# Summary of Benefits and Coverage

**Coverage Period:** [See Instructions]

**Coverage for:** __________ | **Plan Type:** _____

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**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$</td>
<td></td>
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<tr>
<td>Are there other deductibles for specific services?</td>
<td>$</td>
<td></td>
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<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>$</td>
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<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td></td>
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<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
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<tr>
<td>Does this plan use a network of providers?</td>
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<tr>
<td>Do I need a referral to see a specialist?</td>
<td></td>
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<tr>
<td>Are there services this plan doesn’t cover?</td>
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</tbody>
</table>

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

If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.

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OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Released on April 23, 2013 (corrected)
**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage Period: [See Instructions]**

**Coverage for: __________ | Plan Type: _____**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use ___________ **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Specialist visit</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Other practitioner office visit</td>
<td></td>
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<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td></td>
<td></td>
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<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td></td>
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<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td></td>
<td></td>
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<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
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<td></td>
<td>Preferred brand drugs</td>
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<td></td>
<td>Non-preferred brand drugs</td>
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<tr>
<td></td>
<td>Specialty drugs</td>
<td></td>
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</tr>
</tbody>
</table>

**Common Medical Event**

- **Primary care visit to treat an injury or illness**
- **Specialist visit**
- **Other practitioner office visit**
- **Preventive care/screening/immunization**
- **Diagnostic test (x-ray, blood work)**
- **Imaging (CT/PET scans, MRIs)**
- **Generic drugs**
- **Preferred brand drugs**
- **Non-preferred brand drugs**
- **Specialty drugs**

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

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<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
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<td></td>
<td>Emergency medical transportation</td>
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<td></td>
<td>Urgent care</td>
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<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
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<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td></td>
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<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
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<td></td>
<td>Mental/Behavioral health inpatient services</td>
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<td></td>
<td>Substance use disorder outpatient services</td>
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<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
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<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
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<td></td>
<td>Delivery and all inpatient services</td>
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<td></td>
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<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
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<td></td>
<td>Rehabilitation services</td>
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<td>Habilitation services</td>
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<td></td>
<td>Skilled nursing care</td>
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<td>Durable medical equipment</td>
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<td>Hospice service</td>
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<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
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<td></td>
<td>Glasses</td>
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<td></td>
<td>Dental check-up</td>
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</tbody>
</table>

Questions: Call 1-800-[insert] or visit us at www.[insert].
If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: ____________ | Plan Type: ______

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)

•

Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

•

Your Rights to Continue Coverage: [insert applicable information from instructions]

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: [insert applicable contact information from instructions]. You may also want to contact the [state] Department of Insurance consumer information helpline.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy [does/does not] provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage [does/does not] meet the minimum value standard for the benefits it provides.

[Insert heading and applicable tagline(s):

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

Questions: Call 1-800-[insert] or visit us at www.[insert]. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: [See Instructions]

Coverage for: ____________ | Plan Type: _____

Questions: Call 1-800-[insert] or visit us at www.[insert].
If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.
### About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

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**Having a baby**
(normal delivery)

- **Amount owed to providers**: $7,540
- **Plan pays $**
- **Patient pays $**

**Sample care costs:**
- Hospital charges (mother): $2,700
- Routine obstetric care: $2,100
- Hospital charges (baby): $900
- Anesthesia: $900
- Laboratory tests: $500
- Prescriptions: $200
- Radiology: $900
- Vaccines, other preventive: $40
- **Total**: $7,540

**Patient pays:**
- Deductibles: $
- Copays: $
- Coinsurance: $
- Limits or exclusions: $
- **Total**: $

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

- **Amount owed to providers**: $5,400
- **Plan pays $**
- **Patient pays $**

**Sample care costs:**
- Prescriptions: $2,900
- Medical Equipment and Supplies: $1,300
- Office Visits and Procedures: $700
- Education: $300
- Laboratory tests: $100
- Vaccines, other preventive: $100
- **Total**: $5,400

**Patient pays:**
- Deductibles: $
- Copays: $
- Coinsurance: $
- Limits or exclusions: $
- **Total**: $

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This is not a cost estimator. Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

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**Questions:** Call 1-800-[insert] or visit us at www.[insert]. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

**No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

**No.** Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

**Yes.** When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

**Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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

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