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://senderohealth.com/idealcareeng/benefits.html or by calling 1-844-800-4693.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** individual/ **$1,000** family	For services that are paid based on coinsurance, 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 your costs for services this plan covers
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 covers.
Is there an out–of–pocket limit on my expenses?	**Yes. $2,350** individual/ **$4,700** family	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** and health care this plan doesn't cover.	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**. For a list of in-network providers, see http://senderohealth.com/idealcareeng/providers.html or call 1-844-800-4693	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs for covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the terms 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**.	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 the 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 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	$10 copay per visit	Not covered	Copayment (Copay) per visit.
	Specialist visit	$30 copay per visit	Not covered	Copay per visit.
	Other practitioner office visit	$30 copay per visit for Habilitation and Rehabilitation $10 copay per visit all others	Not covered	Habilitation/Rehabilitation includes: Chiropractors, Physical Therapists (PT), Occupational Therapists (OT) and Speech Therapists (ST). Copay per visit. Pre-authorization may apply. Acupuncture: Not Covered
	Preventive care/screening/immunization	No Charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance per occurrence	Not covered	None. Coinsurance per occurrence.
	Imaging (CT/PET scans, MRIs)	10% coinsurance per occurrence	Not covered	None. Coinsurance per occurrence.
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is	Generic drugs	$5 copay per occurrence	Not covered	Covers up to a 30 day supply. Certain preventative drugs are covered with no copay. Oral & injectable fertility drugs are excluded. Copay and coinsurance per
	Preferred brand drugs	$8 copay per occurrence	Not covered	
	Non-preferred brand drugs	$20 copay per occurrence	Not covered	

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
available at http://senderohealth.com/idealcareeng/formulary.html.	Specialty drugs	30% coinsurance per occurrence	Not covered	occurrence.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	28% coinsurance per occurrence	Not covered	None. Coinsurance per occurrence.
	Physician/surgeon fees	20% coinsurance per occurrence	Not covered	None. Coinsurance per occurrence.
If you need immediate medical attention	Emergency room services	$200 copay per visit after deductible	$200 copay per visit after deductible	Copay per visit. Emergency room services copay is waived if admitted and inpatient copay applies.
	Emergency medical transportation	$150 copay per transport after deductible	$150 copay per transport after deductible	Copay per transport.
	Urgent care	$40 copay per visit	Not covered	Copay per visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay per stay	Not covered	Copay per stay.
	Physician/surgeon fee	No Charge	Not covered	Copay per stay.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copay per visit	Not covered	Copay per visit.
	Mental/Behavioral health inpatient services	$150 copay per admission	Not covered	Copay per admission.
	Substance use disorder outpatient services	$10 copay per visit	Not covered	Copay per visit.
	Substance use disorder inpatient services	$150 copay per admission	Not covered	Copay per admission.
If you are pregnant	Prenatal and postnatal care	$10 copay per initial prenatal visit	Not covered	Copay per initial visit and delivery. No charge for subsequent prenatal visits with the same provider or provider group per pregnancy. Depending on

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
	Delivery and all inpatient services	$450 copay per delivery after deductible	Not covered	the type of services, coinsurance may apply. Maternity care does not include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	10% coinsurance per occurrence	Not covered	Limited to 60 visits per year. Coinsurance per occurrence.
	Rehabilitation services	$30 copay per visit	Not covered	Habilitation/Rehabilitation includes: Chiropractors, Physical Therapist (PT), Occupational Therapists (OT) and Speech Therapist (ST). Copay per visit. Pre-authorization may apply. Acupuncture: Not Covered
	Habilitation services	$30 copay per visit	Not covered	
	Skilled nursing care	$150 copay per stay	Not covered	Limited to 25 days per year. Copay per visit.
	Durable medical equipment	10% coinsurance per occurrence	Not covered	None. Coinsurance per occurrence.
	Hospice service	10% coinsurance	Not covered	None. Coinsurance per occurrence.
If your child needs dental or eye care	Eye exam	$30 copay per visit	Not covered	Limited to one (1) visit per year. Copay per visit.
	Glasses	10% coinsurance per occurrence	Not covered	Limited to contact lenses or 1 pair of glasses (frames and lenses) per calendar year for members 0-19 years of age. Limited to the end of the plan year in which age 19 is reached.
	Dental check-up	Not covered	Not covered	Available through a separate offering.

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
- Bariatric surgery
- Cosmetic surgery
- Dental Care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 is combined with habilitation/rehabilitation (PT, OT, ST, and Chiropractic Services)
- Hearing aids are limited to 1 per ear every 3 years
- Infertility treatment is limited to diagnostic services only. Treatment to correct the infertility condition and services such as in vitro fertilization and artificial insemination are excluded from coverage.
- Routine eye care (Adult) is limited to 1 eye exam per calendar year.
- Routine foot care is limited to foot care in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.

Your Rights to Continue Coverage: Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside of the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-844-800-4693. You may also contact your state insurance department at 1-800-578-4677.

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 insurer at 1-844-800-4693. You may also contact your state insurance department at 1-800-578-4677.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Questions: Call 1-844-800-4693 or visit us at http://senderohealth.com/idealcareeng. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cms.gov/cciio or call 1-800-318-2596 to request a copy.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-800-4693.

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** $6,340
- **Patient pays** $1,200

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	$500
Copays	$500
Coinsurance	$100
Limits or exclusions	$100
Total	**$1,200**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,080
- **Patient pays** $2,320

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	$100
Copays	$400
Coinsurance	$20
Limits or exclusions	$1,800
Total	**$2,320**

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.