This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other **bolded** terms see the **Glossary**. You can view the Glossary at **www.[insert].com** or call 1-800-[**insert**] to request a copy.

Important Questions	Answers	Why This Matters:
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?		
Does this plan use a network of providers?		
Do I need a referral to see a specialist?		

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
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 **prescription drug coverage** is available at www.[insert].	Generic drugs			
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)			
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services			
	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)			
	Physician/surgeon fees			

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
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 are pregnant	Prenatal and postnatal care			
	Delivery and all inpatient services			

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	**Home health care**			
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice services			
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 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: Federal and State laws may provide protections that allow you to continue health coverage after it would otherwise end. For more information, contact us at [insert contact information] or contact: [insert State, HHS, and/or DOL contact information, as applicable]. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the **Marketplace**, visit www.HealthCare.gov or call 1-800-318-2596.

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 more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

Individual Responsibility: [insert applicable language from instructions].

[Insert heading and applicable tagline(s):

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (□□): □□□□□□□□□□□□□□□□ [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]]

----------To see examples of how this plan might cover costs for a sample medical situation, see the next section.----------

About these Coverage Examples:

These examples show how this **plan** might cover medical care in a few situations and show how **deductibles**, **copayments**, and **coinsurance** can add up. Use these examples to see, in general, how much financial protection a sample patient might get from coverage under this plan compared to other plans by

This is not a cost estimator. Don't use these examples to estimate your actual costs under this **plan**. Treatments shown are just examples and your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Also, costs don't include **premiums**

Having a baby
(normal delivery)

- **Cost of care** $14,150
- **Plan pays** $
- **Patient pays** $

Sample care costs:

Hospital charges (mother)	$6,700
Routine obstetric care	$2,500
Hospital charges (baby)	$2,100
Anesthesia	$1,200
Laboratory tests	$1,000
Prescriptions	$200
Radiology	$200
Education	$200
Vaccines, other preventive	$50
Total	**$14,150**

Patient pays:

Deductibles	$
Copayments	$
Coinsurance	$
Limits or exclusions	$
Total	**$**

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

- **Cost of care** $6,100
- **Plan pays** $
- **Patient pays** $

Sample care costs:

Prescriptions	$3,300
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$800
Education	$300
Laboratory tests	$200
Vaccines, other preventive	$200
Total	**$6,100**

Patient pays:

Deductibles	$
Copayments	$
Coinsurance	$
Limits or exclusions	$
Total	**$**

Simple fracture
(with emergency room visit)

- **Cost of care** $2,400
- **Plan pays** $
- **Patient pays** $

Sample care costs:

Emergency Services	$1,400
Medical Equipment and Supplies	$400
Office Visits and Procedures	$300
Physical Therapy	$200
Laboratory tests	$90
Prescriptions	$10
Total	**$2,400**

Patient pays:

Deductibles	$
Copayments	$
Coinsurance	$
Limits or exclusions	$
Total	**$**