**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services **Coverage Period: 1/1/2021-12/31/2021**

**Western Area Schools Health Benefit Plan: Red Plan $1,000** **Coverage for: Individual/Family | Plan Type: PPO**

|  |
| --- |
| Picture of exclamation point to label important information**The Summary of Benefits and Coverage (SBC) document will help you choose a health** [**plan.**](https://www.healthcare.gov/sbc-glossary/#plan) **The SBC shows you how you and the** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **would share the cost for covered health care services. NOTE: Information about the cost of this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **(called the** [**premium**](https://www.healthcare.gov/sbc-glossary/#premium)**) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, see your Human Resources Department. For general definitions of common terms, such as [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) [balance billing,](https://www.healthcare.gov/sbc-glossary/#balance-billing) [coinsurance,](https://www.healthcare.gov/sbc-glossary/#coinsurance) [copayment,](https://www.healthcare.gov/sbc-glossary/#copayment) [deductible](https://www.healthcare.gov/sbc-glossary/#deductible), [provider,](https://www.healthcare.gov/sbc-glossary/#provider) or other underlined terms, see the Glossary. You can view the Glossary at [www.consociatehealth.com](http://www.consociatehealth.com) or call 1-800-798-2422 to request a copy. |

| **Important Questions** | **Answers** | **Why This Matters:** |
| --- | --- | --- |
| **What is the overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | **$1,000** person/ **$3,000** family for  HealthLink Open Access PPO, other PPO, and Non-PPO providers. | Generally, you must pay all of the costs from providers up to the [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount before this [plan](https://www.healthcare.gov/sbc-glossary/#plan) begins to pay. If you have other family members on the [plan](https://www.healthcare.gov/sbc-glossary/#plan), each family member must meet their own individual [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) until the total amount of [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) expenses paid by all family members meets the overall family [deductible](https://www.healthcare.gov/sbc-glossary/#deductible). |
| **Are there services covered before you meet your** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | Yes. [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care) and primary care services are covered before you meet your [deductible](https://www.healthcare.gov/sbc-glossary/#deductible). | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers some items and services even if you haven’t yet met the [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount. But a [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) or [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) may apply. For example, this [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers certain [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care) without [cost-sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) and before you meet your [deductible](https://www.healthcare.gov/sbc-glossary/#deductible). See a list of covered [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care) at <https://www.healthcare.gov/coverage/preventive-care-benefits/>. |
| **Are there other** [**deductibles**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | No. | There are no additional specific [deductible](https://www.healthcare.gov/sbc-glossary/#deductible)amounts before this [plan](https://www.healthcare.gov/sbc-glossary/#plan)begins to pay for these services. |
| **What is the** [**out-of-pocket**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)[**limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) **for this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**?** | **$2,500** person/ **$6,250** family for PPO providers and **$5,000** person / **$15,000** family for Non-PPO providers | The [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) is the most you could pay in a year for covered services. If you have other family members in this [plan](https://www.healthcare.gov/sbc-glossary/#plan), they have to meet their own [out-of-pocket limits](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) until the overall family [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) has been met. |
| **What is not included in the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)**?** | Premiums, balance-billed charges, dental or vision charges, prescription drug copayments, copayments, penalties for failure to obtain preauthorization, ineligible 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](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit). |
| **Will you pay less if you use a** [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** | Yes. See [**www.healthlink.com**](http://www.healthlink.com) for a list of participating providers and ***If elected*** see [**www.hfninc.com**](http://www.hfninc.com) for a list of participating providers within Knox, Tazewell and Peoria Counties in Illinois | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) uses a provider [network](https://www.healthcare.gov/sbc-glossary/#network). You will pay less if you use a [provider](https://www.healthcare.gov/sbc-glossary/#provider) in the plan’s [network](https://www.healthcare.gov/sbc-glossary/#network). You will pay the most if you use an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider), and you might receive a bill from a [provider](https://www.healthcare.gov/sbc-glossary/#provider) for the difference between the provider’s charge and what your [plan](https://www.healthcare.gov/sbc-glossary/#plan) pays ([balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). Be aware, your [network provider](https://www.healthcare.gov/sbc-glossary/#network-provider) might use an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) for some services (such as lab work). Check with your [provider](https://www.healthcare.gov/sbc-glossary/#provider) before you get services. |
| **Do you need a** [**referral**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)**?** | No. You do not need a referral to see a specialist. | A [referral](https://www.healthcare.gov/sbc-glossary/#referral) is not required to see a [specialist](https://www.healthcare.gov/sbc-glossary/#specialist)for covered services. |

