# Health Plan Name: Insurance Company 1

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

**Policy Period: 9/15/2010 - 9/14/2011**

**Coverage for: Individual | Plan Type: HMO**

**This is not a policy.** You can get the policy at www.insurancecompany.com/HMO1500 or by calling 1-800-XXX-XXXX. 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?** | **$280** monthly | 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?** | **$1,500** Doesn't apply to office visits, preventive care, and generic drugs. | You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy 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?** | Yes; **$500** for pharmacy expenses. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. **$5,000** | The **out-of-pocket** limit is the most you could pay during a policy period 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?** | Copayments, premium, balance-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. So, a longer list of expenses means you have less coverage. |
| **Is there an overall annual limit on what the insurer pays?** | No. There is no *overall* annual limit, but see page 2 for *specific* limits on covered services. | The chart starting on page 2 describes any limits on what the insurer will pay for specific covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. See insurancecompany.com for a list of participating doctors and hospitals. | If you use an **in-network** doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the term **in-network**, **preferred**, or **participating** for providers in their network. |
| **Do I need a referral to see a specialist?** | Yes. You need a referral to see a specialist. | This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the specialist. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 3. |

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com

If you aren't clear 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 participating **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 |
|---|---|---|---|---|
| | | Participating Provider | Non-Participating Provider | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $35 copay/visit | Not Covered | none |
| | Specialist visit | $50 copay/visit | Not Covered | none |
| | Other practitioner office visit | 30% coinsurance for chiropractor and 20% coinsurance for accupuncture | Not Covered | none |
| | Preventive care/screening/immunization | $35 copay/visit | Not Covered | No charge for mammograms at a participating provider |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% coinsurance | Not Covered | none |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | Not Covered | none |

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|---|---|---|---|---|
| | | Participating Provider | Non-Participating Provider | |
| **If you need drugs to treat your illness or condition**<br><br>More information about drug coverage is at www.insurancecompany.com/prescriptions | Generic drugs | $15 copay (retail); $30 copay (mail order) | Not Covered | Covers up to a 30-day supply (retail prescription); 31-60 day supply (mail order prescription) |
| | Preferred brand drugs | $40 copay (retail); $80 copay (mail order) | Not Covered | |
| | Non-preferred brand drugs | $60 copay (retail); $120 copay (mail order) | Not Covered | |
| | Specialty drugs (e.g., chemotherapy) | Covered | Not Covered | |
| **If you have outpatient surgery** | Facility fee (example, ambulatory surgery center) | 30% coinsurance | Not Covered | none |
| | Physician/surgeon fees | 30% coinsurance | Not Covered | none |
| **If you need immediate medical attention** | Emergency room services | 30% coinsurance | 30% coinsurance | none |
| | Emergency medical transportation | 30% coinsurance | Not Covered | none |
| | Urgent care | $50 copay/visit | Not Covered | none |
| **If you have a hospital stay** | Facility fee (example: hospital room) | 30% coinsurance | Not Covered | none |
| | Physician/surgeon fee | 30% coinsurance | Not Covered | none |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $50 copay/visit | Not Covered | none |
| | Mental/Behavioral health inpatient services | 30% coinsurance | Not Covered | none |
| | Substance use disorder outpatient services | $50 copay/visit | Not Covered | none |
| | Substance use disorder inpatient services | 30% coinsurance | Not Covered | none |
| **If you become pregnant** | Prenatal and postnatal care | 30% coinsurance | Not Covered | none |
| | Delivery and all inpatient services | 30% coinsurance | Not Covered | none |

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|---|---|---|---|---|
| | | Participating Provider | Non-Participating Provider | |
| **If you have a recovery or other special health need** | Home health care | 30% coinsurance | Not Covered | 60 visits per calendar year |
| | Rehabilitation services | 30% coinsurance | Not Covered | 60 consecutive day period per instance of illness or injury |
| | Habilitation services | 30% coinsurance | Not Covered | none |
| | Skilled nursing care | 30% coinsurance | Not Covered | 60 days per calendar year |
| | Durable medical equipment | 30% coinsurance | Not Covered | Covered up to $1,000 per calendar year |
| | Hospice service | 30% coinsurance | Not Covered | none |
| **If your child needs dental or eye care** | Eye exam | Not Covered | Not Covered | none |
| | Glasses | Not Covered | Not Covered | none |
| | Dental check-up | Not Covered | Not Covered | none |

## Excluded Services & Other Covered Services:

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

- Bariatric surgery
- Non-emergency care when traveling outside the U.S.
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Routine hearing tests
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- Hearing aids

## 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. Xxxxxxxxxxxxx.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. Xxxxxxxxxxxxx.gov.