



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.imstpa.com or by calling 1-800-687-5944.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$3,000 Individual; \$6,000 Family for PPO/ \$10,000 Individual; \$20,000 Family for Non-PPO. Does not apply to Preventive.	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 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet your deductible .
Are there other deductibles for specific services?	There are no other specific deductibles .	You do not 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?	There is no out-of-pocket for PPO. Non-PPO is Unlimited .	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 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 <i>specific</i> coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See www.imstpa.com , or call 1-800-687-5944 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 .
Does this coverage provide minimum essential coverage?	This plan or policy does provide essential coverage.	The <i>Affordable Care Act</i> requires most people to have health coverage that qualifies as "minimum essential coverage" and "minimum essential coverage."
Does this coverage meet the minimum value standard?	This health coverage does meet the minimum value standard for the benefits it provides.	The <i>Affordable Care Act</i> establishes a minimum standard of benefits of a health plan. This minimum value standard is 60% (actuarial value).

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- **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 participating **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		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	0% Co-insurance	40% Co-insurance	Care Today; Family Medicine Center; Faith Medical Clinic 0% Co-insurance; Subject to Deductible
	Specialist visit	0% Co-insurance	40% Co-insurance	Subject to Deductible
	Other practitioner office visit – Chiropractor	0% Co-insurance	40% Co-insurance	Subject to Deductible; Plan Yr. Max \$1,500
	Preventive care/screening/immunization	No Charge	40% Co-insurance	All Other Services: PPO No Charge/ Non-PPO Not Covered; PPO Plan Yr. Max \$500 then Subject to Deductible
If you have a test	Diagnostic test (laboratory)	0% Co-insurance	40% Co-insurance	Subject to Deductible
	Radiology (x-ray)	0% Co-insurance	40% Co-insurance	Subject to Deductible
	Imaging (CT/PET scans, MRIs)	0% Co-insurance	40% Co-insurance	Subject to Deductible
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Maxorplus.com	Generic drugs	0% Co-insurance	Not Covered	Subject to Deductible; Retail -30 day; Mail – 90 day
	Preferred brand drugs	0% Co-insurance	Not Covered	Subject to Deductible; Retail -30 day; Mail – 90 day
	Non-preferred brand drugs	0% Co-insurance	Not Covered	Subject to Deductible; Retail -30 day; Mail – 90 day
	Specialty drugs	0% Co-insurance	Not Covered	Subject to Deductible; Restricted to Maxor Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% Co-insurance	40% Co-insurance	Subject to Deductible
	Physician/surgeon fees	0% Co-insurance	40% Co-insurance	Subject to Deductible

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you need immediate medical attention	Emergency room services	0% Co-insurance	40% Co-insurance	Subject to Deductible
	Emergency medical transportation	0% Co-insurance	40% Co-insurance	Subject to Deductible
	Urgent care	0% Co-insurance	40% Co-insurance	Care Today and Family Medicine Center 0% Co-insurance; Subject to Deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	0% Co-insurance	40% Co-insurance	Subject to Deductible; \$500 Non-Pre-certified Inpatient Hospital Penalty
	Physician/surgeon fee	0% Co-insurance	40% Co-insurance	Subject to Deductible
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% Co-insurance	40% Co-insurance	Care Today and Family Medicine Center 0% Co-insurance; Subject to Deductible
	Mental/Behavioral health inpatient services	0% Co-insurance	40% Co-insurance	Subject to Deductible; \$500 Non-Pre-certified Inpatient Hospital Penalty
	Substance use disorder outpatient services	0% Co-insurance	40% Co-insurance	Care Today and Family Medicine Center 0% Co-insurance; Subject to Deductible
	Substance use disorder inpatient services	0% Co-insurance	40% Co-insurance	Subject to Deductible; \$500 Non-Pre-certified Inpatient Hospital Penalty
If you are pregnant	Prenatal and postnatal care	0% Co-insurance	40% Co-insurance	Subject to Deductible
	Delivery and all inpatient services	0% Co-insurance	40% Co-insurance	Subject to Deductible
If you need help recovering or have other special health needs	Home health care	0% Co-insurance	40% Co-insurance	Subject to Ded; Plan Yr. Max 30 Visits
	Rehabilitation services	0% Co-insurance	40% Co-insurance	Subject to Deductible
	Habilitation services	0% Co-insurance	40% Co-insurance	Subject to Deductible
	Skilled nursing care	0% Co-insurance	40% Co-insurance	Subject to Ded; Plan Yr. Max 30 Days
	Durable medical equipment	0% Co-insurance	40% Co-insurance	Subject to Deductible
	Hospice service	0% Co-insurance	40% Co-insurance	Subject to Deductible
If your child needs dental or eye care	Eye exam	No Charge	40% Co-insurance	Coverage limited to routine eye exam.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No Charge	40% Co-insurance	Coverage limited to Fluoride Treatment for children age 6 months to 5 years.

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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	• Long Term Care	• Routine Foot Care
• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.	• Infertility Treatment
• Hearing Aids	• Bariatric surgery	• 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	• Routine Eye Care
• Diabetic Education	• Private Duty Nursing	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on 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 1-800-687-5944. 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, ext. 61565 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: Insurance Management Services at 1-800-687-5944 or www.imstpa.com; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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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 \$7,390**
- **Patient pays \$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	\$0
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$150

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$5,320**
- **Patient pays \$80**

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$200
Vaccines, other preventive	\$200
Total	\$5,400

Patient pays:

Deductibles	\$0
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$1,080

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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.

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