                                                          | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | <b>\$3,300</b> person/ <b>\$6,600</b> family Level I & Level II EHN<br><b>\$4,500</b> person/ <b>\$9,000</b> family All Other Level I & Level II MultiPlan PPO & Non-PPO                                                                                                                                                                                                                                                         | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | <b>Yes.</b> Preventive services do not apply towards the <a href="#">deductible</a> .                                                                                                                                                                                                                                                                                                                                            | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | <b>Yes, \$4,500</b> Non-Imagine Health <a href="#">deductible</a> applies per person for prescriptions.                                                                                                                                                                                                                                                                                                                          | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | <b>\$4,000</b> person/ <b>\$8,000</b> family Level I & Level II EHN<br><b>\$6,550</b> person/ <b>\$13,100</b> family All Other Level I & Level II MultiPlan PPO & Non-PPO                                                                                                                                                                                                                                                        | The <a href="#">out-of-pocket</a> limit is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Premiums; balance-billed charges; charges in excess of Allowable Claims Limits; any noncompliance penalties; and health care this plan doesn't cover                                                                                                                                                                                                                                                                             | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | <b>Yes.</b> See page 2 for an explanation of Level I & Level II <a href="#">Providers</a> .<br>Visit <a href="https://members.ehnconnects.com/">https://members.ehnconnects.com/</a> for a list of participating EHN Level I & II <a href="#">providers</a> .<br>Visit <a href="http://www.multiplan.com/mpipracanc">www.multiplan.com/mpipracanc</a> for a list of participating Multiplan Level II <a href="#">providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | <b>No.</b>                                                                                                                                                                                                                                                                                                                                                                                                                       | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Level I [Facilities](#) include but are not limited to: Hospitals (Inpatient and Outpatient treatment); Inpatient Facilities (such as Rehabilitation Facilities, Skilled Nursing Facilities and [Hospice](#)); Inpatient and Outpatient Facilities of Mental Disorders, Chemical Dependency, Drug and Substance Abuse; Ambulatory Surgery Centers and Dialysis Clinics

Level II [Physicians](#) and all other [Providers](#) of service not defined as a Level I [Provider](#).

| Common Medical Event                                                   | Services You May Need                            | What You Will Pay                                                    |                              |                                                                      |                                                                      | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------|------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                        |                                                  | Level I & Level II EHN Facilities and Physicians                     | Level I All Other Facilities | Level II MultiPlan PPO Physicians                                    | Level II Non-PPO Physicians                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness | 20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | N/A                          | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | \$10 consult fee applies to Plans Telehealth/Telemedicine vendor Virtual Emergent & Urgent Care consultations. There is no charge for female office sterilization & all FDA approved contraceptive methods, 20% <a href="#">coinsurance</a> ( <a href="#">deductible</a> applies) applies to Plans Telehealth/Telemedicine vendor Virtual Primary Care consultations. 20% <a href="#">coinsurance</a> ( <a href="#">deductible</a> applies) applies to Plans Telehealth/Telemedicine vendor Virtual Mental Health consultations. 0% <a href="#">coinsurance</a> ( <a href="#">deductible</a> applies) applies for IH x-ray/blood work. Non-PPO charges are based on Allowable Claims Limits. |
|                                                                        | <a href="#">Specialist</a> visit                 | 20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | N/A                          | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

