



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-472-4352. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-888-472-4352 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                        |                                                                       | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | <a href="#">In-Network</a> /Out-of-Area (OOA)<br>\$2,050/individual<br>\$4,200/family                                                                                                                                          | <a href="#">Non-Network</a><br>\$4,150/individual<br>\$8,300/family   | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.                                                                                                                                                                                                                                                                                                       |
|                                                                                 | <a href="#">Network</a> and <a href="#">non-network deductibles</a> are separate.                                                                                                                                              |                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes, <a href="#">network preventive services</a> .                                                                                                                                                                             |                                                                       | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                                                            |                                                                       | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | <a href="#">In-Network</a> /Out-of-Area (OOA)<br>\$4,750/individual<br>\$9,500/family                                                                                                                                          | <a href="#">Non-Network</a><br>\$12,200/individual<br>\$24,400/family | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                 | <a href="#">Network</a> and <a href="#">non-network out-of-pocket limits</a> are separate.                                                                                                                                     |                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance billing</a> charges (unless <a href="#">balance billing</a> is prohibited), prescription drug brand-name drug penalty, and health care this <a href="#">plan</a> doesn't cover. |                                                                       | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="https://login.personifyhealth.com">login.personifyhealth.com</a> or call 1-888-472-4352 for a list of <a href="#">network providers</a> .                                                                    |                                                                       | This plan uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use a <a href="#">non-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">non-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |

| Important Questions                                                          | Answers | Why This Matters:                                                                          |
|------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------|
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No.     | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> . |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event                                                   | Services You May Need                                  | What You Will Pay                               |                                                  | Limitations, Exceptions, & Other Important Information<br><br><i>*If you live outside the In-Network service area (called out-of-area), your cost for Non-network providers is 20% instead of the usual 30% coinsurance level.</i> |
|------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                        |                                                        | In-Network Provider<br>(You will pay the least) | Non-Network Provider*<br>(You will pay the most) |                                                                                                                                                                                                                                    |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness       | 10% <a href="#">coinsurance</a>                 | 30% <a href="#">coinsurance</a>                  | Teleheath services via AZ Blue are payable at 10% <a href="#">coinsurance</a> after deductible per visit. Call 1-844-606-1612 or visit <a href="#">AZBlueTelehealth.com</a> to start a visit.                                      |
|                                                                        | <a href="#">Specialist</a> visit                       | 10% <a href="#">coinsurance</a>                 | 30% <a href="#">coinsurance</a>                  |                                                                                                                                                                                                                                    |
|                                                                        | <a href="#">Preventive care/screening/immunization</a> | No charge                                       | 30% <a href="#">coinsurance</a>                  | None                                                                                                                                                                                                                               |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 10% <a href="#">coinsurance</a>                 | 30% <a href="#">coinsurance</a>                  | None                                                                                                                                                                                                                               |
|                                                                        | Imaging (CT/PET scans, MRIs)                           | 10% <a href="#">coinsurance</a>                 | 30% <a href="#">coinsurance</a>                  | None                                                                                                                                                                                                                               |

