This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.nhp.org** or by calling the Member Service Center at **1-800-462-5449 (toll free) or 1-800-655-1761 (TTY)**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250**/Individual **$500**/Family Doesn't apply to preventive visits, most outpatient visits, behavioral health services, prescription drug coverage, and urgent care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1). 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. **$250**/Individual **$500**/Family for prescription drug coverage. There are no other specific deductibles.	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**/Individual **$10,000**/Family for medical expenses and **$2,000**/Individual **$4,000**/Family for prescription drug coverage.	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for your health care expenses.
What is not included in the out-of-pocket limit?	Medical service copays less than $100, premiums, and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **in-network providers**, see www.nhp.org or call 1-800-462-5449.	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. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term **in-network**, **preferred**, or **participating** for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes, you need a written or oral 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 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-462-5449 (toll free) or 1-800-655-1761 (TTY)** or visit us at **www.nhp.org.**
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.nhp.org** or call the Member Service Center at **1-800-462-5449 (toll free) or 1-800-655-1761 (TTY)** to request a copy.

- **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. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays 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 in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

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	$25 copay/visit	Not covered.	None.
	Specialist visit	$40 copay/visit	Not covered.	None.
	Other practitioner office visit	$25 copay/visit for chiropractor	Not covered.	Chiropractic care is covered up to 10 visits per member per benefit year.
	Preventive care/ screening/immunization	No charge	Not covered.	None.
If you have a test	Diagnostic test (x-ray, blood work)	35% coinsurance after deductible	Not covered.	None.
	Imaging (CT/PET scans, MRIs)	35% coinsurance after deductible	Not covered.	May require prior authorization.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.nhp.org	Generic drugs	Retail: $15 copay Maintenance 90: $30 copay	Not covered.	None.
	Preferred brand drugs	Retail: 50% coinsurance after Rx deductible Maintenance 90: 50% coinsurance on cost of 60-day prescription after Rx deductible	Not covered.	May require prior authorization.
	Non-preferred brand drugs	Retail: 50% coinsurance after Rx deductible Maintenance 90: 50% coinsurance on cost of 60-day prescription after Rx deductible	Not covered.	May require prior authorization.
	Specialty drugs	Generic: $15 Preferred or non-preferred brand-name: 50% coinsurance after Rx deductible	Not covered.	Copay based on tier of specialty drug. Prior authorization required for specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	35% coinsurance after deductible	Not covered.	May require prior authorization.
	Physician/surgeon fees	No charge	Not covered.	None.
If you need immediate medical attention	Emergency room services	$150 copay/visit	$150 copay/visit	Emergency room copay waived admitted to hospital.
	Emergency medical transportation	35% coinsurance after deductible	35% coinsurance after deductible	None.
	Urgent care	$25 copay/visit	$25 copay/visit	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	35% coinsurance after deductible	Not covered.	May require prior authorization.
	Physician/surgeon fee	No charge	Not covered.	None.

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	$25 copay/visit	Not covered.	8 initial visits, then authorization required for additional visits.
	Mental/Behavioral health inpatient services	No charge.	Not covered.	May require prior authorization.
	Substance use disorder outpatient services	$25 copay/visit	Not covered.	8 initial visits, then authorization required for additional visits.
	Substance use disorder inpatient services	No charge.	Not covered.	May require prior authorization.
If you are pregnant	Prenatal and postnatal care	$40 copay/visit	Not covered.	None.
	Delivery and all inpatient services	35% coinsurance after deductible	Not covered.	May require prior authorization.
If you need help recovering or have other special health needs	Home health care	No charge.	Not covered.	May require prior authorization.
	Rehabilitation services	Outpatient: $40 copay/visit Inpatient: 35% coinsurance after deductible	Not covered.	**Outpatient**: Covered up to 90 consecutive days per condition for Physical Therapy/Occupational Therapy. **Inpatient:** Covered up to 60 days per calendar year. Prior authorization required.
	Habilitation services	Outpatient: $40 copay/visit Inpatient: 35% coinsurance after deductible	Not covered.	**Outpatient**: Covered up to 90 consecutive days per condition for Physical Therapy/Occupational Therapy. **Inpatient:** Covered up to 60 days per calendar year. Prior authorization required.
	Skilled nursing care	35% coinsurance after deductible	Not covered.	Covered up to 100 days per calendar year. May require prior authorization.

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	Durable medical equipment	35% coinsurance after deductible	Not covered.	May require prior authorization.
	Hospice service	No charge.	Not covered.	May require prior authorization.
If your child needs dental or eye care	Eye exam	$15 copay/visit	Not covered.	Covered up to one eye exam every 12 months per child covered under this plan.
	Glasses	Not covered.	Not covered.	None.
	Dental check-up	No charge.	Not covered.	Covered up to one dental check up every 12 months per child covered under this plan.

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.)

- Acupuncture
- Cosmetic surgery
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (except for certain medical conditions)
- Weight loss programs (except approved medically supervised programs)

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.)

- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-462-5449. 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. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 questions about your rights, this notice, or assistance, you can contact: the Member Service Center at **1-800-462-5449 (toll free) or 1-800-655-1761 (TTY)**.

Language Access Services:

Para obtener asistencia en Español, llame al **1-800-462-5449.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,079
- **Patient pays** $1,461

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$250
Copays	$261
Coinsurance	$950
Limits or exclusions	$0
Total	**$1,461**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,227
- **Patient pays** $973

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$18
Copays	$915
Coinsurance	$0
Limits or exclusions	$40
Total	**$973**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles, copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.