|  |
| --- |
| Picture of exclamation point to label important informationAll [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) costs shown in this chart are after your [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) has been met, if a [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) applies. |

| **Common Medical Event** | **Services You May Need** | **What You Will Pay** | | | **Limitations, Exceptions, & Other Important Information** |
| --- | --- | --- | --- | --- | --- |
| **HealthLink Open Access Provider and (if elected)**  **HFN CHC Elite Provider in Knox and Peoria County** | **Network PPO Provider** | **Out-of-Network Provider**  **(You will pay the most)** |
| **If you visit a health care** [**provider’s**](https://www.healthcare.gov/sbc-glossary/#provider) **office or clinic** | Primary care visit to treat an injury or illness | $35 [copayment](https://www.healthcare.gov/sbc-glossary/#copayment)/visit (up to $200) then 10% coinsurance | $35 [copayment](https://www.healthcare.gov/sbc-glossary/#copayment)/visit (up to $200) then 20% coinsurance | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Chiropractic care is limited to $1,000 maximum per calendar year. |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit | $50 [copayment](https://www.healthcare.gov/sbc-glossary/#copayment)/visit (up to $200) then 10% coinsurance | $50 [copayment](https://www.healthcare.gov/sbc-glossary/#copayment)/visit (up to $200) then 20% coinsurance | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)/[screening](https://www.healthcare.gov/sbc-glossary/#screening)/  immunization | Covered at 100% | Covered at 100% | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | You may have to pay for services that aren’t [preventive](https://www.healthcare.gov/sbc-glossary/#preventive-care). Ask your [provider](https://www.healthcare.gov/sbc-glossary/#provider) if the services you need are preventive. Then check what your [plan](https://www.healthcare.gov/sbc-glossary/#plan) will pay for. |
| **If you have a test** | [Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (x-ray, blood work) | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | None |
| Imaging (CT/PET scans, MRIs) | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Services must be pre-certified to avoid a $250 penalty. |
| **If you need drugs to treat your illness or condition**  More information about [**prescription drug** **coverage**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) is available at  www.serve-you-rx.com | Generic drugs | $10/prescription (retail), and  $20/prescription (mail order) | | Not Covered (unless emergency) | If physician approves the use of a chemically equivalent generic drug and you request a brand name drug, you will pay the copayment plus the cost difference between the brand and generic. Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription). |
| Preferred brand drugs | $35/prescription (retail), and  $70/prescription (mail order) | |
| Non-preferred brand drugs | $50/prescription (retail), and $100/prescription (mail order) | |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) | Covered at applicable Rx co-pay. If not available under Rx program, covered under Major Medical. | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 15% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 15% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required |
| Physician/surgeon fees | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 15% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| **If you need immediate medical attention** | [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) | $150 [copayment](https://www.healthcare.gov/sbc-glossary/#copayment), then 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $150 [copayment](https://www.healthcare.gov/sbc-glossary/#copayment), then 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after Network PPO deductible | | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required if admitted |
| [Emergency medical transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | For facility-to-facility air ambulance transports, [preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required through Sentinel Air Medical Alliance: 1-877-542-8828. |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) | $35 [copayment](https://www.healthcare.gov/sbc-glossary/#copayment)/visit (up to $200) then 10% coinsurance | $35 [copayment](https://www.healthcare.gov/sbc-glossary/#copayment)/visit (up to $200) then 10% coinsurance | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required for all inpatient stays.  Limited to the semi-private room rate. |
| Physician/surgeon fees | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required |
| Inpatient services | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required for all inpatient stays |
| **If you are pregnant** | Office visits | $35 [copayment](https://www.healthcare.gov/sbc-glossary/#copayment)/visit (up to $200) then 10% coinsurance | $35 [copayment](https://www.healthcare.gov/sbc-glossary/#copayment)/visit (up to $200) then 20% coinsurance | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) does not apply to certain [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care). Depending on the type of services, [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required for some maternity stays |
| Childbirth/delivery professional services | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| Childbirth/delivery facility services | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| **If you need help recovering or have other special health needs**  **If you need help recovering or have other special health needs** | [Home health care](https://www.healthcare.gov/sbc-glossary/#home-health-care) | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Limited to 40 visits per calendar year. |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required. Physical, Occupational, and Speech Therapy limited to 25 visits each. |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Within 14 days of hospital confinement. [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchases and rental equipment (up to the purchase price). [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required. |
| **If your child needs dental or eye care** | Children’s eye exam | No charge | | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Limited to 1 exam between ages 3-5. |
| Children’s glasses | Not Covered | | | None |
| Children’s dental check-up | Not Covered | | | None |