| Common Medical Event                                                                                                                                                        | Services You May Need                                  | What You Will Pay                                                                               |                                                                      |                                                                      |                                                                      | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                             |                                                        | Level I & Level II EHN Facilities and Physicians                                                | Level I All Other Facilities                                         | Level II MultiPlan PPO Physicians                                    | Level II Non-PPO Physicians                                          |                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                             | <a href="#">Preventive care/screening/immunization</a> | No Charge                                                                                       |                                                                      |                                                                      |                                                                      | See your plan document for additional benefit information & limitations. Level I & Non-PPO charges are based on Allowable Claims Limits. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your plan will pay for. |
| If you have a test                                                                                                                                                          | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 0% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies                             | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 0% <a href="#">coinsurance</a> (Imagine <a href="#">deductible</a> applies) applies for blood work billed by Quest. Level I & Non-PPO charges are based on Allowable Claims Limits.                                                                                                                                                                  |
|                                                                                                                                                                             | Imaging (CT/PET scans, MRIs)                           | 20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies                            | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | UR notification required for MRI/MRA and PET scans or 25% benefit reduction non-compliance penalty applies. Level I & Non-PPO charges are based on Allowable Claims Limits.                                                                                                                                                                          |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.medimpact.com</a> | Generic drugs                                          | Non-Imagine <a href="#">Deductible</a> then 30% <a href="#">coinsurance</a> Retail & Mail Order |                                                                      |                                                                      |                                                                      | Covers a 30-day supply for Retail/90-day supply for Mail Order/30-day supply for Specialty. See your plan document for information about drugs that require prior authorization and drugs that are excluded. Coverage for specialty medications may be available through ArchimedesRX.                                                               |
|                                                                                                                                                                             | Preferred brand drugs                                  | Non-Imagine <a href="#">Deductible</a> then 30% <a href="#">coinsurance</a> Retail & Mail Order |                                                                      |                                                                      |                                                                      |                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                             | Non-preferred brand drugs                              | Non-Imagine <a href="#">Deductible</a> then 30% <a href="#">coinsurance</a> Retail & Mail Order |                                                                      |                                                                      |                                                                      |                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                             | <a href="#">Specialty drugs</a>                        | Non-Imagine <a href="#">Deductible</a> then 30% <a href="#">coinsurance</a>                     |                                                                      |                                                                      |                                                                      |                                                                                                                                                                                                                                                                                                                                                      |

| Common Medical Event                    | Services You May Need                            | What You Will Pay                                                            |                                                                      |                                                                      |                                                                      | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                 |
|-----------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                         |                                                  | Level I & Level II EHN Facilities and Physicians                             | Level I All Other Facilities                                         | Level II MultiPlan PPO Physicians                                    | Level II Non-PPO Physicians                                          |                                                                                                                                                                                                                                        |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center)   | 20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies         | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | N/A                                                                  | N/A                                                                  | UR notification required or 25% benefit reduction non-compliance penalty applies. Level I & Non-PPO charges are based on Allowable Claims Limits.                                                                                      |
|                                         | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies         | N/A                                                                  | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies |                                                                                                                                                                                                                                        |
| If you need immediate medical attention | <a href="#">Emergency room care</a>              | 20% <a href="#">coinsurance</a> ; Imagine <a href="#">deductible</a> applies |                                                                      |                                                                      |                                                                      | Non-Imagine subject to Imagine <a href="#">out-of-pocket</a> . UR notification required if admitted inpatient or 25% benefit reduction non-compliance penalty applies. Level I & Non-PPO charges are based on Allowable Claims Limits. |
|                                         | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a> ; Imagine <a href="#">deductible</a> applies |                                                                      |                                                                      |                                                                      | Non-Imagine subject to Imagine <a href="#">out-of-pocket</a> . Level I & Non-PPO charges are based on Allowable Claims Limits.                                                                                                         |
|                                         | <a href="#">Urgent care</a>                      | 20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies         | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | Level I & Non-PPO charges are based on Allowable Claims Limits.                                                                                                                                                                        |
| If you have a hospital stay             | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies         | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | N/A                                                                  | N/A                                                                  | UR notification required or 25% benefit reduction non-compliance penalty applies. Level I & Non-PPO charges are                                                                                                                        |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                             |                                                                               |                                                                               |                                                                               | Limitations, Exceptions, & Other Important Information                                                                                                                                                                           |
|---------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | Level I & Level II EHN Facilities and Physicians                              | Level I All Other Facilities                                                  | Level II MultiPlan PPO Physicians                                             | Level II Non-PPO Physicians                                                   |                                                                                                                                                                                                                                  |
|                                                                           | Physician/surgeon fees                    | 20%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | N/A                                                                           | 30%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | 30%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | based on Allowable Claims Limits.                                                                                                                                                                                                |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | 20%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | 30%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | 30%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | 30%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | UR notification required for Inpatient admissions and day treatment or 25% benefit reduction non-compliance penalty applies. Level I & Non-PPO charges are based on Allowable Claims Limits.                                     |
|                                                                           | Inpatient services                        | 20%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | 30%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | 30%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | 30%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies |                                                                                                                                                                                                                                  |
| If you are pregnant                                                       | Office visits                             | 20%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | N/A                                                                           | 30%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | 30%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | Contact UR for coordination of care. Level I & Non-PPO charges are based on Allowable Claims Limits.                                                                                                                             |
|                                                                           | Childbirth/delivery professional services | 20%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | N/A                                                                           | 30%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | 30%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies |                                                                                                                                                                                                                                  |
|                                                                           | Childbirth/delivery facility services     | 20%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | 30%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | N/A                                                                           | N/A                                                                           |                                                                                                                                                                                                                                  |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | 20%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | 30%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | 30%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | 30%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | Services are limited per calendar year to 120 visits for Home Health, 90 visits combined for Physical/Speech/Occupational Therapy, 90 days for Rehabilitation Facilities & 120 days for Skilled Nursing Facilities. Treatment of |
|                                                                           | <a href="#">Rehabilitation services</a>   | 20%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | 30%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | 30%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies | 30%<br><a href="#">coinsurance</a> ;<br><a href="#">deductible</a><br>applies |                                                                                                                                                                                                                                  |

