



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.cnichs.com or http://secure.healthx.com/cnic_new.aspx or by calling 1-877-321-4412.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	\$2,500 person / \$5,000 family for network providers. Doesn't apply to in-hospital newborn care, lab charges (network), office visits, prevention, outpatient supplies, preadmission testing, prescriptions, sterilization procedures & urgent care.	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 <u>deductibles</u> 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 offers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For participating providers \$5,000 person / \$10,000 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 <u>out-of-pocket limit</u>?	Balance-billed charges, cost containment penalties, health care this plan doesn't cover, premiums, & prescription charges.	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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u>?	Yes. For a list of participating providers see: www.wiseprovider.net or call 1-866-485-5205 (WY); or www.rmhp.org or call 1-877-321-4412 (CO); or www.multiplan.com or call 1-800-678-7427 (UT); or www.multiplan.com or call 1-800-678-7427 all other locations.	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 <u>specialist</u>?	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 .

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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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$50 copay/visit	20% coinsurance	-----none-----
	Specialist visit	\$50 copay/visit	20% coinsurance	-----none-----
	Other practitioner office visit	20% coinsurance TMJ treatment.	20% coinsurance	Limited to \$2,000 per lifetime.
	Preventive care/screening/immunization	No charge	No charge	Routine colonoscopy is limited to 1 per year and includes removal of a polyp(s) at the time of the colonoscopy and any related charges over reasonable and customary.
If you have a test	Diagnostic test – X-ray	20% coinsurance	20% coinsurance	-----none-----
	Diagnostic test – Outpatient lab services	\$50 copay/test	20% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	-----none-----

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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
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.welldynrx.com</p>	Generic drugs	\$5 copay + 20% coins/prescription (retail and mail order)	Not covered	<p>\$1,500 calendar year out-of-pocket maximum. Covers up to a 34-day supply (retail); 90-day supply (mail order). If an individual is prescribed a Preferred/Brand or Non-Preferred/Brand medication, and a generic is available, the individual must take the generic medication. If the individual chooses to take the Preferred/Brand or Non-Preferred/Brand medication, the individual will be responsible for paying the Preferred/Brand or Non-Preferred/Brand copayment, plus the difference in cost between the generic and Preferred/Brand or Non-Preferred/Brand medication. Certain over-the counter drugs are available for \$0 copayment or discounted pharmacy rate with prescription. Birth control covered under mail order benefit only.</p>
	Preferred brand drugs	\$20 copay + 20% coins/prescription (retail and mail order)	Not covered	
	Non-preferred brand drugs	\$30 copay + 50% coins/prescription (retail and mail order)	Not covered	
	Specialty drugs	20% coinsurance	Not covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	Precertification is required for outpatient surgery not performed in physician's office, except for routine colonoscopies, or payment will be reduced by \$200.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	-----none-----
<p>If you need immediate medical attention</p>	Emergency room services	20% coinsurance, no charge for pre-admission testing	20% coinsurance	-----none-----
	Emergency medical transportation	20% coinsurance	20% coinsurance	-----none-----
	Urgent care	\$50 copay/visit	20% coinsurance	-----none-----

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If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	Precertification is required. If not precertified payment will be reduced by \$200.
	Physician/surgeon fee	20% coinsurance	20% coinsurance	-----none-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$50 copay/office visit, 20% coinsurance for outpatient facility	20% coinsurance	-----none-----
	Mental/Behavioral health inpatient services	20% coinsurance	20% coinsurance	Precertification is required or payment will be reduced by \$200.
	Substance use disorder outpatient services	\$50 copay/office visit, 20% coinsurance for outpatient facility	20% coinsurance	-----none-----
	Substance use disorder inpatient services	20% coinsurance	20% coinsurance	Precertification is required or payment will be reduced by \$200.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	20% coinsurance	There is no coverage of pregnancy for a dependent child.
	Delivery and all inpatient services	20% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	60-visit calendar year maximum.
	Rehabilitation services	20% coinsurance	20% coinsurance	Includes therapy services such as occupational, physical and speech therapies. Only first 12 visits are covered without a physician's prescription. With a prescription visits are unlimited.
	Habilitation services			

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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
	Skilled nursing care	20% coinsurance	20% coinsurance	Care must start within 14 days of a 3-day hospital stay. 90-day calendar year maximum.
	Durable medical equipment	20% coinsurance	20% coinsurance	-----none-----
	Hospice service	No charge	No charge	Bereavement counseling covered at 20% coinsurance within 3 months of death.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Annual eye exams covered at no charge for diagnosis of diabetes and heart disease. Also, the exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.
	Glasses	Not covered	Not covered	Initial contact lenses or glasses required following cataract surgery.
	Dental check-up	Not covered	Not covered	-----none-----

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.)		
<ul style="list-style-type: none"> • Cosmetic surgery (except when such surgery is required as the result of a congenital anomaly or an accidental injury) • Dental care (Adult) • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. (if travel is for the sole purpose of obtaining medical services) • Routine eye care (Adult) (except exams for diagnosis of diabetes and heart disease. Also, the exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages) 	<ul style="list-style-type: none"> • Routine foot care (except open cutting operations or unless needed in treatment of a metabolic or peripheral-vascular disease) • Weight loss programs

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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 limited to 10 visits per year.
- Bariatric surgery, when medically necessary; precertification is required. If not precertified payment may be reduced by \$200.
- Chiropractic care limited to 10 visits per year.
- Hearing aids (for dependent children only)
- Infertility treatment (for diagnosis of infertility only)
- Private-duty nursing (inpatient only)

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 307-235-8344. 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 the plan at 307-235-8344 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-426-7453.

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: \$3,850**
- **Patient pays: \$3,690**

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	\$2,500
Copays	\$260
Coinsurance	\$930
Limits or exclusions	\$0
Total	\$3,690

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

- **Amount owed to providers: \$5,400**
- **Plan pays: \$2,750**
- **Patient pays: \$2,650**

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	\$1,500
Copays	\$960
Coinsurance	\$140
Limits or exclusions	\$50
Total	\$2,650

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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**, **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.

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