



**This is only a summary.** *This plan only pays cost sharing amounts under a specific group medical plan.* If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document for this plan and the specific group medical plan at [www.claritybenefitsolutions.com](http://www.claritybenefitsolutions.com) or by calling 1-888-423-6359

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	This plan has no <u>out-of-pocket limit</u>	Not applicable because there's no <u>out-of-pocket limit</u> on your expenses.
Is there an overall annual limit on what the plan pays?	Yes, up to the individual's account balance	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes specific coverage limits.
Does this plan use a <u>network of providers</u> ?	No.	This plan treats <u>providers</u> the same in determining payment for the same services.
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan does not cover are listed on page 4. See your policy or plan document for additional information about <u>excluded services</u> .

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- **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**.)
- Your cost sharing does not depend on whether a **provider** is in a network.

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	No Charge for amounts subject to cost sharing under specific group medical plan	Coverage (a) limited to amounts subject to cost sharing under specific group medical plan, and (b) limited to individual's account balance
	Specialist visit		
	Other practitioner office visit		
	Preventive care/screening/immunization		
If you have a test	Diagnostic test (x-ray, blood work)		
	Imaging (CT/PET scans, MRIs)		
If you need drugs to treat your illness or condition	Generic drugs		
	Preferred brand drugs		
	Non-preferred brand drugs		
	Specialty drugs		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)		
	Physician/surgeon fees		

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Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	No Charge for amounts subject to cost sharing under specific group medical plan	Coverage (a) limited to amounts subject to cost sharing under specific group medical plan, and (b) limited to individual's account balance
	Emergency medical transportation		
	Urgent care		
If you have a hospital stay	Facility fee (e.g., hospital room)		
	Physician/surgeon fee		
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		
	Mental/Behavioral health inpatient services		
	Substance use disorder outpatient services		
	Substance use disorder inpatient services		
If you are pregnant	Prenatal and postnatal care		
	Delivery and all inpatient services		
If you need help recovering or have other special health needs	Home health care		
	Rehabilitation services		
	Habilitation services		
	Skilled nursing care		
	Durable medical equipment		
	Hospice service		
If your child needs dental or eye care	Eye exam		
	Glasses		
	Dental check-up		

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## 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.)

- Amounts other than those subject to the **deductible** under specific group medical plan
- Amounts that exceed the individual's account balance
- Out of Network Expenses

### Other Covered Services (Check your policy or plan document of for the specific group medical plan for covered services under that plan and your costs for these services.)

- This plan only covers **deductible** expenses under the specific group medical plan
- Prescriptions

## 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 516-869-2453. You may also contact government agencies including your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://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 516-869-2453, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

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## Language Access Services:

☒ [X] [Spanish (Español): Para obtener asistencia en Español, llame al]

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

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## 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 (after cost sharing under specific group medical plan)
- **Plan pays up to individual's account balance**
- **Patient pays remainder**

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays under this plan:

Deductibles	\$0
Copays	\$0
Coinsurance	\$0
Limits or exclusions	-
<b>Total</b>	<b>*</b>

\* Amount in excess of individual's account balance

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

- **Amount owed to providers:** \$5,400 (after cost sharing under specific group medical plan)
- **Plan pays up to individual's account balance**
- **Patient pays remainder**

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays under this plan:

Deductibles	\$0
Copays	\$0
Coinsurance	\$0
Limits or exclusions	-
<b>Total</b>	<b>*</b>

\* Amount in excess of individual's account balance

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs do not 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.
- Expenses are *only* those referring to the deductible under a specific group medical plan.

### 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 consider the coverage under the specified group health plan. You should also consider contributions to other accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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