| Common Medical Event                   | Services You May Need                     | What You Will Pay                                                    |                                                                      |                                                                      |                                                                      | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                            |
|----------------------------------------|-------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                           | Level I & Level II EHN Facilities and Physicians                     | Level I All Other Facilities                                         | Level II MultiPlan PPO Physicians                                    | Level II Non-PPO Physicians                                          |                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                        | <a href="#">Habilitation services</a>     | 20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | developmental delays may not be covered. See your plan document for additional information. UR notification required for inpatient admission, Skilled Nursing/ Rehabilitation Facility, Inpatient/ Homebound Hospice, Home Health, All DME rentals and any purchase that exceeds \$1,500 or 25% benefit reduction non-compliance penalty applies. Level I & Non-PPO charges are based on Allowable Claims Limits. |
|                                        | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies |                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                        | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies |                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                        | <a href="#">Hospice services</a>          | 20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies | 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies |                                                                                                                                                                                                                                                                                                                                                                                                                   |
| If your child needs dental or eye care | Children's eye exam                       | No Charge                                                            |                                                                      |                                                                      |                                                                      | Benefit applies to routine vision screenings for children. Non-PPO charges are based on Allowable Claims Limits.                                                                                                                                                                                                                                                                                                  |
|                                        | Children's glasses                        | Not Covered                                                          |                                                                      |                                                                      |                                                                      | Not Covered                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                        | Children's dental check-up                | Not Covered                                                          |                                                                      |                                                                      |                                                                      | Not Covered                                                                                                                                                                                                                                                                                                                                                                                                       |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                              |                                                                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Cosmetic Surgery</li> <li>Dental Care (Adult)</li> <li>Infertility Treatment</li> </ul>                                                                    | <ul style="list-style-type: none"> <li>Long Term Care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> <li>Routine foot care</li> <li>Weight Loss Programs</li> </ul> |

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Acupuncture
- Chiropractic Care
- Private Duty Nursing (Outpatient **only**)
- Bariatric Surgery
- Hearing Aids

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: 800-903-4360 or the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).]

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Español: Para obtener asistencia en Español, llame al 800-903-4360.

Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-903-4360.

中文: 如果需要中文的帮助, 请拨打这个号码 800-903-4360.

Dine: Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 800-903-4360.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [Imagine deductible](#) **\$3,300**
- [Specialist coinsurance](#) **20%**
- Hospital (facility) [coinsurance](#) **20%**
- Other [coinsurance](#) **20%**

**This EXAMPLE event includes services like:**

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles*</a>      | \$3,310        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$700          |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,070</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [Imagine deductible](#) **\$3,300**
- [Specialist coinsurance](#) **20%**
- Hospital (facility) [coinsurance](#) **20%**
- Other [coinsurance](#) **20%**

**This EXAMPLE event includes services like:**

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles*</a>      | \$5,420        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$5,440</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [Imagine deductible](#) **\$3,300**
- [Specialist coinsurance](#) **20%**
- Hospital (facility) [coinsurance](#) **20%**
- Other [coinsurance](#) **20%**

**This EXAMPLE event includes services like:**

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

**In this example, Mia would pay:**

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,800        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,800</b> |

\*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.