| Common Medical Event                                                                                                                                                                                                                                 | Services You May Need                                             | What You Will Pay                                                                                                                                                                                                                         |                                                                                                                                                    | Limitations, Exceptions, & Other Important Information<br><br><i>*If you live outside the In-Network service area (called out-of-area), your cost for Non-network providers is 20% instead of the usual 30% coinsurance level.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                      |                                                                   | In-Network Provider (You will the least)                                                                                                                                                                                                  | Non-Network Provider* (You will pay the most)                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="http://www.express-scripts.com">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> . | Generic drugs (Tier 1)                                            | <b>Retail</b> (30-day supply)<br>\$10/prescription<br><b>Retail* &amp; Mail Order</b> (90-day supply)<br>\$20/prescription                                                                                                                |                                                                                                                                                    | *Retail pharmacy 90-day supply is available only at Walgreens and select pharmacies in remote locations.<br><br>Maintenance medications must be filled for 90-day supply at Walgreens, select pharmacies in remote locations, or Mail Order after the first (2) 30-day fills.<br><br>All <a href="#">In-Network</a> preventive medication and contraceptives are covered at no charge as required by law. Preventive medication and contraceptives not required by law are covered subject to applicable copayment; deductible waived.<br><br>EncircleRx Plus Omada for Weight Management is offered through Express Scripts. For more information, contact Express Scripts at (866) 229-5806.<br><br>Specialty drugs must be filled through Accredo Specialty Pharmacy or they are not covered.<br><br>Brand-name drug penalty: If you or your physician chooses a brand name drug when a generic equivalent is available, you must pay the cost difference between the brand and generic in addition to the brand name copayment.<br><br>Step therapy requirements may apply to certain drugs. |
|                                                                                                                                                                                                                                                      | Preferred brand drugs (Tier 2)                                    | <b>Retail</b> (30-day supply)<br>25% <a href="#">coinsurance</a><br>(\$25 min/\$50 max) per prescription<br><b>Retail* &amp; Mail Order</b> (90-day supply)<br>25% <a href="#">coinsurance</a><br>(\$50 min/\$100 max) per prescription   | <b>Retail:</b> You pay the full cost upfront and submit your receipt to Express Scripts for possible reimbursement. You may have additional costs. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                      | Non-preferred brand drugs (Tier 3)                                | <b>Retail</b> (30-day supply)<br>50% <a href="#">coinsurance</a><br>(\$50 min/\$150 max) per prescription<br><b>Retail* &amp; Mail Order</b> (90-day supply)<br>50% <a href="#">coinsurance</a><br>(\$100 min/\$300 max) per prescription | <b>Specialty &amp; Mail Order:</b><br>Not Covered                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                      | <a href="#">Specialty drugs</a> (high dollar or injectable drugs) | Tier 1: \$10/prescription<br>Tier 2: 25% <a href="#">coinsurance</a><br>(\$25 min/\$50 max) per prescription<br>Tier 3: 50% <a href="#">coinsurance</a><br>(\$50 min/\$150 max) per prescription                                          |                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                               |                                                  | Limitations, Exceptions, & Other Important Information<br><br><i>*If you live outside the In-Network service area (called out-of-area), your cost for Non-network providers is 20% instead of the usual 30% coinsurance level.</i>                          |
|---------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | In-Network Provider<br>(You will pay the least) | Non-Network Provider*<br>(You will pay the most) |                                                                                                                                                                                                                                                             |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | 10% <a href="#">coinsurance</a>                 | 30% <a href="#">coinsurance</a>                  | None                                                                                                                                                                                                                                                        |
|                                                                           | Physician/surgeon fees                           | 10% <a href="#">coinsurance</a>                 | 30% <a href="#">coinsurance</a>                  | None                                                                                                                                                                                                                                                        |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 10% <a href="#">coinsurance</a>                 |                                                  | None                                                                                                                                                                                                                                                        |
|                                                                           | <a href="#">Emergency medical transportation</a> | 10% <a href="#">coinsurance</a>                 |                                                  | None                                                                                                                                                                                                                                                        |
|                                                                           | <a href="#">Urgent care</a>                      | 10% <a href="#">coinsurance</a>                 | 30% <a href="#">coinsurance</a>                  | None                                                                                                                                                                                                                                                        |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 10% <a href="#">coinsurance</a>                 | 30% <a href="#">coinsurance</a>                  | <a href="#">Precertification</a> is required or a penalty of \$250 may apply.                                                                                                                                                                               |
|                                                                           | Physician/surgeon fees                           | 10% <a href="#">coinsurance</a>                 | 30% <a href="#">coinsurance</a>                  | None                                                                                                                                                                                                                                                        |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | 10% <a href="#">coinsurance</a>                 | 30% <a href="#">coinsurance</a>                  | None                                                                                                                                                                                                                                                        |
|                                                                           | Inpatient services                               | 10% <a href="#">coinsurance</a>                 | 30% <a href="#">coinsurance</a>                  | <a href="#">Precertification</a> is required or a penalty of \$250 may apply.                                                                                                                                                                               |
| If you are pregnant                                                       | Office visits                                    | No charge                                       | 30% <a href="#">coinsurance</a>                  | Cost sharing does not apply for <a href="#">network preventive care</a> services. Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                           | Childbirth/delivery professional services        | 10% <a href="#">coinsurance</a>                 | 30% <a href="#">coinsurance</a>                  | None                                                                                                                                                                                                                                                        |
|                                                                           | Childbirth/delivery facility services            | 10% <a href="#">coinsurance</a>                 | 30% <a href="#">coinsurance</a>                  | <a href="#">Precertification</a> is required for an inpatient stay that is in excess of 48 hours (vaginal delivery) or 96 hours (caesarean delivery) or a penalty of \$250 may apply.                                                                       |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                            |                                               | Limitations, Exceptions, & Other Important Information<br><br><i>*If you live outside the In-Network service area (called out-of-area), your cost for Non-network providers is 20% instead of the usual 30% coinsurance level.</i>                                                                                                                                                                                                                                                                  |
|----------------------------------------------------------------|-------------------------------------------|----------------------------------------------|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | In-Network Provider (You will pay the least) | Non-Network Provider* (You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 10% <a href="#">coinsurance</a>              | 30% <a href="#">coinsurance</a>               | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                | <a href="#">Rehabilitation services</a>   | 10% <a href="#">coinsurance</a>              | 30% <a href="#">coinsurance</a>               | No coverage for speech therapy for developmental delays unless associated with autism diagnosis.<br><br>Cardiac rehab, occupational, physical, speech, & vision therapies are limited to 75 outpatient visits/year combined, and 75 inpatient visits per illness/injury combined. Limits do not apply to mental/behavioral health or substance use services.                                                                                                                                        |
|                                                                | <a href="#">Habilitation services</a>     | 10% <a href="#">coinsurance</a>              | 30% <a href="#">coinsurance</a>               | Limited to occupational and speech therapy for autism.                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                | <a href="#">Skilled nursing care</a>      | 10% <a href="#">coinsurance</a>              | 30% <a href="#">coinsurance</a>               | Limited to 365 days lifetime max for same or related injury/illness. <a href="#">Precertification</a> is required or a penalty of \$250 may apply.                                                                                                                                                                                                                                                                                                                                                  |
|                                                                | <a href="#">Durable medical equipment</a> | 10% <a href="#">coinsurance</a>              | 30% <a href="#">coinsurance</a>               | Durable medical equipment & prosthetics require <a href="#">precertification</a> if over \$5,000 or services and supplies will not be covered.<br><br>Replacement of equipment limited to every 3 years unless it cannot be repaired or due to growth of child.<br><br>Sleep apnea mouth guard only if patient has used a CPAP/BIPAP machine for 3 or more months.<br><br>Anti-embolism stockings limited to 2 pair per calendar year.<br><br>Cooling cap for chemo is limited to one per Lifetime. |
|                                                                | <a href="#">Hospice services</a>          | 10% <a href="#">coinsurance</a>              | 30% <a href="#">coinsurance</a>               | Limited to 365 days lifetime max.                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [login.personifyhealth.com](https://login.personifyhealth.com).

