



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 1-888-217-2363. 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 1-888-217-2363 to request a copy.

| Important Questions                                                                   | Answers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | For <a href="#">network providers</a> \$300 individual / \$600 family. <a href="#">Out-of-network providers</a> are not covered.                                                                                                                                                                                                                                                                                                                                                                                                                                              | 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 <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                      |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes. For example: In-network office visits for primary care, <a href="#">specialist</a> and <a href="#">urgent care</a> , virtual care visits, most <a href="#">preventive care</a> , office visits for outpatient behavioral health services, outpatient <a href="#">rehabilitation services</a> , and <a href="#">habilitation services</a> , most in and <a href="#">out-of-network</a> prescription medications, in-network children's routine eye exams and glasses, adult eye exams, and hearing 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> . |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | For <a href="#">network providers</a> \$1,800 individual / \$3,600 family. <a href="#">Out-of-network providers</a> are not covered.                                                                                                                                                                                                                                                                                                                                                                                                                                          | 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.                                                                                                                                                                                                                                                                                       |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, expenses incurred due to brand substitution 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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

| Important Questions                                                                | Answers                                                                                                                                      | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>            | Yes. See <a href="http://www.modahealth.com">www.modahealth.com</a> or call 1-888-217-2363 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. |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b> | 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) |                                                                                                                                                                                                                             |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b> | Primary care visit to treat an injury or illness        | \$10 <a href="#">copay</a> /office and virtual care visit,<br>No charge for CirrusMD virtual visit;<br><a href="#">Deductible</a> does not apply                                                                        | Not Covered                                        | None                                                                                                                                                                                                                        |
|                                                                               | <a href="#">Specialist visit</a>                        | \$20 <a href="#">copay</a> /office visit,<br>\$10 <a href="#">copay</a> /acupuncture, spinal manipulation and virtual care visit,<br>No charge for CirrusMD virtual visit;<br><a href="#">Deductible</a> does not apply | Not Covered                                        | Office visits by naturopaths, acupuncturists and chiropractors are <a href="#">specialist</a> visits. <a href="#">Preauthorization</a> may be required. Failure to get preauthorization results in denial.                  |
|                                                                               | <a href="#">Preventive care/screening</a> /immunization | No charge for most services.<br>\$10 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply or<br>20% <a href="#">coinsurance</a> for remaining services.                                              | Not Covered                                        | 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. |
| <b>If you have a test</b>                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)     | 20% <a href="#">coinsurance</a>                                                                                                                                                                                         | Not Covered                                        | Includes other tests such as EKG, allergy testing and sleep study.                                                                                                                                                          |
|                                                                               | Imaging (CT/PET scans, MRIs)                            | 20% <a href="#">coinsurance</a>                                                                                                                                                                                         | Not Covered                                        | <a href="#">Preauthorization</a> may be required. Failure to get preauthorization results in denial.                                                                                                                        |

| 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="http://www.modahealth.com/pdl">prescription drug coverage</a> is available at <a href="http://www.modahealth.com/pdl">www.modahealth.com/pdl</a> | Value tier                                       | \$5 <a href="#">copay</a> /retail prescription, \$15 <a href="#">copay</a> /90-day retail and mail order prescription; <a href="#">deductible</a> does not apply          | \$5 <a href="#">copay</a> /retail prescription, <a href="#">deductible</a> does not apply | <a href="#">Preauthorization</a> may be required.<br><br>Covers up to a 30-day supply (retail pharmacy) and 90-day supply (mail order and participating retail pharmacies).<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 20% <a href="#">coinsurance</a><br><br>Maximum cost sharing for insulin is \$35 for 30-day supply and \$105 for 90-day supply, <a href="#">deductible</a> does not apply. |
|                                                                                                                                                                                                                                              | Select tier                                      | \$5 <a href="#">copay</a> /retail prescription, \$15 <a href="#">copay</a> /90-day retail and mail order prescription; <a href="#">deductible</a> does not apply          | \$5 <a href="#">copay</a> /retail prescription, <a href="#">deductible</a> does not apply |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                                              | Preferred tier                                   | 40% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply                                                                                               | 40% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                                              | Non-preferred tier                               | 50% <a href="#">coinsurance</a>                                                                                                                                           | 50% <a href="#">coinsurance</a>                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                                              | <a href="#">Specialty drug tier</a>              | 45% <a href="#">coinsurance</a> preferred specialty prescription.<br>50% <a href="#">coinsurance</a> non-preferred specialty prescription.                                | Not covered                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                        | Facility fee (e.g., ambulatory surgery center)   | 20% <a href="#">coinsurance</a>                                                                                                                                           | Not Covered                                                                               | <a href="#">Preauthorization</a> may be required. Failure to get preauthorization results in denial.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                              | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>                                                                                                                                           | Not Covered                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                               | <a href="#">Emergency room care</a>              | 20% <a href="#">coinsurance</a>                                                                                                                                           | 20% <a href="#">coinsurance</a>                                                           | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                              | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a>                                                                                                                                           | 20% <a href="#">coinsurance</a>                                                           | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                              | <a href="#">Urgent care</a>                      | \$20 <a href="#">copay</a> /office visit, \$10 <a href="#">copay</a> /virtual care visit, No charge for CirrusMD virtual visit; <a href="#">Deductible</a> does not apply | Not Covered                                                                               | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you have a hospital stay</b>                                                                                                                                                                                                           | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a>                                                                                                                                           | Not Covered                                                                               | <a href="#">Preauthorization</a> may be required. Failure to get preauthorization results in denial.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                              | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>                                                                                                                                           | Not Covered                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

