



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, visit us at PriorityHealth.com or call 1-888-389-6645. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-888-389-6645 to request a copy.

| Important Questions                                                | Answers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Why this Matters                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | For <u>network providers</u> \$250 person / \$500 family.<br>For <u>non-network providers</u> \$500 person / \$1,000 family.<br>The <u>deductible</u> for each benefit level is calculated separately. Amounts you pay toward the <u>deductible</u> do not count toward any co-insurance maximums.                                                                                                                                                                                                                                                                                                                                                  | Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                                                                      |
| <b>Are there services covered before you meet your deductible?</b> | Yes, the network benefits <u>deductible</u> doesn't apply to <u>preventive care</u> , services subject to flat dollar <u>co-pays</u> and <u>prescription drugs</u> . Emergency room, ambulance and advanced imaging services are subject to the <u>deductible</u> and a <u>co-pay</u> .                                                                                                                                                                                                                                                                                                                                                             | This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without cost-sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                  |
| <b>Are there other deductibles for specific services?</b>          | No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>What is the out-of-pocket limit for this plan?</b>              | For <u>network providers</u> \$8,550 person / \$17,100 family.<br>For <u>non-network providers</u> \$17,100 person / \$34,200 family.<br>Your plan also has a co-insurance maximum.<br>For <u>network providers</u> \$1,500 person / \$3,000 family.<br>For <u>non-network providers</u> \$3,000 person / \$6,000 family.<br>The co-insurance maximum limits the total amount of co-insurance you will pay for certain covered services during a coverage period. The co-insurance maximum is included in the <u>out-of-pocket limit</u> . The <u>out-of-pocket limit</u> and co-insurance maximum for each benefit level is calculated separately. | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                              |
| <b>What is not included in the out-of-pocket limit?</b>            | Premiums, <u>balance-billed</u> charges, health care this plan doesn't cover, services that exceed an annual day/visit limit, and any <u>co-pays</u> and <u>co-insurance</u> you pay for any non-essential health benefit.                                                                                                                                                                                                                                                                                                                                                                                                                          | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See PriorityHealth.com or call 1-888-389-6645 for a list of <u>network providers</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your plan pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a referral to see a specialist?</b>                 | No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |



All co-payment and co-insurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event                                          | Services You May Need                            | What You Will Pay                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                | Limitations, Exceptions & Other Important Information                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               |                                                  | Network Provider<br>(You will pay the least)                                                                                                                                                                                                                                                                                       | Non-Network Provider<br>(You will pay the most)                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                    |
| <b>If you visit a health care provider's office or clinic</b> | Primary care visit to treat an injury or illness | \$20 co-pay/ visit                                                                                                                                                                                                                                                                                                                 | 30% co-insurance/ visit                                                                                                                                                                                                                                                                                                                        | Network benefit level deductible does not apply to certain services subject to flat dollar co-pays.<br>Prescription drug co-pay may also apply when selected injectable drugs are provided.<br>Prescription drugs for infertility treatment covered only with prescription drug addendum.                                                                          |
|                                                               | Specialist visit                                 | \$35 co-pay/ visit                                                                                                                                                                                                                                                                                                                 | 30% co-insurance/ visit                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                    |
|                                                               | Other practitioner office visit                  | <ul style="list-style-type: none"> <li>• \$75 co-pay/ visit for evaluation/ management services only at retail health clinics.</li> <li>• 50% co-insurance/ visit for family planning/ infertility services.</li> <li>• 50% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery.</li> </ul> | <ul style="list-style-type: none"> <li>• Evaluation/management services only at retail health clinics covered at the network benefit level.</li> <li>• 50% co-insurance/visit for family planning/ infertility services.</li> <li>• 50% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery.</li> </ul> |                                                                                                                                                                                                                                                                                                                                                                    |
|                                                               | Preventive care/screening/immunization           | No charge                                                                                                                                                                                                                                                                                                                          | 30% co-insurance/ visit                                                                                                                                                                                                                                                                                                                        | Preventive care services are those listed in Priority Health's Preventive Health Care Guidelines, including women's preventive health care services. Network benefit level deductible does not apply.<br>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| <b>If you have a test</b>                                     | Diagnostic test (x-ray, blood work)              | 10% co-insurance/ visit                                                                                                                                                                                                                                                                                                            | 30% co-insurance                                                                                                                                                                                                                                                                                                                               | Prior Authorization required for genetic testing.                                                                                                                                                                                                                                                                                                                  |
|                                                               | Imaging (CT/PET scans, MRIs)                     | \$150 co-pay                                                                                                                                                                                                                                                                                                                       | 30% co-insurance                                                                                                                                                                                                                                                                                                                               | Prior Authorization required.<br>Network benefits co-pay waived if performed while confined in a hospital as an inpatient.                                                                                                                                                                                                                                         |

