



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, contact Moda Health at [www.modahealth.com](http://www.modahealth.com) or by calling 1-844-274-9117. 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 [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-844-274-9117 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                                                 | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$0                                                                                                                                                                                                                                                                                                     | See the Common Medical Events chart below for your costs and services this <a href="#">plan</a> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. All services are covered before you meet your <a href="#">deductible</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> ? | For <a href="#">network providers</a> \$3,500 individual / \$7,000 family;<br><a href="#">Out-of-network providers</a> \$10,500 individual / \$21,000 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> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, expenses incurred due to brand substitution, preauthorization penalties 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://www.modahealth.com/ProviderSearch?productCategory=medical&amp;selectedNetwork=Moda%20Select">https://www.modahealth.com/ProviderSearch?productCategory=medical&amp;selectedNetwork=Moda%20Select</a> or call 1-844-274-9117 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> 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="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| 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                                                                                                                                                                      |
|------------------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                        |                                                         | Network Provider<br>(You will pay the least)                                                                                                                    | Out-of-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        | \$0 <a href="#">copay</a> /visit                                                                                                                                | 60% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                        |
|                                                                        | <a href="#">Specialist visit</a>                        | \$0 <a href="#">copay</a> /acupuncture, massage therapy, spinal manipulation, virtual care and CirrusMD virtual visit, \$10 <a href="#">copay</a> /office visit | 60% <a href="#">coinsurance</a>                    | Office visits by naturopaths, acupuncturists and chiropractors are <a href="#">specialist</a> visits. <a href="#">Preauthorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.      |
|                                                                        | <a href="#">Preventive care/screening</a> /immunization | No charge for most services, 25% coinsurance for remaining services.                                                                                            | 60% <a href="#">coinsurance</a>                    | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)     | 25% <a href="#">coinsurance</a>                                                                                                                                 | 60% <a href="#">coinsurance</a>                    | Includes other tests such as EKG, allergy testing and sleep study.                                                                                                                                                          |
|                                                                        | Imaging (CT/PET scans, MRIs)                            | 25% <a href="#">coinsurance</a>                                                                                                                                 | 60% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.                                                                                                            |

