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.liveandworkwell.com or by calling 1-866-248-4098.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	You don't have to meet deductibles for specific services, but see the following chart for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the following chart for your costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	N/A	This plan has no out-of-pocket costs to you, but the coverage is limited to the services described in the following chart.
What is not included in the out–of–pocket limit?	N/A	This plan has no out-of-pocket costs to you, but the coverage is limited to the services described in the following chart.
Is there an overall annual limit on what the plan pays?	No	Coverage under this plan is limited to the services described in the following chart.
Does this plan use a network of providers?	Yes. For a list of providers see www.liveandworkwell.com **or call 1-866-248-4098** providers.	This plan covers only in-network providers. If you use an in-network health care provider, this plan will pay some of all the costs of covered services as described on the following chart.
Do I need a referral to see a specialist?	N/A	N/A
Are there services this plan doesn't cover?	Yes	This plan only covers a limited number and type of services, as described on the following chart.

- **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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	N/A	N/A	This plan doesn't provide any coverage for this type of service.
	Specialist visit	N/A	N/A	This plan doesn't provide any coverage for this type of service.
	Other practitioner office visit	N/A	N/A	This plan doesn't provide any coverage for this type of service.
	Preventive care/screening/immunization	N/A	N/A	This plan doesn't provide any coverage for this type of service.
If you have a test	Diagnostic test (x-ray, blood work)	N/A	N/A	This plan doesn't provide any coverage for this type of service.
	Imaging (CT/PET scans, MRIs)	N/A	N/A	This plan doesn't provide any coverage for this type of service.
If you need drugs to treat your illness or condition	Generic drugs	N/A	N/A	This plan doesn't provide any coverage for this type of service.
	Preferred brand drugs	N/A	N/A	This plan doesn't provide any coverage for this type of service.
	Non-preferred brand drugs	N/A	N/A	This plan doesn't provide any coverage for this type of service.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Specialty drugs	N/A	N/A	This plan doesn't provide any coverage for this type of service.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	N/A	N/A	This plan doesn't provide any coverage for this type of service.
	Physician/surgeon fees	N/A	N/A	This plan doesn't provide any coverage for this type of service.
If you need immediate medical attention	Emergency room services	N/A	N/A	This plan doesn't provide any coverage for this type of service.
	Emergency medical transportation	N/A	N/A	This plan doesn't provide any coverage for this type of service.
	Urgent care	N/A	N/A	This plan doesn't provide any coverage for this type of service.
If you have a hospital stay	Facility fee (e.g., hospital room)	N/A	N/A	This plan doesn't provide any coverage for this type of service.
	Physician/surgeon fee	N/A	N/A	This plan doesn't provide any coverage for this type of service.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No copay	N/A	This plan covers up to 6 sessions per year.
	Mental/Behavioral health inpatient services	N/A	N/A	This plan doesn't provide any coverage for this type of service.
	Substance use disorder outpatient services	No copay	N/A	This plan covers up to 6 sessions per year.
	Substance use disorder inpatient services	N/A	N/A	This plan doesn't provide any coverage for this type of service.
If you are pregnant	Prenatal and postnatal care	N/A	N/A	This plan doesn't provide any coverage for this type of service.
	Delivery and all inpatient services	N/A	N/A	This plan doesn't provide any coverage for this type of service.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	N/A	N/A	This plan doesn't provide any coverage for this type of service.
	Rehabilitation services	N/A	N/A	This plan doesn't provide any coverage for this type of service.
	Habilitation services	N/A	N/A	This plan doesn't provide any coverage for this type of service.
	Skilled nursing care	N/A	N/A	This plan doesn't provide any coverage for this type of service.
	Durable medical equipment	N/A	N/A	This plan doesn't provide any coverage for this type of service.
	Hospice service	N/A	N/A	This plan doesn't provide any coverage for this type of service.
If your child needs dental or eye care	Eye exam	N/A	N/A	This plan doesn't provide any coverage for this type of service.
	Glasses	N/A	N/A	This plan doesn't provide any coverage for this type of service.
	Dental check-up	N/A	N/A	This plan doesn't provide any coverage for this type of service.

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 (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Most coverage provided outside the United States. See www.[insert]
- 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.)**

- N/A

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 1-866-248-4098. 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:

Optum Appeals Department
P.O. Box 30512
Salt Lake City, UT 94130-0512

You may also contact Optum at 866-248-4098.

www.liveandworkwell.com

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.

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** $5,490
- **Patient pays** $2,050

Sample care costs:

Hospital charges (mother)	N/A
Routine obstetric care	N/A
Hospital charges (baby)	N/A
Anesthesia	N/A
Laboratory tests	N/A
Prescriptions	N/A
Radiology	N/A
Vaccines, other preventive	N/A
Total	N/A

Patient pays:

Deductibles	N/A
Copays	N/A
Coinsurance	N/A
Limits or exclusions	N/A
Total	N/A

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,520
- **Patient pays** $1,880

Sample care costs:

Prescriptions	N/A
Medical Equipment and Supplies	N/A
Office Visits and Procedures	N/A
Education	N/A
Laboratory tests	N/A
Vaccines, other preventive	N/A
Total	N/A

Patient pays:

Deductibles	N/A
Copays	N/A
Coinsurance	N/A
Limits or exclusions	N/A
Total	N/A

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**, **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 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.