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.MyPOMCO.com** or by calling 1-844-344-8045.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-and Out-of-Network: **$1,300** per individual/**$2,600** per family unit. You must pay all costs up to the deductible amount before this plan begins to pay for covered services.	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You do not have to meet **deductibles** for specific services, but see the chart on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-Network **$3,000** per individual/**$6,000** per family unit. Out-of-Network **$5,000** per individual/**$10,000** per family unit.	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?	Services paid at 100%, Acupuncture, Chiropractic Care, penalties for failure to follow pre-authorization, premiums, balance-billed charges, health care this plan does not cover, and other services as described in your plan document.	Even though you pay these expenses, they do not 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. For a list of in-network **providers**, call 1-844-344-8045 or see www.MyPOMCO.com.	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 does not cover are listed on page 5. See your plan document for additional information about **excluded services**.

- **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 **co-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 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	$20* copay/visit	30% coinsurance	----------none----------
	Specialist visit	$20* copay/visit	30% coinsurance	----------none----------
	Other practitioner office visit	Acupuncture: $20* copay/visit Chiropractic: $15* copay/visit	30% coinsurance	Precertify Acupuncture services. Chiropractic limited to 20 visits/calendar year. Appliances limited to $50 max per year.
	Preventive care/screening/immunization	No charge	30% coinsurance	Nutritional Counseling limited to 4 wellness visits per year. Tobacco Cessation limited to 2 attempts per year.
If you have a test	Diagnostic test (x-ray, blood work)	$10* copay/visit	30% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	$25* copay/visit	30% coinsurance	Precertify PET/CAT scans, MRA, MRS, MRI, and Nuclear Cardiac Imaging.

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.cvshealth.com.	Generic drugs	*Copay/prescription **Retail**: $10 for 30 day/$20 for 31-60 day/$30 for 61-100 day; **Mail Order** $10 for 30 days/$20 for 31-100 days.	$10 copay plus 50% of the remaining maximum allowed amount and cost in excess of the maximum allowed amount	Covers up to a 100-day supply (retail or mail order).
	Preferred brand drugs	*Copay/prescription **Retail**: $25 for 30 day/$50 for 31-60 day/$75 for 61-100 day; **Mail Order** $25 for 30 days/$50 for 31-100 days.	$30 copay plus 50% of the remaining maximum allowed amount and cost in excess of the maximum allowed amount	Covers up to a 100-day supply (retail or mail order).
	Non-preferred brand drugs	*Copay/prescription **Retail**: $25 for 30 day/$50 for 31-60 day/$75 for 61-100 day; **Mail Order** $25 for 30 days/$50 for 31-100 days.	Not covered	Only covered if determined to be medically necessary through clinical review. Covers up to a 100-day supply (retail or mail order).
	Specialty drugs	See www.cvshealth.com for details		Covers up to a 100-day supply (retail or mail order).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100* copay/visit	30% coinsurance	----------none----------
	Physician/surgeon fees	Office: $20* copay/visit Other: No charge	30% coinsurance	Precertify.
If you need immediate medical attention	Emergency room services	$75* copay/visit	10% coinsurance	Copay waived if admitted.
	Emergency medical transportation	$50* copay	10% coinsurance	----------none----------
	Urgent care	$20* copay/visit	30% 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 a hospital stay	Facility fee (e.g., hospital room)	$150* copay/admission	30% coinsurance	Precertify.
	Physician/surgeon fee	No charge	30% coinsurance	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Individual Therapy: $20* copay. Group Therapy: $10* copay	30% coinsurance	----------none----------
	Mental/Behavioral health inpatient services	General Hospital or Private Proprietary Psychiatric Facility: $150* copay. Partial Hospitalization or Intensive Outpatient: No charge	30% coinsurance	Precertify
	Substance use disorder outpatient services	Individual Therapy: $20* copay. Group Therapy: $5* copay	30% coinsurance	----------none----------
	Substance use disorder inpatient services	General Hospital or Certified Alcohol/Substance Use Disorder Facility Program: $150* copay. Partial Hospitalization or Intensive Outpatient: $5* copay per day. Transitional Residential Facility: $50* copay	30% coinsurance	Precertify.
If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	Applies to Routine Prenatal only. Deductibles and copays apply for all non-routine prenatal visits and testing.
	Delivery and all inpatient services	$150* copay	30% 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 help recovering or have other special health needs	Home health care	No charge*	30% coinsurance	Limited to 100 visits per calendar year and 3 visits per person per day.
	Rehabilitation services	$20* copay/visit	30% coinsurance	----------none----------
	Habilitation services			
	Skilled nursing care	$200* copay/visit	30% coinsurance	Precertify. Limited to 100 days per calendar year.
	Durable medical equipment	$20* copay	20% coinsurance	----------none----------
	Hospice service	No charge*	30% coinsurance	Respite care limited to 5 consecutive days per approved admission.
If your child needs dental or eye care	Eye exam	$10* copay/visit	30% coinsurance	----------none----------
	Glasses	Not covered	Not covered	----------none----------
	Dental check-up	Not covered	Not covered	----------none----------

*** Deductible Applies**

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
- Dental care (adult, child)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. unless travel is for the sole purpose of obtaining medical services
- Long-term 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic Care
- Hearing Aids
- Private-duty nursing (inpatient only)
- Routine eye care (adult, child)

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 1-844-344-8045. 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: POMCO, 2425 James St. Syracuse, NY 13206, Tel. 1-844-344-8045. You may also contact the 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 or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-344-8045.

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** $5,740
- **Patient pays** $1,800

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	$1,300
Co-pays	$350
Co-insurance	$0
Limits or exclusions	$150
Total	**$1,800**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,210
- **Patient pays** $2,190

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	$1,300
Co-pays	$810
Co-insurance	$0
Limits or exclusions	$80
Total	**$2,190**

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.