

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services





Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition.</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>.</p>	Generic drugs (Tier 1)	Benefits are applied by outside vendor	Benefits are applied by outside vendor	None
	Preferred brand drugs (Tier 2)	Benefits are applied by outside vendor	Benefits are applied by outside vendor	
	Non-preferred brand drugs (Tier 3)	Benefits are applied by outside vendor	Benefits are applied by outside vendor	
	<a href="#">Specialty drugs</a> (Tier 4)	Benefits are applied by outside vendor	Benefits are applied by outside vendor	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory)			

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If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	\$20 Copay per visit; Deductible Waived Office visits; 20% Coinsurance other outpatient services	40% Coinsurance	<a href="#">Preauthorization</a> is required for Partial <a href="#">hospitalization</a> .
	Inpatient services	20% Coinsurance	40% Coinsurance	<a href="#">Preauthorization</a> is required.

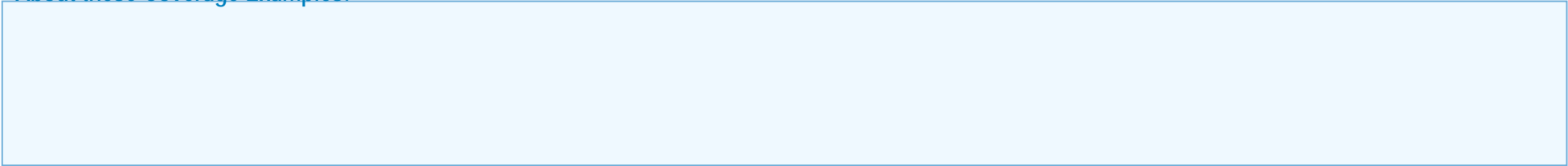
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% Coinsurance	40% Coinsurance	<a href="#">Preauthorization</a> is required.
	<a href="#">Rehabilitation services</a>	\$20 Copay per visit; Deductible Waived office therapy; 20% Coinsurance hospital therapy	40% Coinsurance	90 Maximum visits per calendar year OT; 90 Maximum visits per calendar year PT; 40 Maximum visits per calendar year ST; Habilitation services for Learning Disabilities are not covered.
	<a href="#">Habilitation services</a>	\$20 Copay per visit; Deductible Waived office therapy; 20% Coinsurance hospital therapy	40% Coinsurance	
	<a href="#">Skilled nursing care</a>	20% Coinsurance		
	<a href="#">Durable medical equipment</a>	20% Coinsurance	40% Coinsurance	None
	<a href="#">Hospice service</a>			

Excluded Services & Other Covered Services:

Services Your [Plan](#) Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long
- Routine foot care
- Weight loss programs

About these Coverage Examples:



**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

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

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*pre-natal care*)

Childbirth/Delivery Professional Services

Childbirth/Delivery Facility Services

[Diagnostic tests](#) (*ultrasounds and blood work*)

[Specialist visit](#) (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay: Ct8 (9TJ ET Q q 220.8 234.88 49.2 15 re W n BT /CS0 cs 0 scn /TT1 1 Tf 12 -0 0 12 234.08 180.Tm (\$)Tj ET Q q 220.8 162.88 49.2 15 r

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$