**Excluded Services & Other Covered Services:**

| **Services Your** [**Plan**](https://www.healthcare.gov/sbc-glossary/#plan) **Generally Does NOT Cover (Check your policy or** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services)**.)** | | |
| --- | --- | --- |
| * Acupuncture * Bariatric surgery * Cosmetic surgery * Dental care (Adult) * Dental check-up (Child | * Glasses (Child) * Hearing aids * Infertility treatment * Long-term care * Non-emergency care when traveling outside the U.S. | * Private-duty nursing * Routine eye care (Adult) * Routine foot care * Weight loss programs |

| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document.)** | | |
| --- | --- | --- |
| * Chiropractic ($1,000 per calendar year) |  |  |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Consociate Health: 1-800-798-2422. 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](http://www.dol.gov/ebsa%20or%20the%20U.S). Department of Health and Human Services at 1-877-267-232 x 61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance](https://www.healthcare.gov/sbc-glossary/#health-insurance) [Marketplace.](https://www.healthcare.gov/sbc-glossary/#marketplace) For more information about the [Marketplace,](https://www.healthcare.gov/sbc-glossary/#marketplace) visit [www.HealthCare.gov](http://www.healthcare.gov/) or call 1-800-318- 2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](https://www.healthcare.gov/sbc-glossary/#plan) for a denial of a [claim.](https://www.healthcare.gov/sbc-glossary/#claim) This complaint is called a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) or [appeal.](https://www.healthcare.gov/sbc-glossary/#appeal) For more information about your rights, look at the explanation of benefits you will receive for that medical [claim.](https://www.healthcare.gov/sbc-glossary/#claim) Your [plan](https://www.healthcare.gov/sbc-glossary/#plan) documents also provide complete information on how to submit a [claim,](https://www.healthcare.gov/sbc-glossary/#claim) [appeal,](https://www.healthcare.gov/sbc-glossary/#appeal) or a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) for any reason to your [plan.](https://www.healthcare.gov/sbc-glossary/#plan) For more information about your rights, this notice, or assistance, contact: Consociate Health: 1-800-798-2422.

**Does this plan provide Minimum Essential Coverage?** **Yes**

[Minimum Essential Coverage](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) generally includes [plans](https://www.healthcare.gov/sbc-glossary/#plan), [health insurance](https://www.healthcare.gov/sbc-glossary/#health-insurance) available through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage,](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) you may not be eligible for the [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits).

