B

Acme Corporation: Acme HealthPlan

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

Coverage Period: 01/01/2015 - 12/31/2015
Coverage for: All Coverage Tiers | Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.acmehealthplan.com or by calling 1-877-877-7777.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Network:** $650/person, up to $2,000 max; **Non-Network:** $1,500/person, up to $4,500 max; Network and Non-Network are not combined. **Out-of-Area (OOA):** same as Network benefit (combined Network and Non-Network). **NOTE:** You may be able to offset some of the cost associated with the deductible by completing Healthy Actions to earn credits in your HealthFund.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	**Network: Medical:** $2,150 per person up to a $5,000 maximum (includes $650/$2,000 deductible); **Pharmacy:** $2,000 per person up to a $4,000 maximum **Non-Network: Medical:** $6,500 per person, up to a $14,500 maximum (includes $1,500/$4,500 deductible); **Out-of-Area (OOA):** same as Network benefit (combined Network and Non-network)	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Preventive Care, Recognized Charges overages and services not covered under the Plan.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Questions: Call 1-877-XXX-XXXX or visit us at www.acmehealthplan.com.
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.dol.gov/ebsa/healthreform or call the Acme Employee Service Center (ESC) at 1-866-XXX-XXXX to request a copy.

Common Medical Event	Services You May Need	Your Cost If You Use a(n) Network	Your Cost If You Use a(n) Non-Network	Limitations & Exceptions
	Other practitioner office visit	15% after deductible	35% (20% OOA) after deductible	Chiropractic: limited to 20 visits/calendar year; Acupuncture: limitations apply.
	Preventive care/screening/ immunization	No charge, no deductible	No charge, no deductible	Age and frequency limitations apply.
If you have a test	Diagnostic test (x-ray, blood work)	15% after deductible	35% (20% OOA) after deductible	none
	Imaging (CT/PET scans, MRIs)	15% after deductible	35% (20% OOA) after deductible	none

Common Medical Event	Services You May Need	Your Cost If You Use a(n) Network	Your Cost If You Use a(n) Non-Network	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	15% after deductible	15% after deductible	none
	Emergency medical transportation	15% after deductible	15% after deductible	none
	Urgent care	15% after deductible	35% (20% OOA) after deductible	none
If you have a hospital stay	Facility fee (e.g., hospital room)	15% after deductible	35% (20% OOA) after deductible	Precertification required. An out of network provider or facility may bill you for charges – in addition to deductible and coinsurance, as applicable – which exceed the Plan's reimbursement for a covered service. You may be responsible for these charges.
	Physician/surgeon fee	15% after deductible	35% (20% OOA) after deductible	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	15% after deductible	35% (20% OOA) after deductible	Precertification required for certain services.
	Mental/Behavioral health inpatient services	15% after deductible	35% (20% OOA) after deductible	Precertification required.
	Substance use disorder outpatient services	15% after deductible	35% (20% OOA) after deductible	Precertification required for certain services.
	Substance use disorder inpatient services	15% after deductible	35% (20% OOA) after deductible	Precertification required.
If you are pregnant	Prenatal and postnatal care	Acme Health Plan I Designated Provider: 10% after deductible; Non-Aexcel Designated Provider: 15% after deductible	35% (20% OOA) after deductible	none

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.)

- Children's glasses
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care - adult
- Routine foot care
- Weight loss programs

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Private-duty nursing

IMPORTANT: For additional limitations & exclusions please refer to the SPD.

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the Acme Employee Service Center (ESC) at 1-866-xxx-xxxx or www.acme.com. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-877-877-7777.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Questions: Call 1-877-XXX-XXXX or visit us at www.acmehealthplan.com.
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.dol.gov/ebsa/healthreform or call the Acme Employee Service Center (ESC) at 1-866-XXX-XXXX 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.

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,740
- **Patient pays** $1,800

Sample care costs:

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

Patient pays:

Deductibles	$700
Copays	$0
Coinsurance	$900
Limits or exclusions	$200
Total	**$1,800**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,720
- **Patient pays** $1,680

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	$700
Copays	$600
Coinsurance	$300
Limits or exclusions	$80
Total	**$1,680**

Note: These costs do not reflect any HealthFund credits, which offset your deductible and coinsurance. HealthFund credits are earned by completing certain Healthy Actions. For more information, please contact the *Acme HealthPlan* Plan at 1-877-XXX-XXXX or visit www.acme.com.