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.hometownhealth.com or by calling 1-800-336-0123.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In Network: **$ 250 Person / $ 750 Family** Out of Network: **$ 500 Person / $ 1500 Family**	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 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. In Network: **$ 4,000 Person /$ 12,000 Family** Out of Network: **$ 8,000 Person / $ 24,000 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?	Copays. Deductible.	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. Please, see **www.hometownhealth.com** or call **1-800-336-0123** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan 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 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**.

Questions: Call **1-800-336-0123** or visit us at **www.hometownhealth.com**.
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.hometownhealth.com** or call **1-800-336-0123** to request a copy.

- **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 **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	$ 15 copay / visit	40% Coinsurance	——————none——————
	Specialist visit	$ 30 copay / visit	40% Coinsurance	——————none——————
	Other practitioner office visit	$ 30 copay / visit Alternative Medicine $ 30 copay / visit Spinal Manipulation	40% Coinsurance Alternative Medicine 40% Coinsurance Spinal Manipulation	Limited to $1000 per calendar year.
	Preventive care/screening/immunization	No Charge	40% Coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: No charge General Lab:No charge	X-Ray: 40% Coinsurance General Lab:40% Coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	$ 100 copay / visit $ 100 copay / visit $ 100 copay / visit	40% Coinsurance 40% Coinsurance 40% Coinsurance	——————none——————

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.hometownhealth.com.	Generic drugs	$5 copay / script	Must submit receipt to Catamaran	——————none——————
	Preferred brand drugs	$15 copay / script	Must submit receipt to Catamaran	——————none——————
	Non-preferred brand drugs	Greater of $30 copay / script or 40% co-insurance	Must submit receipt to Catamaran	——————none——————
	Specialty drugs	20% Coinsurance	Must submit receipt to Catamaran	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Outpatient: 20% Coinsurance Same Day Surgery: 20% Coinsurance	Outpatient: 40% Coinsurance Same Day Surgery: 40% Coinsurance	——————none——————
	Physician/surgeon fees	PCP Office: $ 15 copay / visit Specialist Office: $ 30 copay / visit	PCP Office: 40% Coinsurance Specialist Office: 40% Coinsurance	Copay applies when services are done in Physician's office.
If you need immediate medical attention	Emergency room services	$ 100 copay / visit	$ 100 copay / visit	——————none——————
	Emergency medical transportation	$ 100 copay / trip (Ground) $ 200 copay / trip (Air\Water)	$ 100 copay / trip (Ground) $ 200 copay / trip (Air\Water)	——————none——————
	Urgent care	$ 35 copay / visit	$ 35 copay / visit	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	——————none——————
	Physician/surgeon fee	20% Coinsurance	40% Coinsurance	——————none——————

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$ 30 copay / visit	40% Coinsurance	——————none——————
	Mental/Behavioral health inpatient services	20% Coinsurance	40% Coinsurance	——————none——————
	Substance use disorder outpatient services	$ 30 copay / visit	40% Coinsurance	——————none——————
	Substance use disorder inpatient services	20% Coinsurance	40% Coinsurance	——————none——————
If you are pregnant	Prenatal and postnatal care	No charge.	40% Coinsurance	——————none——————
	Delivery and all inpatient services	20% Coinsurance	40% Coinsurance	——————none——————
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	Limited to $5000 per calendar year. Requires prior authorization.
	Rehabilitation services	20% Coinsurance	40% Coinsurance	Inpatient: Limited to 30 days per calendar year.
	Habilitation services	20% Coinsurance	40% Coinsurance	Inpatient: Limited to 30 days per calendar year.
	Skilled nursing care	20% Coinsurance	40% Coinsurance	Inpatient: Limited to 30 days per calendar year.
	Durable medical equipment	20% Coinsurance Orthopedic and Prosthetic 20% Coinsurance	40% Coinsurance Orthopedic and Prosthetic 40% Coinsurance	All medical supplies, including oxygen and oxygen related equipment, require prior authorization. Certain supply orders are limited to a 30-day supply.
	Hospice service	20% Coinsurance	40% Coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	No charge	N/A	Covered by Preventative.
	Glasses	N/A	N/A	Not Applicable
	Dental check-up	N/A	N/A	Not Applicable

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.)**

- Complications of Non-Covered Treatment
- Cosmetic & Reconstructive surgery
- Dental care (Adult)
- Exercise Equipment
- Hearing aids and exams
- Infertility treatment or Testing
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Personal Comfort of Convenience Items
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- 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.)**

- Acupuncture
- Chiropractic care

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 may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-336-0123. 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: www.hometownhealth.com or call 1-800-336-0123.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [1-800-336-0123].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-800-336-0123].]

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