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 **http://secure.healthx.com/cnic_new.aspx** or by calling **1-877-229-4541**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,500** single person/**$5,000** family Copays don't apply toward deductible. Deductible waived for network office visit, first $1,000 of lab or X-ray, mammogram, preadmission testing, preventive care, prenatal visits, and prescription drug charges.	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 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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan offers.
Is there an out–of–pocket limit on my expenses?	Yes. **Single/Family** Network Tier 1 **$6,000/$12,000** Network Tier 2 **$6,500/$13,000** Non-Network **$11,500/$23,000**	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 health care expenses.
What is not included in the out–of–pocket limit?	Premiums, cost containment penalties, health care charges not covered by this plan, and charges over reasonable and customary.	Even though you pay these expenses, they don't 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. See http://secure.healthx.com/cnic_new.aspx or call **1-877-229-4541**	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?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
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.**

- **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 the **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider Tier 1	Your Cost if You Use a Network Provider Tier 2	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/ visit	$35 copay/ visit	50% coinsurance	---------------------------None---------------------------
	Specialist visit	$75 copay/ visit	$75 copay/ visit	50% coinsurance	---------------------------None---------------------------
	Other practitioner office visits	No charge	20% coinsurance	50% coinsurance	Acupuncture is limited to charges for anesthesia and pain management with a $1,000 per calendar year maximum. TMJ charges are limited to $2,000 per lifetime.
	Preventive care/ screening/immunizations	No charge	No charge	No charge	Preventive colonoscopy limited to 1 every 5 years.
If you have a test	Diagnostic test (X-ray, blood work)	No charge up to $1,000; then no charge	No charge up to $1,000; then 20% coinsurance	No charge up to $1,000; then 50% coinsurance	The plan pays the first $1,000 in lab or X-ray charges, thereafter deductible and appropriate tier coinsurance applies.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	50% coinsurance	Precertification is required for non-emergency Imaging. Payment will be reduced by $250 if precertification is not obtained.

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider Tier 1	Your Cost if You Use a Network Provider Tier 2	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. **More information about prescription drug coverage is available at** www.pti-nps.com	Preferred generic drugs	$0 per prescription retail and mail order		N/A	Except for Specialty drugs, retail will provide a 30-day supply (1 copay) or up to a 90-day supply (3 copays); mail order will provide a 90-day supply (2 ½ copays). Specialty drugs: (1) are limited to a 30-day supply, (2) are not available through mail order, (3) must be purchased from NPS Walgreens Specialty Pharmacy, (4)always require the specialty drug copay, and (5) require precertification or payment will be reduced by $250. If a brand name drug is chosen when a generic is available, the cost will be the brand drug copay plus the difference between the generic and brand name drug. The difference in cost will not accrue toward the out-of-pocket maximum. However, if a Provider recommends a particular contraceptive service or FDA-approved contraceptive item based on medical necessity, the service or item is covered at 100%.
	Non-preferred generic drugs	$20 per prescription retail; $50 per prescription mail order		N/A	
	Preferred brand name drugs	$45 per prescription retail; $112.50 per prescription mail order		N/A	
	Non-preferred brand name drugs	$85 per prescription retail; $212.50 per prescription mail order		N/A	
	Specialty drugs	$250 per prescription		N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center);	No charge	20% coinsurance	$500 copay/ visit 50% coinsurance	Precertification is required for all outpatient surgeries. Payment will be reduced by $250 if precertification is not obtained. Copayment applies only to a non-network facility.
	Physician/surgeon fees	No charge	20% coinsurance	50% coinsurance	---------------------------None----------------------------
If you need immediate medical attention	Emergency room services	No charge	No charge	No charge	$250 Penalty for non-emergency use. All emergency room related charges are covered at the Tier 1 level. Non-network charges are subject to reasonable and customary.
	Emergency medical transportation	No charge	No charge	No charge	---------------------------None-----------------------------
	Urgent care	$35 copay/ visit	$35 copay/ visit	50% coinsurance	Allergy injections without other services subject to deductible and coinsurance.