| Common Medical Event                                                                                                                                                                                             | Services You May Need                            | What You Will Pay                                                                                                       |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                  |                                                  | Network Provider<br>(You will pay the least)                                                                            | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.modahealth.com/pdl">www.modahealth.com/pdl</a> | Value tier                                       | No charge                                                                                                               | No charge                                          | <a href="#">Preauthorization</a> may be required.<br><br>Covers up to a 90-day supply for retail and mail order prescriptions.<br><br>One copay for each 30-day supply<br><br>Mail order at a Moda Health designated mail order pharmacy only.<br><br>Covers up to a 30-day supply for most specialty medications. Moda Health designated specialty pharmacy only.<br><br>Anticancer medication is covered at \$150 <a href="#">copay</a> or 25% <a href="#">coinsurance</a> , whichever is less |
|                                                                                                                                                                                                                  | Select tier                                      | No charge                                                                                                               | No charge                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                  | Preferred tier                                   | \$15 <a href="#">copay</a> /retail prescription, \$45 <a href="#">copay</a> /90-day retail and mail order prescription  | \$15 <a href="#">copay</a> /prescription           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                  | Non-preferred tier                               | \$50 <a href="#">copay</a> /retail prescription, \$150 <a href="#">copay</a> /90-day retail and mail order prescription | \$50 <a href="#">copay</a> /prescription           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                  | <a href="#">Specialty drug tier</a>              | \$150 <a href="#">copay</a> /prescription                                                                               | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>If you have outpatient surgery</b>                                                                                                                                                                            | Facility fee (e.g., ambulatory surgery center)   | 25% <a href="#">coinsurance</a>                                                                                         | 60% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                  | Physician/surgeon fees                           | 25% <a href="#">coinsurance</a>                                                                                         | 60% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>If you need immediate medical attention</b>                                                                                                                                                                   | <a href="#">Emergency room care</a>              | 25% <a href="#">coinsurance</a>                                                                                         | 25% <a href="#">coinsurance</a>                    | In-network <a href="#">out-of-pocket limit</a> applies                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                                                                                                                                                                  | <a href="#">Emergency medical transportation</a> | 25% <a href="#">coinsurance</a>                                                                                         | 25% <a href="#">coinsurance</a>                    | Commercial transportation is limited to one-way for a sudden, life-endangering medical condition. In-network <a href="#">out-of-pocket limit</a> applies                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                  | <a href="#">Urgent care</a>                      | \$5 <a href="#">copay</a> /office visit, \$0 <a href="#">copay</a> /virtual care and CirrusMD virtual visit             | 60% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>If you have a hospital stay</b>                                                                                                                                                                               | Facility fee (e.g., hospital room)               | 25% <a href="#">coinsurance</a>                                                                                         | 60% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                  | Physician/surgeon fees                           | 25% <a href="#">coinsurance</a>                                                                                         | 60% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay                                                                                                                                                     |                                                                                         | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                   |
|----------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                           | Network Provider<br>(You will pay the least)                                                                                                                          | Out-of-Network Provider<br>(You will pay the most)                                      |                                                                                                                                                                                                                                                                                                                          |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$0 <a href="#">copay</a> /office and intensive outpatient, virtual care and CirrusMD virtual visit,<br>25% <a href="#">coinsurance</a> for other outpatient services | 60% <a href="#">coinsurance</a>                                                         | Psychological or neuropsychological testing limited to 12 hours per calendar year<br><a href="#">Preauthorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.                                                                                                                    |
|                                                                                  | Inpatient services                        | 25% <a href="#">coinsurance</a>                                                                                                                                       | 60% <a href="#">coinsurance</a>                                                         | <a href="#">Preauthorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.                                                                                                                                                                                                         |
| <b>If you are pregnant</b>                                                       | Office visits                             | No charge                                                                                                                                                             | 60% <a href="#">coinsurance</a>                                                         | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copay</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|                                                                                  | Childbirth/delivery professional services | 25% <a href="#">coinsurance</a>                                                                                                                                       | 60% <a href="#">coinsurance</a>                                                         |                                                                                                                                                                                                                                                                                                                          |
|                                                                                  | Childbirth/delivery facility services     | 25% <a href="#">coinsurance</a>                                                                                                                                       | 60% <a href="#">coinsurance</a>                                                         |                                                                                                                                                                                                                                                                                                                          |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | 25% <a href="#">coinsurance</a>                                                                                                                                       | 60% <a href="#">coinsurance</a>                                                         | Limited to 130 visits per year.                                                                                                                                                                                                                                                                                          |
|                                                                                  | <a href="#">Rehabilitation services</a>   | \$0 <a href="#">copay</a> /outpatient visit<br>25% <a href="#">coinsurance</a> for inpatient                                                                          | 60% <a href="#">coinsurance</a>                                                         | Calendar Year maximum of 30 inpatient days for rehabilitation and 45 outpatient sessions for rehabilitation and habilitation. Limits apply separately to outpatient rehabilitative and habilitative services.                                                                                                            |
|                                                                                  | <a href="#">Habilitation services</a>     | \$0 <a href="#">copay</a> /outpatient visit.<br>Not covered for inpatient.                                                                                            | 60% <a href="#">coinsurance</a> for outpatient, not covered for inpatient.              | <a href="#">Preauthorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.                                                                                                                                                                                                         |
|                                                                                  | <a href="#">Skilled nursing care</a>      | 25% <a href="#">coinsurance</a>                                                                                                                                       | 60% <a href="#">coinsurance</a>                                                         | Limited to 60 days per calendar year.                                                                                                                                                                                                                                                                                    |
|                                                                                  | <a href="#">Durable medical equipment</a> | 25% <a href="#">coinsurance</a><br><br>20% <a href="#">coinsurance</a> for hearing aids                                                                               | 60% <a href="#">coinsurance</a><br><br>20% <a href="#">coinsurance</a> for hearing aids | Includes supplies and prosthetics. Frequency limits apply to some <a href="#">durable medical equipment</a> (DME). <a href="#">Preauthorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.                                                                                      |
|                                                                                  | <a href="#">Hospice services</a>          | 25% <a href="#">coinsurance</a>                                                                                                                                       | 60% <a href="#">coinsurance</a>                                                         | Lifetime maximum of 10 inpatient days and 240 hours respite care.                                                                                                                                                                                                                                                        |
|                                                                                  |                                           |                                                                                                                                                                       |                                                                                         |                                                                                                                                                                                                                                                                                                                          |