| Common Medical Events                                                                                                                                                                                                                                                         | Services You May Need                          | What You Will Pay                                                         |                                                             | Limitations, Exceptions & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                               |                                                | Network Provider<br>(You will pay the least)                              | Non-Network Provider<br>(You will pay the most)             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b>prescription drug coverage</b> is available at <a href="https://www.priorityhealth.com/prog/pharmacy/pharmacy.cgi">https://www.priorityhealth.com/prog/pharmacy/pharmacy.cgi</a> | Generic drugs (Tier 1)                         | \$10 co-pay/ retail prescription<br>\$20 co-pay/ mail order prescription  | Not covered                                                 | Costs shown in the "What You Will Pay" columns apply to drugs on the approved drug list when obtained from a Participating Provider.<br><br>Covers up to a 31-day supply (retail prescription); Covers up to a 90-day supply (mail order prescription)<br>Up to a 90-day supply of medication (excluding Specialty Drugs) may be obtained at one time for three applicable Copayments at a retail Participating Pharmacy.<br>50% co-insurance/ prescription for infertility drugs.<br>Deductible does not apply. |
|                                                                                                                                                                                                                                                                               | Preferred brand drugs (Tier 2)                 | \$40 co-pay/ retail prescription<br>\$80 co-pay/ mail order prescription  | Not covered                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                               | Non-preferred brand drugs (Tier 3)             | \$80 co-pay/ retail prescription<br>\$160 co-pay/ mail order prescription | Not covered                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                               | Preferred specialty drugs (Tier 4)             | \$40 co-pay/ retail prescription                                          | Not covered                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                               | Non-Preferred specialty drugs (Tier 5)         | \$80 co-pay/ retail prescription                                          | Not covered                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                                         | Facility fee (e.g., ambulatory surgery center) | 10% co-insurance/ visit                                                   | 30% co-insurance/ visit                                     | Including outpatient care, observation care and ambulatory surgery center care. Prior Authorization may be required.<br>Prior Authorization is required for bariatric surgery.<br>Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.                                                                                                                             |
|                                                                                                                                                                                                                                                                               | Physician/surgeon fees                         | 10% co-insurance/ visit                                                   | 30% co-insurance/ visit                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                                                                | Emergency room services                        | \$150 co-pay/ visit                                                       | Covered at the network benefit level; R&C limitations apply | Co-pay waived if you become confined in a Hospital as an inpatient.                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                               | Emergency medical transportation               | \$150 co-pay                                                              | Covered at the network benefit level; R&C limitations apply | -----none-----                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                               | Urgent care                                    | \$75 co-pay/ visit                                                        | 30% co-insurance/ visit                                     | Co-pay applies to all urgent care visits.<br>Network benefit level deductible does not apply.                                                                                                                                                                                                                                                                                                                                                                                                                    |