| 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                       | \$10 <a href="#">copay</a> /office and intensive outpatient and virtual care visit, <a href="#">deductible</a> does not apply, No charge for CirrusMD virtual visit, 20% <a href="#">coinsurance</a> for other outpatient services | Not Covered                                        | <a href="#">Preauthorization</a> may be required. Failure to get preauthorization results in denial.                                                                                                                                                                                                                     |
|                                                                                  | Inpatient services                        | 20% <a href="#">coinsurance</a>                                                                                                                                                                                                    | Not Covered                                        | <a href="#">Preauthorization</a> may be required. Failure to get preauthorization results in denial.                                                                                                                                                                                                                     |
| <b>If you are pregnant</b>                                                       | Office visits                             | No charge                                                                                                                                                                                                                          | Not Covered                                        | <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 | 20% <a href="#">coinsurance</a>                                                                                                                                                                                                    | Not Covered                                        |                                                                                                                                                                                                                                                                                                                          |
|                                                                                  | Childbirth/delivery facility services     | 20% <a href="#">coinsurance</a>                                                                                                                                                                                                    | Not Covered                                        |                                                                                                                                                                                                                                                                                                                          |

| 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 help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | 20% <a href="#">coinsurance</a>                                                                                                           | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                       | <a href="#">Rehabilitation services</a>   | \$20 <a href="#">copay</a> /outpatient visit, <a href="#">deductible</a> does not apply.<br>20% <a href="#">coinsurance</a> for inpatient | Not Covered                                        | Calendar Year maximum of 30 sessions for outpatient rehabilitation and habilitation; and up to 60 rehabilitation sessions to treat neurologic conditions. Calendar Year maximum of 30 days for inpatient rehabilitation and habilitation or 60 days rehabilitation for head or spinal cord injury. Limits apply separately to rehabilitative and habilitative services. <a href="#">Preauthorization</a> may be required. Failure to get preauthorization results in denial. |
|                                                                       | <a href="#">Habilitation services</a>     | \$20 <a href="#">copay</a> /outpatient visit, <a href="#">deductible</a> does not apply.<br>20% <a href="#">coinsurance</a> for inpatient | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                       | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>                                                                                                           | Not Covered                                        | Limited to 60 days per calendar year.                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                       | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a><br>67% <a href="#">coinsurance</a> for wigs                                                               | Not Covered                                        | Includes supplies and prosthetics. Frequency limits apply to some <a href="#">durable medical equipment</a> (DME). Wigs are covered once per year for hair loss resulting from chemotherapy or radiation therapy. <a href="#">Preauthorization</a> may be required. Failure to get preauthorization results in denial.                                                                                                                                                       |
|                                                                       | <a href="#">Hospice services</a>          | 20% <a href="#">coinsurance</a>                                                                                                           | Not Covered                                        | Hospice coverage includes respite care limits of 5 consecutive days and a lifetime maximum of 30 days..                                                                                                                                                                                                                                                                                                                                                                      |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | No charge                                                                                                                                 | Not Covered                                        | Limited to 1 per year for children under age 19/1 per year for age 19 and over.                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                       | Children's glasses                        | No charge                                                                                                                                 | Not Covered                                        | Coverage limited to 1 pair of glasses per year for children under age 19.                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                       | Children's dental check-up                | Not Covered                                                                                                                               | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

## 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.)

- |                                                       |                                                             |                                                              |
|-------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------|
| • Abortion                                            | • Chiropractic care, limited to 20 visits per calendar year | • Routine eye care (Adult), limited to one eye exam per year |
| • Acupuncture, limited to 12 visits per calendar year | • Hearing aids, limited to one per ear every 3 years        |                                                              |

**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, and the Oregon Division of Financial Regulation at 1-888-877-4894 or [www.dfr.oregon.gov](http://www.dfr.oregon.gov) 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 1-888-217-2363. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact the Oregon Division of Financial Regulation at 1-888-877-4894 or [www.dfr.oregon.gov](http://www.dfr.oregon.gov).

**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> | \$300 |
| ■ <a href="#">Specialist copayment</a>                          | \$20  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 20%   |

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>       | \$300           |
| <a href="#">Copayments</a>        | \$0*            |
| <a href="#">Coinsurance</a>       | \$1,500*        |
| What isn't covered                |                 |
| Limits or exclusions              | \$50            |
| <b>The total Peg would pay is</b> | <b>\$1,850*</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> | \$300 |
| ■ <a href="#">Specialist copayment</a>                          | \$20  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 20%   |

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>       | \$300          |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$1,300        |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,820</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> | \$300 |
| ■ <a href="#">Specialist copayment</a>                          | \$20  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 20%   |

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>       | \$300        |
| <a href="#">Copayments</a>        | \$80         |
| <a href="#">Coinsurance</a>       | \$400        |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$780</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.