| Common Medical Event                          | Services You May Need      | What You Will Pay                               |                                                  | Limitations, Exceptions, & Other Important Information<br><i>*If you live outside the In-Network service area (called out-of-area), your cost for Non-network providers is 20% instead of the usual 30% coinsurance level.</i> |
|-----------------------------------------------|----------------------------|-------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                               |                            | In-Network Provider<br>(You will pay the least) | Non-Network Provider*<br>(You will pay the most) |                                                                                                                                                                                                                                |
| <b>If your child needs dental or eye care</b> | Children's eye exam        | Not covered                                     | Not covered                                      | No coverage for children's eye exam.                                                                                                                                                                                           |
|                                               | Children's glasses         | Not covered                                     | Not covered                                      | No coverage for children's glasses.                                                                                                                                                                                            |
|                                               | Children's dental check-up | Not covered                                     | Not covered                                      | No coverage for dental check-up.                                                                                                                                                                                               |

**Excluded Services & Other Covered Services:**

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                                                                                            |                                                                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult) / (Child)</li> <li>• Long-term care</li> </ul>                                                           | <ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S., except for an unexpected medical condition as determined by the Plan Administrator</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult) / (Child)</li> </ul> |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Acupuncture, up to \$1,250/calendar year</li> <li>• Bariatric surgery, up to 1 surgery lifetime max; must be rendered at a BlueCross® BlueShield® Blue Distinction Center (BDC)</li> <li>• Chiropractic care (limited to 26 visits/calendar year)</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids (retirees &amp; their dependents are ineligible; cannot be replaced within 2 years)</li> <li>• Infertility: eligible treatment up to \$2,000/calendar year. Prescription drugs are not covered unless administered and billed through a physician's office</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care if medically necessary due to diabetes or neuro/vascular insufficiency affecting the feet, and administered by a podiatrist</li> <li>• Weight loss programs up to \$500 lifetime max</li> </ul> |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [login.personifyhealth.com](https://login.personifyhealth.com).

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-472-4352.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-472-4352.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-472-4352.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-472-4352.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**About these Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**

(9 months of in-network pre-natal care and a hospital delivery)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,050 |
| ■ <a href="#">Specialist coinsurance</a>                        | 10%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 10%     |
| ■ Other (Tests) <a href="#">coinsurance</a>                     | 10%     |

**This EXAMPLE event includes services like:**

[Specialist](#) office visits (*prenatal care*)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

|                                        |                 |
|----------------------------------------|-----------------|
| <b>Total Example Cost</b>              | <b>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| <a href="#">Deductibles</a>            | \$2,050         |
| <a href="#">Copayments</a>             | \$10            |
| <a href="#">Coinsurance</a>            | \$1,100         |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$60            |
| <b>The total Peg would pay is</b>      | <b>\$3,220</b>  |

**Managing Joe's Type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,050 |
| ■ <a href="#">Specialist coinsurance</a>                        | 10%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 10%     |
| ■ Other (Brand drug) <a href="#">coinsurance</a>                | 25%     |

**This EXAMPLE event includes services like:**

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$5,600</b> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$2,050        |
| <a href="#">Copayments</a>             | \$40           |
| <a href="#">Coinsurance</a>            | \$20           |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$20           |
| <b>The total Joe would pay is</b>      | <b>\$2,130</b> |

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,050 |
| ■ <a href="#">Specialist coinsurance</a>                        | 10%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 10%     |
| ■ Other (Physical Therapy) <a href="#">coinsurance</a>          | 10%     |

**This EXAMPLE event includes services like:**

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$2,800</b> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$2,050        |
| <a href="#">Copayments</a>             | \$0            |
| <a href="#">Coinsurance</a>            | \$80           |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$2,130</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.