|  |  |
| --- | --- |
| **Exclamation** | **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.BollingerColleges.com/LCB** or by calling **1-866-267-0092**. |

|  |  |  |
| --- | --- | --- |
| **Important Questions** | **Answers** | **Why this Matters:** |
| **What is the overall deductible?** | **$2,000 in network \ $4,000 out of network** per Policy Year.  Does not apply to In-Network preventative and wellness services. | 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 must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. **$5,000 per Individual /**  **$10,000 per Family per** Policy Year. | 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, balance-billed charges, 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. | Coverage is limited to $500,000 aggregate maximum per Policy Year. 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 **www.FirstHealth.com**  or call **1-800-226-5116** for a list of participating providers. | If you use an in-network doctor or other health care **provider**, thisplan 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 participatingfor **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. | OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146  Some of the services thisplan doesn’t cover are listed on page 4. See your policy or plan document for additional information about **excluded services**. |

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| **Exclamation** | * **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service. * **Co-insurance** 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 c**o-insurance** 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**, **co-payments** and **co-insurance** amounts. |

| **Common  Medical Event** | **Services You May Need** | **Your cost if you use a** | | **Limitations & Exceptions** |
| --- | --- | --- | --- | --- |
| **In-Network Provider** | **Out of Network Provider** |
| **If you visit a health care provider’s office or clinic** | Primary care visit to treat an injury or illness | $15 co-pay/visit and 30% co-insurance | $15 co-pay/visit and 50% co-insurance | Services that are normally provided without charge at the student health center are not covered. |
| Specialist visit | $15 co-pay/visit and 30% co-insurance | $15 co-pay/visit and 50% co-insurance |
| Other practitioner office visit | 30% co-insurance | 50% co-insurance |
| Preventive care/screening/immunization | No charge | 40% co-insurance | –––––––––––none––––––––––– |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% co-insurance | 50% co-insurance | –––––––––––none––––––––––– |
| Imaging (CT/PET scans, MRIs) | 20% co-insurance | 40% co-insurance |
| **If you need drugs to treat your illness or condition**  More information about **prescription drug coverage** is available at www.caremark.com. | Generic drugs  Brand name | $15 co-payment for generic  $35 co-payment for brand name  or  $50 co-payment for specialty drugs, per prescription | |  |
| Specialty drugs |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% co-insurance | 50% co-insurance | –––––––––––none––––––––––– |
| Physician/surgeon fees | 30% co-insurance | 50% co-insurance | –––––––––––none––––––––––– |
| **If you need immediate medical attention** | Emergency room services | $250 co-pay/visit  and 30% co-insurance | $250 co-pay/visit and 30% co-insurance | Services that are normally provided without charge at the student health center are not covered. Copay waived, if Admitted. A true Medical Emergency will be considered at In Network co-insurance amounts |
| Emergency medical transportation | 30% co-insurance | 30% co-insurance | Medical Emergency covered at In Network co-insurance amounts |
| Urgent care | 30% co-insurance | 50% co-insurance | Services that are normally provided without charge at the student health center are not covered. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $150 co-pay/30% co-insurance | $150 co-pay/50% co-insurance | –––––––––––none––––––––––– |
| Physician/surgeon fee | $15 co-pay/visit and 30% co-insurance | $15 co-pay/visit and 50% co-insurance | –––––––––––none––––––––––– |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 30% co-insurance | 50% co-insurance | –––––––––––none––––––––––– |
| Mental/Behavioral health inpatient services | 30% co-insurance | 50% co-insurance | –––––––––––none––––––––––– |
| Substance use disorder outpatient services | 30% co-insurance | 50% co-insurance | –––––––––––none––––––––––– |
| Substance use disorder inpatient services | 30% co-insurance | 50% co-insurance | –––––––––––none––––––––––– |
| **If you are pregnant** | Prenatal and postnatal care | 30% co-insurance | 50% co-insurance | –––––––––––none––––––––––– |
| Delivery and all inpatient services | 30% co-insurance | 50% co-insurance | –––––––––––none––––––––––– |
| **If you need help recovering or have other special health needs** | Home health care | 30% co-insurance | 50% co-insurance | Coverage is limited to one visit per day |
| Rehabilitation services | 30% co-insurance | 50% co-insurance | Coverage is limited to one visit per day |
| Habilitation services | 30% co-insurance | 50% co-insurance | Coverage is limited to one visit per day |
| Skilled nursing care | 30% co-insurance | 50% co-insurance | Coverage is limited to one visit per day |
| Durable medical equipment | 30% co-insurance | 50% co-insurance | –––––––––––none––––––––––– |
| Hospice service | 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.)** | | |
| * Cosmetic surgery * Bariatric surgery * Dental care (Adult) * Elective Abortion | * Elective Surgery or treatment * Eyeglasses * Infertility treatment * Long-term care | * Private-duty nursing * Routine eye care (Adult) * Routine foot care * Treatment for Acne |

|  |  |  |
| --- | --- | --- |
| **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.)** | | |
| * Acupuncture (if prescribed for rehabilitation purposes) | * Chiropractic care * Hearing aids | * Non-emergency care when traveling outside the U.S. * Weight loss programs |

**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 the coverage area   For more information on your rights to continue coverage, contact the insurer at 1-866-267-0092. You may also contact your state insurance department at 1-877-563-4467 or e-mail your inquiry to doicss.mailbox@state.ma.us. |  |  |

**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 Massachusetts Office of Consumer Affairs and Business Regulations by calling their toll-free line at 877-563-4467 or refer to their website at http://www.mass.gov/ocabr/consumer/insurance/file-a-complaint/filing-a-complaint.html.

**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 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.**

––––––––––––––––––––––*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.

**Having a baby**(normal delivery)

**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.

**Exclamation**

 **Amount owed to providers:** $7,540

 **Plan pays** $3,563

 **Patient pays** $3,977

**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 | $2,000 |
| Co-pays | $450 |
| Co-insurance | $1,527 |
| Limits or exclusions | $0 |
| **Total** | **$3,977** |

**Managing type 2 diabetes**(routine maintenance of

a well-controlled condition)

◼ **Amount owed to providers:** $5,400

◼ **Plan pays** $4,500

◼ **Patient pays** $900

**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 | $510 |
| Co-insurance | $390 |
| Limits or exclusions | $0 |
| **Total** | **$900** |

\*assume $100 per Generic Rx in this scenario

\*\*assume 5 visits in this scenario

**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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.