_____________________: _______________________

**What This Plan Covers & What it Costs**

**Policy Period: __________ - __________**
**Coverage for: __________ | Plan Type: _____**

**This is not a policy.** You can get the policy at ____________________ or by calling _______________.
A policy has more detail about how to use the plan and what you and your insurer must do. It also has more detail about your coverage and costs.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the premium? | $ | The premium is the amount paid for health insurance. This is only an estimate based on information you've provided. After the insurer reviews your application, your actual premium may be higher or your application may be denied. |
| What is the overall deductible? | $ | |
| Are there other deductibles for specific services? | $ | |
| Is there an out–of–pocket limit on my expenses? | $ | |
| What is not included in the out–of–pocket limit? | | |
| Is there an overall annual limit on what the insurer pays? | | |
| Does this plan use a network of providers? | | |
| Do I need a referral to see a specialist? | | |
| Are there services this plan doesn't cover? | | |

Questions: Call ____________ or visit us at www.____________________
If you're unclear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

## Covered Services, Cost Sharing, Limitations and Exception

- **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. You pay this plus any deductible amounts you owe under this health insurance plan. For example, if the health plan's allowed amount for an overnight hospital stay is $1,000 and you've met your deductible, your coinsurance payment of 20% would be $200. If you haven't met any of the deductible and it's at least $1,000, you would pay the full cost of the hospital stay.
- The plan's payment 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.

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|---|---|---|---|---|
| | | ___________ Provider | ___________ Provider | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | | | |
| | Specialist visit | | | |
| | Other practitioner office visit | | | |
| | Preventive care/screening/immunization | | | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | | | |
| | Imaging (CT/PET scans, MRIs) | | | |
| **If you need drugs to treat your illness or condition** More information about drug coverage is at www.___________ | Generic drugs | | | |
| | Preferred brand drugs | | | |
| | Non-preferred brand drugs | | | |
| | Specialty drugs (e.g., chemotherapy) | | | |
| **If you have outpatient surgery** | Facility fee (example, ambulatory surgery center) | | | |
| | Physician/surgeon fees | | | |
| **If you need immediate medical attention** | Emergency room services | | | |
| | Emergency medical transportation | | | |
| | Urgent care | | | |

| Common Medical Event | Services You May Need | Your cost if you use a ____ Provider | ____ Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have a hospital stay** | Facility fee (example: hospital room) | | | |
| | Physician/surgeon fee | | | |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | | | |
| | Mental/Behavioral health inpatient services | | | |
| | Substance use disorder outpatient services | | | |
| | Substance use disorder inpatient services | | | |
| **If you become pregnant** | Prenatal and postnatal care | | | |
| | Delivery and all inpatient services | | | |
| **If you have a recovery or other special health need** | Home health care | | | |
| | Rehabilitation services | | | |
| | Habilitation services | | | |
| | Skilled nursing care | | | |
| | Durable medical equipment | | | |
| | Hospice service | | | |
| **If your child needs dental or eye care** | Eye exam | | | |
| | Glasses | | | |
| | Dental check-up | | | |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy for others.)

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

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## Coverage Facts:

## Your Rights to Continue Coverage:

You can keep this insurance as long as you pay your premium unless one or more of the following happens:

- you commit fraud
- the insurer stops offering services in the state
- you move outside the coverage area

## Your Grievance and Appeals Rights:

- A **grievance** is a complaint you have about your health insurer or plan. You have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this health insurance. Call 1-800-XXX-XXXX or visit www. Xxxxxxxxxxxxxx.com.
- An **appeal** is a request for your health insurer or plan to review a decision or a grievance again. For more information on the appeals process, call your state office of health insurance customer assistance at: 1-800-XXX-XXXX or visit www. Xxxxxxxxxxxxxx.gov.