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.FreedomCareBenefits.com or by calling 1-844-657-1575.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$ 7,150.00** Per Covered Person **$ 14,300.00** Maximum Per 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 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. There are no other specific deductibles.	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?	**$ 7,150.00** Per Covered Person **$ 14,300.00** Maximum Per 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?	Penalties for failure to obtain prior authorization, premiums, balance-billed charges, and health care this plan does not 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.	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.FreedomCareBenefits.com or call 1-844-657-1575 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 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 4. See your plan document for additional information about excluded services.

Questions: Call 1-844-657-1575 or visit us at www.FreedomCareBenefits.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.cciio.cms.gov or call 1-844-657-1575 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**.)
- Your cost sharing does depend on whether a provider is a Network Provider.

Common Medical Event	Services You May Need	Your Cost if You Use a 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	$20 Copayment per visit. 0% Coinsurance after Deductible has been met.	Not Covered.	*Plan will pay up to $1,000 per Calendar Year before Deductible applies.
	Specialist visit	Not Covered.	Not Covered.	No Coverage.
	Other practitioner office visit	Not Covered.	Not Covered.	No Coverage.
	Preventive care/screening/immunization	No Cost.	Not Covered.	None.
If you have a test	Diagnostic test (x-ray, blood work)	$75 Copayment per visit. 0% Coinsurance after Deductible has been met.	Not Covered.	**Plan will pay up to $1,000 per Calendar Year before Deductible applies.
	Imaging (CT/PET scans, MRIs)	$250 Copayment per visit. 0% Coinsurance after Deductible has been met.	Not Covered.	

**The $1,000 benefit per Calendar Year paid prior to meeting the deductible is combined between Physician Services and Urgent Care Services.*
***The $1,000 benefit per Calendar Year paid prior to meeting the deductible is combined between Diagnostic Testing and Imaging Services.*

Common Medical Event	Services You May Need	Your Cost if You Use a 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.rxvalet.com	Generic drugs	Not Covered.	Not Covered.	No Coverage.
	Diabetic Insulin	Not Covered.	Not Covered.	No Coverage.
	Brand Name and Specialty drugs	Not Covered.	Not Covered.	No Coverage.
	Preventive drugs	No Cost.	Not Covered.	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered.	Not Covered.	No Coverage.
	Physician/surgeon fees	Not Covered.	Not Covered.	No Coverage.
If you need immediate medical attention	Emergency room services	For medical emergency only: $250 Copayment, 0% Coinsurance after Deductible has been met.		***Plan will pay up to $2,500 per Calendar Year before Deductible applies. Non-emergency medical care is not covered.
	Emergency medical transportation	$150 Copayment, 0% Coinsurance after Deductible has been met.		
	Urgent care	$50 Copayment, 0% Coinsurance after Deductible has been met.	Not Covered.	*Plan will pay up to $1,000 per Calendar Year before Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered.	Not Covered.	No Coverage.
	Physician/surgeon fee	Not Covered.	Not Covered.	No Coverage.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not Covered.	Not Covered.	No Coverage.
	Mental/Behavioral health inpatient services	Not Covered.	Not Covered.	No Coverage.
	Substance use disorder outpatient services	Not Covered.	Not Covered.	No Coverage.

**The $1,000 benefit per Calendar Year paid prior to meeting the deductible is combined between Physician Services and Urgent Care Services.*
***The $2,500 benefit per Calendar Year paid prior to meeting the deductible is combined between Emergency Room Services and Ambulance.*

Questions: Call 1-844-657-1575 or visit us at www.FreedomCareBenefits.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.cciio.cms.gov or call 1-844-657-1575 to request a copy.

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out of Network Provider	Limitations & Exceptions
	Substance use disorder inpatient services	Not Covered.	Not Covered.	No Coverage.
If you are pregnant	Prenatal and postnatal care	Not Covered.	Not Covered.	Prenatal office visits, certain prenatal blood tests, and prenatal tobacco cessation counseling may be covered under Preventive Care.
	Delivery and all inpatient services	Not Covered.	Not Covered.	No Coverage.
If you have mental health, behavioral health, or substance abuse needs **If you need help recovering or have other special health needs**	Home health care	Not Covered.	Not Covered.	No Coverage.
	Rehabilitation services	Not Covered.	Not Covered.	No Coverage.
	Habilitation services	Not Covered.	Not Covered.	No Coverage.
	Skilled nursing care	Not Covered.	Not Covered.	No Coverage.
If you need help recovering or have other special health needs	Durable medical equipment	Not Covered.	Not Covered.	No Coverage.
	Hospice service	Not Covered.	Not Covered.	No Coverage.
If your child needs dental or eye care	Eye exam	Not Covered.	Not Covered.	No Coverage.
	Glasses	Not Covered.	Not Covered.	No Coverage.
	Dental check-up	Not Covered.	Not Covered.	No Coverage.

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	• Abortion	• Bariatric Surgery
• Cosmetic Surgery	• Chiropractic Care	• Dental Care
• Dialysis	• Hearing Aids	• Infertility Treatment
• Mental & Substance Abuse Treatment	• Naturopathic Care	• Non Emergency Care when travelling outside US
• Private Duty Nursing Care	• Organ Transplant	• Routine Eye Care
• 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.)
None

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 1-844-657-1575 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: FreedomCare at -1844-657-1575 or 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 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 not meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-657-1575
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-657-1575
Chinese (中文): 如果需要中文的帮助, **请拨打这个号码** 1-844-657-1575
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-657-1575

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

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	$ 7,150
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$7,150**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $100
- **Patient pays** $5,300

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	$5,300
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$5,300**

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.