**Does this plan meet the Minimum Value Standards?** **Yes**

If your [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn’t meet the [Minimum Value Standards,](https://www.healthcare.gov/sbc-glossary/#minimum-value-standard) you may be eligible for a [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits) to help you pay for a [plan](https://www.healthcare.gov/sbc-glossary/#plan) through the [Marketplace.](https://www.healthcare.gov/sbc-glossary/#marketplace)

**Language Access Services:**

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-798-2422

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-798-2422

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-798-2422

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-798-2422

***To see examples of how this*** [***plan***](https://www.healthcare.gov/sbc-glossary/#plan) ***might cover costs for a sample medical situation, see the next section.***

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number.  The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection.  If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports ClearanceOfficer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**About these Coverage Examples:**

|  |
| --- |
| Picture of exclamation point to label important information**This is not a cost estimator.** Treatments shown are just examples of how this [plan](https://www.healthcare.gov/sbc-glossary/#plan) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](https://www.healthcare.gov/sbc-glossary/#provider) charge, and many other factors. Focus on the [cost-sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) amounts ([deductibles](https://www.healthcare.gov/sbc-glossary/#deductible), [copayments](https://www.healthcare.gov/sbc-glossary/#copayment) and [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance)) and [excluded services](https://www.healthcare.gov/sbc-glossary/#excluded-services) under the [plan](https://www.healthcare.gov/sbc-glossary/#plan). Use this information to compare the portion of costs you might pay under different health [plans](https://www.healthcare.gov/sbc-glossary/#plan). Please note these coverage examples are based on self-only coverage. |

**Peg is Having a Baby**

(9 months of in-network pre-natal care and a hospital delivery)

* The [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) overall [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) $1,000

◼ [Primary](https://www.healthcare.gov/sbc-glossary/#specialist) [copayment](https://www.healthcare.gov/sbc-glossary/#cost-sharing) $35

◼ Hospital (facility) [coinsurance](https://www.healthcare.gov/sbc-glossary/#cost-sharing) 20%

◼ Other [coinsurance](https://www.healthcare.gov/sbc-glossary/#cost-sharing) 20%

**This EXAMPLE event includes services like:**

[Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) office visits *(prenatal care)*

Childbirth/Delivery Professional Services

Childbirth/Delivery Facility Services

[Diagnostic tests](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) *(ultrasounds and blood work)*

[Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
| --- | --- |
| **In this example, Peg would pay:** |  |
| *Cost Sharing* | |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $1,000 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $35 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $1,500 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$2,535** |

**Managing Joe’s Type 2 Diabetes** (a year of routine in-network care of a well- controlled condition)

* The [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) overall [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) $1,000

◼ [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) [copayment](https://www.healthcare.gov/sbc-glossary/#cost-sharing) $50

◼ Hospital (facility) [coinsurance](https://www.healthcare.gov/sbc-glossary/#cost-sharing) 20%

◼ Other [coinsurance](https://www.healthcare.gov/sbc-glossary/#cost-sharing) 20%

**This EXAMPLE event includes services like:**

[Primary care physician](https://www.healthcare.gov/sbc-glossary/#primary-care-physician) office visits *(including disease education)*

[Diagnostic tests](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) *(blood work)*

[Prescription drugs](https://www.healthcare.gov/sbc-glossary/#prescription-drugs)

[Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) *(glucose meter)*

| **Total Example Cost** | **$5,600** |
| --- | --- |
| **In this example, Joe would pay:** |  |
| *Cost Sharing* | |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $1,000 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $500 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $820 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$2,320** |

**Mia’s Simple Fracture**

(in-network emergency room visit and follow up care)

* The [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) overall [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) $1,000

◼ [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) & ER [copayment](https://www.healthcare.gov/sbc-glossary/#cost-sharing) $200

◼ Hospital (facility) [coinsurance](https://www.healthcare.gov/sbc-glossary/#cost-sharing) 20%

◼ Other [coinsurance](https://www.healthcare.gov/sbc-glossary/#cost-sharing) 20%

**This EXAMPLE event includes services like:**

[Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) *(including medical supplies)*

[Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (*x-ray*)

[Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) *(crutches)*

[Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) *(physical therapy)*

| **Total Example Cost** | **$2,800** |
| --- | --- |
| **In this example, Mia would pay:** |  |
| *Cost Sharing* | |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $1,000 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $200 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $320 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,520** |

The [plan](https://www.healthcare.gov/sbc-glossary/#plan) would be responsible for the other costs of these EXAMPLE covered services.