Common Medical Events	Services You May Need	Your Cost if You Use a Network Provider Tier 1	Your Cost if You Use a Network Provider Tier 2	Your Cost if You Use a Non-Network Provider	Limitations and Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	$1,000 copay/ admission 50% coinsurance	Precertification is required for all hospitalizations. Payment will be reduced by $250 if precertification is not obtained. Copayment applies only to a non-network facility.
	Physician/surgeon fee	No charge	20% coinsurance	50% coinsurance	---------------------------None---------------------------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	20% coinsurance	$500 copay/ facility visit 50% coinsurance	Copayment applies only to a non-network facility.
	Mental/Behavioral health office visit	$35 copay/ visit	$35 copay/ visit	50% coinsurance	---------------------------None---------------------------
	Mental/Behavioral health inpatient services	No charge	20% coinsurance	$1,000 copay/ admission 50% coinsurance	Precertification is required for all hospitalizations. Payment will be reduced by $250 if precertification is not obtained. Copayment applies only to a non-network facility.
	Substance use disorder inpatient or outpatient services	Not covered	Not covered	Not covered	Substance use disorder services are not covered.
If you are pregnant	Prenatal and postnatal care	No charge for prenatal visits; No charge for other services	No charge for prenatal visits; No charge for other services	No charge for prenatal visits; No charge for other services	Routine prenatal visits (to include certain lab services, tobacco cessation counseling and certain immunizations as required by applicable regulations) – **no cost share (if billed in office visit setting).** All pregnancy related charges are covered at the Tier 1 level. Non-network charges are subject to reasonable and customary.
	Delivery and all inpatient services	No charge	No charge	No charge	

Common Medical Events	Services You May Need	Your Cost if You Use a Network Provider Tier 1	Your Cost if You Use a Network Provider Tier 2	Your Cost if You Use a Non-Network Provider	Limitations and Exceptions
If you need help recovering or have other special health need	Home health care	No charge	20% coinsurance	50% coinsurance	Limited to 90 visits per calendar year.
	Rehabilitation services	No charge	20% coinsurance	50% coinsurance	Includes occupational, physical, respiratory and speech therapies. Excludes occupational therapy supplies and any amount covered by Workers' Compensation.
	Habilitation services	No charge	20% coinsurance	50% coinsurance	
	Skilled nursing care	No charge	20% coinsurance	50% coinsurance	Limited to 90 days per calendar year.
	Durable Medical Equipment	No charge	20% coinsurance	50% coinsurance	Precertification required for charges over $250. Payment will be reduced by $250 if precertification is not obtained.
	Hospice service	No charge	20% coinsurance	50% coinsurance	Includes bereavement counseling.
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 or plan document for other excluded services.)

- Acupuncture except for anesthesia and pain management to an annual limit of $1,000.
- Bariatric surgery
- Cosmetic surgery except when the result of a congenital anomaly, disease or accident.
- Dental Care (Adult)
- Hearing aids
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside of the United States
- Routine eye care (Adult)
- Routine foot care
- Weight loss 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.)

- Chiropractic care
- Private duty nursing limited to $2,000 per year and $5,000 in a lifetime

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 1-877-229-4541. 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.cms.gov/cciio/.

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-877-229-4541**.

Does this Coverage Provide Minimum Essential Coverage and Meet the Minimum Value Standard?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage" and establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This plan or policy does provide minimum essential coverage. This health coverage does meet the minimum value standard for the benefits it provides.**

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:** $4,140
- **Patient pays:** $2,500

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	$2,500
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$2,500**

*Note: *Hospital charge (baby)* applies to baby's deductible. Thus, *Amount owed to providers* does not include this cost (subtract $900 *Hospital charges (baby)* from $7,540 total *Amount owed to providers* = $6,640).

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,590
- **Patient pays:** $1,810

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	$1,810
Copays	$210
Coinsurance	$0
Limits or exclusions	$0
Total	**$1,810**

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.