| Common Medical Events                                                            | Services You May Need                        | What You Will Pay                            |                                                 | Limitations, Exceptions & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|----------------------------------------------------------------------------------|----------------------------------------------|----------------------------------------------|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                              | Network Provider<br>(You will pay the least) | Non-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)           | 10% co-insurance/ visit                      | 30% co-insurance/ visit                         | <p>Prior Authorization is required at least 5 working days in advance, except in emergencies or for Hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section.</p> <p>Notification must be provided for all admissions following emergency room care.</p> <p>Prior Authorization is required for bariatric surgery.</p> <p>Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.</p> |
|                                                                                  | Physician/surgeon fee                        | 10% co-insurance/ visit                      | 30% co-insurance/ visit                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Mental/Behavioral health outpatient services | \$20 co-pay/ visit                           | 30% co-insurance/ visit                         | <p>No charge for first three visits with network provider within 90 days of discharge from a network hospital for mental health inpatient care.</p> <p>Including medication management visits.</p> <p>Network benefit level deductible does not apply.</p>                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                  | Mental/Behavioral health inpatient services  | 10% co-insurance/ visit                      | 30% co-insurance/ visit                         | <p>Including Residential Treatment and partial hospitalization.</p> <p>Except in an emergency, Prior Authorization required.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                  | Substance use disorder outpatient services   | \$20 co-pay/ visit                           | 30% co-insurance/ visit                         | <p>Including medication management visits.</p> <p>Network benefit level deductible does not apply.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                  | Substance use disorder inpatient services    | 10% co-insurance/ visit                      | 30% co-insurance/ visit                         | <p>Including subacute Residential Treatment and partial hospitalization.</p> <p>Except in an emergency, Prior Authorization required.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>If you are pregnant</b>                                                       | Routine prenatal and postnatal care          | No charge                                    | 30% co-insurance/ visit                         | <p>Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit.</p> <p>Appropriate office visit charge (PCP or specialist) may apply to physician office services for complications of pregnancy.</p>                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                  | Delivery professional fees                   | 10% co-insurance/ visit                      | 30% co-insurance/ visit                         | -----none-----                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                  | Delivery facility fees                       | 10% co-insurance/ visit                      | 30% co-insurance/ visit                         | -----none-----                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

| Common Medical Events                                                 | Services You May Need                                                            | What You Will Pay                                                                                                                                                                    |                                                 | Limitations, Exceptions & Other Important Information                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                                                                  | Network Provider<br>(You will pay the least)                                                                                                                                         | Non-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>If you need help recovering or have other special health needs</b> | Home health care                                                                 | 10% co-insurance/ visit                                                                                                                                                              | 30% co-insurance/ visit                         | Including hospice care services; excluding rehabilitation and habilitation services.<br>Prior Authorization required, except for hospice care.                                                                                                                                                                                                                                                                        |
|                                                                       | Rehabilitation services <i>not</i> for the treatment of Autism Spectrum Disorder | \$20 co-pay/ visit                                                                                                                                                                   | 50% co-insurance/ visit                         | Physical and occupational therapy limited to a combined 30 visits per contract year.<br>Osteopathic and chiropractic manipulation limited to a combined 30 visits per contract year.<br>Speech therapy limited to a combined 30 visits per contract year.<br>Cardiac rehabilitation & pulmonary rehabilitation limited to a combined 30 visits per contract year.<br>Network benefit level deductible does not apply. |
|                                                                       | Habilitation services for treatment of Autism Spectrum Disorder <b>only</b>      | <ul style="list-style-type: none"> <li>•\$20 co-pay/ visit for Physical, Occupational and Speech Therapy</li> <li>•No charge for Applied Behavior Analysis (ABA) services</li> </ul> | 50% co-insurance/ visit                         | Prior Authorization required for Applied Behavior Analysis (ABA).<br>Services are Covered for children and adolescents under age 19 only.<br>Multiple charges may apply during one day of service.<br>Network benefit level deductible does not apply to flat dollar co-pays.                                                                                                                                         |
|                                                                       | Habilitation services not for the treatment of Autism Spectrum Disorder          | Not covered                                                                                                                                                                          | Not covered                                     | Not covered                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                       | Skilled nursing care                                                             | 10% co-insurance/ visit                                                                                                                                                              | 30% co-insurance/ visit                         | Services received in a skilled nursing care facility, subacute facility, inpatient rehabilitation care facility or hospice care facility are limited to a combined 45 days per contract year. Prior Authorization required, except for hospice care.                                                                                                                                                                  |
|                                                                       | Durable medical equipment (DME)                                                  | 50% co-insurance/ visit                                                                                                                                                              | 50% co-insurance/ visit                         | Including rental, purchase or repair.<br>Prior Authorization required for equipment over \$1,000, all rentals and all shoe inserts.                                                                                                                                                                                                                                                                                   |
|                                                                       | Prosthetics & orthotics                                                          | 50% co-insurance/ visit                                                                                                                                                              | 50% co-insurance/ visit                         |                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                       | Hospice service                                                                  | 10% co-insurance/ visit                                                                                                                                                              | 30% co-insurance/ visit                         | This benefit applies to hospice services provided in the home only.<br>Any hospice services provided in a facility will be subject to the appropriate facility benefit.                                                                                                                                                                                                                                               |
| <b>If your child needs dental or eye care</b>                         | Child eye exam                                                                   | Not covered                                                                                                                                                                          | Not covered                                     | Not covered                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                       | Child glasses                                                                    | Not covered                                                                                                                                                                          | Not covered                                     | Not covered                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                       | Child dental check-up                                                            | Not covered                                                                                                                                                                          | Not covered                                     | Not covered                                                                                                                                                                                                                                                                                                                                                                                                           |

