



**This is not a policy.** You can get the policy at [www.insurancecompany.com/HMO1500](http://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 <b>premium</b> ?	<b>\$280</b> monthly	The <b>premium</b> 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 <b>deductible</b> ?	<b>\$1,500</b> Doesn't apply to office visits, preventive care, and generic drugs.	You must pay all the costs up to the <b>deductible</b> amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the <b>deductible</b> 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 <b>deductible</b> .
Are there other <b>deductibles</b> for specific services?	Yes; <b>\$500</b> 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 <b>out-of-pocket limit</b> on my expenses?	Yes. <b>\$5,000</b>	The <b>out-of-pocket</b> 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 <b>not included</b> in the <b>out-of-pocket limit</b> ?	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 <b>out-of-pocket limit</b> . So, a longer list of expenses means you have less coverage.
Is there an overall <b>annual limit</b> on what the insurer pays?	No. There is no <i>overall</i> annual limit, but see page 2 for <i>specific</i> 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 <b>network</b> of providers?	Yes. See <a href="http://insurancecompany.com">insurancecompany.com</a> for a list of participating doctors and hospitals.	If you use an <b>in-network</b> doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the term <b>in-network</b> , <b>preferred</b> , or <b>participating</b> for providers in their network.
Do I need a referral to see a <b>specialist</b> ?	Yes. You need a referral to see a specialist.	This plan will pay some or all of the costs to see a <b>specialist</b> 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.

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## 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 acupuncture	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	
<b>If you need drugs to treat your illness or condition</b>  More information about drug coverage is at <a href="http://www.insurancecompany.com/prescriptions">www.insurancecompany.com/prescriptions</a>	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	
<b>If you have outpatient surgery</b>	Facility fee (example, ambulatory surgery center)	30% coinsurance	Not Covered	_____ none _____
	Physician/surgeon fees	30% coinsurance	Not Covered	_____ none _____
<b>If you need immediate medical attention</b>	Emergency room services	30% coinsurance	30% coinsurance	_____ none _____
	Emergency medical transportation	30% coinsurance	Not Covered	_____ none _____
	Urgent care	\$50 copay/visit	Not Covered	_____ none _____
<b>If you have a hospital stay</b>	Facility fee (example: hospital room)	30% coinsurance	Not Covered	_____ none _____
	Physician/surgeon fee	30% coinsurance	Not Covered	_____ none _____
<b>If you have mental health, behavioral health, or substance abuse needs</b>	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 _____
<b>If you become pregnant</b>	Prenatal and postnatal care	30% coinsurance	Not Covered	_____ none _____
	Delivery and all inpatient services	30% coinsurance	Not Covered	_____ none _____

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

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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](http://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](http://www.XXXXXXXXXXXXXX.gov).

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