| Common Medical Event                   | Services You May Need      | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                      |
|----------------------------------------|----------------------------|----------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                            | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                             |
| If your child needs dental or eye care | Children's eye exam        | No charge                                    | 50% <a href="#">coinsurance</a>                    | Limited to 1 per year.                                                                                                                                                                                      |
|                                        | Children's glasses         | No charge                                    | 50% <a href="#">coinsurance</a>                    | Coverage limited to 1 pair of glasses with frames from the Otis & Piper Eyewear collection per year for children under age 19. For age 19 and over, see member handbook for vision cost sharing and limits. |
|                                        | Children's dental check-up | No charge                                    | 60% <a href="#">coinsurance</a>                    | For members under age 19. Frequency limits and Plan coinsurance may apply to some services.                                                                                                                 |

#### Excluded Services & Other Covered Services:

##### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- |                         |                                                      |                        |
|-------------------------|------------------------------------------------------|------------------------|
| • Bariatric surgery     | • Long-term care                                     | • Private-duty nursing |
| • Cosmetic surgery      | • Naturopathic supplies                              | • Routine foot care    |
| • Dental care (Adult)   | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Infertility treatment |                                                      |                        |

##### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |                                                             |                                                      |                                                              |
|-------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------|
| • Acupuncture, limited to 24 visits per calendar year       | • Hearing aids, limited to one per ear every 3 years | • Routine eye care (Adult), limited to one eye exam per year |
| • Chiropractic care, limited to 24 visits per calendar year |                                                      |                                                              |

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <http://www.dol.gov/ebsa/healthreform> for group health coverage subject to ERISA, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov) for non-federal governmental group health plans, the Alaska Division of Insurance at 1-800-467-8725 or <http://www.commerce.state.ak.us/ins/Insurance/consumer.html> for Church plans. 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: Moda Health at 1-888-873-1395 or the Alaska Division of Insurance at <http://www.commerce.state.ak.us/ins/Insurance/consumer.html> or 1-800-467-8725. For group health coverage subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-

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

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 888-786-7461.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-873-1395.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 888-873-1395.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 888-873-1395.

*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> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$10 |
| ■ Hospital (facility)                                           | 25%  |
| ■ Other <a href="#">coinsurance</a>                             | 25%  |

#### 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> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| Cost Sharing                      |                 |
|-----------------------------------|-----------------|
| <a href="#">Deductibles</a>       | \$0             |
| <a href="#">Copayments</a>        | \$0*            |
| <a href="#">Coinsurance</a>       | \$3,100*        |
| What isn't covered                |                 |
| Limits or exclusions              | \$50            |
| <b>The total Peg would pay is</b> | <b>\$3,150*</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> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$10 |
| ■ Hospital (facility)                                           | 25%  |
| ■ Other <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> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$0          |
| <a href="#">Copayments</a>        | \$600        |
| <a href="#">Coinsurance</a>       | \$90         |
| What isn't covered                |              |
| Limits or exclusions              | \$20         |
| <b>The total Joe would pay is</b> | <b>\$710</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> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$10 |
| ■ Hospital (facility)                                           | 25%  |
| ■ Other <a href="#">coinsurance</a>                             | 25%  |

#### 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> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$0          |
| <a href="#">Copayments</a>        | \$30         |
| <a href="#">Coinsurance</a>       | \$600        |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$630</b> |

\*Note: These numbers assume a global charge. If your provider bills each service separately, these amounts may be different.

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