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan documents for more information and a list of any other excluded services.)

- |                               |                                                         |                                    |
|-------------------------------|---------------------------------------------------------|------------------------------------|
| • Acupuncture                 | • Habilitation services not for the treatment of Autism | • Private-duty nursing             |
| • Cosmetic surgery            | • Spectrum Disorder                                     | • Routine eye care (Adult & Child) |
| • Dental care (Adult & Child) | • Hearing aids                                          | • Routine foot care                |
|                               | • Long-term care                                        |                                    |

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

- |                     |                                                                                                                |                                                      |
|---------------------|----------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| • Bariatric surgery | • Infertility treatment - diagnostic, counseling and planning services for the underlying cause of infertility | • Non-emergency care when traveling outside the U.S. |
| • Chiropractic care |                                                                                                                | • Weight loss programs                               |

**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: Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or [difs-HICAP@michigan.gov](mailto:difs-HICAP@michigan.gov); the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or [www.ccio.cms.gov](http://www.ccio.cms.gov); or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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: Priority Health at 1-888-389-6645 or [www.priorityhealth.com](http://www.priorityhealth.com); the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); or the Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or [difs-HICAP@michigan.gov](mailto:difs-HICAP@michigan.gov). Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) at 1-877-999-6442 or [difs-HICAP@michigan.gov](mailto:difs-HICAP@michigan.gov).

### 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 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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-389-6645.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-389-6645.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-389-6645.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-389-6645.

-----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, co-payments, and co-insurance) and excluded services under this 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 deductible    | \$1,000 |
| ■ Specialist co-payment            | \$50    |
| ■ Hospital (facility) co-insurance | 20%     |
| ■ Other co-insurance               | 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                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,000        |
| Co-payments                       | \$100          |
| Co-insurance                      | \$2,500        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,660</b> |

### Managing Joe's type 2 Diabetes

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

|                                    |         |
|------------------------------------|---------|
| ■ The plan's overall deductible    | \$1,000 |
| ■ Specialist co-payment            | \$50    |
| ■ Hospital (facility) co-insurance | 20%     |
| ■ Other co-insurance               | 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                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,000        |
| Co-payments                       | \$1,500        |
| Co-insurance                      | \$900          |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Joe would pay is</b> | <b>\$3,460</b> |

### Mia's Simple Fracture

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

|                                    |         |
|------------------------------------|---------|
| ■ The plan's overall deductible    | \$1,000 |
| ■ Specialist co-payment            | \$50    |
| ■ Hospital (facility) co-insurance | 20%     |
| ■ Other co-insurance               | 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                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$500          |
| Co-payments                       | \$400          |
| Co-insurance                      | \$100          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,000</b> |

The plan would be responsible for the other costs of these EXAMPLE covered services.