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.accesshma.com/MemberPage.aspx by calling (800)-869-7093.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	There is no deductible for this plan.	
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 possible costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	An out-of-pocket limit does not apply to this plan.	
What is not included in the out-of-pocket limit?	An out-of-pocket limit does not apply to this plan.	
Is there an overall annual limit on what the plan pays?	No.	
Does this plan use a network of providers ?	Yes. See **www.accesshma .com** or call **1-866-738-3924** for a list of Preferred providers.	If you use a Preferred or Participating doctor or other health care **provider** , this plan will pay some or all of the costs of covered services . Be aware, your Preferred or Participating doctor or hospital may use an out-of-network **provider** for some services. Plans use the terms **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, $20) 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 will change if you haven't met your **deductible** .
- The amount the plan pays for covered services is based on the **allowed amount** . If you have services from an out-of-network you may have to pay all charges. For example, if an out-of-network hospital charges $1,500 for an overnight stay you may have to pay the $1,500.
- This plan may encourage you to use preferred **providers** by charging you lower **deductibles** , **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	No charge	Limited to general practice, OB/Gyn, internal medicine, pediatrics and family practice.
	Specialist visit	No charge	No charge	———none———
	Other practitioner office visit	Chiropractic Care No charge Dietary Education No charge	Chiropractic Care No charge Dietary Education No charge	
	Preventive care/screening/immunization	No charge		———none———
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	———none———
	Imaging (CT/PET scans, MRIs)	No charge	No charge	———none———

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling (800) 451-6245.	Generic drugs	No charge 90 day supply limit		No Performance Drug List Covers up to a 90-day supply (retail or mail order prescription.)
	Brand Name drugs On Performance Drug List	No charge 90 day supply limit		
	Brand Name drugs Not on Performance Drug List	No charge 90 day supply limit		
	Specialty drugs	Express Scripts, your prescription drug vendor, for applicable cost.		Please see Prescription Drug Benefit section within your Plan Document for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Preauthorization is recommended 5 days prior to all inpatient admissions (excluding obstetrical) and outpatient surgeries.
	Physician/surgeon fees	No charge	No charge	———none———
If you need immediate medical attention	Emergency room services	No charge		———none———
	Emergency medical transportation	No charge		———none———
	Urgent care	No charge	No charge	———none———
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Preauthorization is recommended 5 days prior to all inpatient admissions (excluding obstetrical) and outpatient surgeries.
	Physician/surgeon fee	No charge	No charge	———none———

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	No charge	Marriage and Family Therapy are not covered.
	Mental/Behavioral health inpatient services	No charge	No charge	———none———
	Substance use disorder outpatient services	No charge	No charge	———none———
	Substance use disorder inpatient services	No charge	No charge	———none———
If you are pregnant	Prenatal and postnatal care	No charge	No charge	———none———
	Delivery and all inpatient services	No charge	No charge	Services should be pre-authorized for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay.
If you need help recovering or have other special health needs	Home health care	No charge		Limited to 130 visits per calendar year.
	Rehabilitation services	No charge	No charge	Swim Therapy is not covered. Inpatient services preauthorization is recommended.
	Habilitation services	Not covered		Not covered.
	Skilled nursing care	No charge	No charge	
	Durable medical equipment	No charge		Purchase of DME over $1000 should be reviewed by HMA's UR Coordinator.
	Hospice service	No charge		Lifetime maximum six months. Inpatient coverage limited to 14 days.
If your child needs	Eye exam	Not covered		Not covered under this plan

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Participating Provider	Limitations & Exceptions
dental or eye care	Glasses	Not covered		Not covered under this plan
	Dental check-up	Not covered		Not 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
- Bariatric Surgery
- Cosmetic Surgery
- Dental care (Adult)
- Dental check-up
- Glasses
- Habilitation services
- Infertility
- Long Term Care
- Routine Foot Care
- Vision exam (Child)
- 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
- Hearing Aids
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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 (800)-869-7093. 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 plan at 1-866-738-3924. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

Does the 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.

Questions: Call **(800)-869-7093** or visit us at www.accesshma.com/MemberPage.aspx.
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.cciio.cms.gov or call (800)-869-7093 to request a copy.

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** $7,390
- **Patient pays** $150

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	$0
Co pays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$150**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $5,010
- **Patient pays** $390

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	$0
Co pays	$0
Coinsurance	$0
Limits or exclusions	$390
Total	**$390**

Questions and answers about the Coverage Example s:

What are some of the assumptions behind the Coverage Example s?

- 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 Preferred **providers**. If the patient had received care from Participating **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 Example s 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 plan s?

✓ **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.