



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:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | For <a href="#">network providers</a> \$1,700 individual / \$3,400 family; for <a href="#">out-of-network providers</a> \$3,400 individual / \$6,800 family.                                                                | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.                                                                                                                                                                                                                                                                                                                               |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. Examples of some services: In-network most <a href="#">preventive care</a> , as well as in and out of network vision services and value tier medications 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> \$5,000 individual / \$10,000 family; for <a href="#">out-of-network providers</a> \$10,000 individual / \$20,000 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 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="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. |
| 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)                                     |                                                                                                                                                                                                                                                                                                                                           |
| <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                           | 0% <a href="#">coinsurance</a> /first 3 in person or virtual visits, then 50% <a href="#">coinsurance</a><br>0% <a href="#">coinsurance</a> /CirrusMD virtual visit | 50% <a href="#">coinsurance</a>                                                        | First 3 visits combined with virtual care, naturopathic physicians, mental health or substance use disorder office visits.                                                                                                                                                                                                                |
|                                                                                                                                                                                                                     | <a href="#">Specialist</a> visit                                           | 50% <a href="#">coinsurance</a><br>0% <a href="#">coinsurance</a> /CirrusMD virtual visit                                                                           | 40% <a href="#">coinsurance</a>                                                        | Calendar year maximum of 12 visits for acupuncture and 20 visits for spinal manipulation. <a href="#">Preauthorization</a> is required for some spinal manipulation. Failure to get <a href="#">preauthorization</a> results in denial.                                                                                                   |
|                                                                                                                                                                                                                     | <a href="#">Preventive care</a> / <a href="#">screening</a> / immunization | No charge for most services. 50% <a href="#">coinsurance</a> for remaining services.                                                                                | Not covered for most services. 50% <a href="#">coinsurance</a> for remaining services. | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. 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)                        | 50% <a href="#">coinsurance</a>                                                                                                                                     | 50% <a href="#">coinsurance</a>                                                        | Includes other tests such as EKG, allergy testing and sleep study.                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                     | Imaging (CT/PET scans, MRIs)                                               | 50% <a href="#">coinsurance</a>                                                                                                                                     | 50% <a href="#">coinsurance</a>                                                        | <a href="#">Preauthorization</a> is required for many services. Failure to get <a href="#">preauthorization</a> results in denial.                                                                                                                                                                                                        |
| <b>If you need drugs to treat your illness or condition</b><br>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                                                                              | Covers up to a 30-day supply (retail pharmacy); and 90-day supply (mail order and participating retail pharmacies). <a href="#">Preauthorization</a> may be required. Mail order at a Moda Health designated mail order pharmacy only.<br><br><a href="#">Cost sharing</a> for anticancer medication is 50% <a href="#">coinsurance</a> . |
|                                                                                                                                                                                                                     | All other medications                                                      | 50% <a href="#">coinsurance</a>                                                                                                                                     | 50% <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 drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.modahealth.com/pdl">www.modahealth.com/pdl</a> | <a href="#">Specialty drug</a> tier              | 50% <a href="#">coinsurance</a>                                                                                                                                      | Not covered                                        | Covers up to a 30-day supply for most specialty. <a href="#">Preauthorization</a> may be required. Moda Health designated pharmacy only.<br><br>\$35 maximum cost share 30-day supply and \$105 maximum cost share 90-day supply for insulin, <a href="#">deductible</a> does not apply. |
| <b>If you have outpatient surgery</b>                                                                                                                                                                               | Facility fee (e.g., ambulatory surgery center)   | 50% <a href="#">coinsurance</a>                                                                                                                                      | 50% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> may be required. Failure to get <a href="#">preauthorization</a> results in denial.                                                                                                                                                                     |
|                                                                                                                                                                                                                     | Physician/surgeon fees                           | 50% <a href="#">coinsurance</a>                                                                                                                                      | 50% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                          |
| <b>If you need immediate medical attention</b>                                                                                                                                                                      | <a href="#">Emergency room care</a>              | 50% <a href="#">coinsurance</a>                                                                                                                                      | 50% <a href="#">coinsurance</a>                    | In-network <a href="#">deductible</a> and <a href="#">out-of-pocket limit</a> apply.                                                                                                                                                                                                     |
|                                                                                                                                                                                                                     | <a href="#">Emergency medical transportation</a> | 50% <a href="#">coinsurance</a>                                                                                                                                      | 50% <a href="#">coinsurance</a>                    | In-network <a href="#">deductible</a> and <a href="#">out-of-pocket limit</a> apply.                                                                                                                                                                                                     |
|                                                                                                                                                                                                                     | <a href="#">Urgent care</a>                      | 50% <a href="#">coinsurance</a><br>0% <a href="#">coinsurance</a> / CirrusMD virtual visit                                                                           | 50% <a href="#">coinsurance</a>                    | None.                                                                                                                                                                                                                                                                                    |
| <b>If you have a hospital stay</b>                                                                                                                                                                                  | Facility fee (e.g., hospital room)               | 50% <a href="#">coinsurance</a>                                                                                                                                      | 50% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required for many services. Failure to get <a href="#">preauthorization</a> results in denial.                                                                                                                                                       |
|                                                                                                                                                                                                                     | Physician/surgeon fees                           | 50% <a href="#">coinsurance</a>                                                                                                                                      | 50% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                          |
| <b>If you need mental health, behavioral health, or substance abuse services</b>                                                                                                                                    | Outpatient services                              | 0% <a href="#">coinsurance</a> /first 3 in person or virtual visits, then 50% <a href="#">coinsurance</a><br>0% <a href="#">coinsurance</a> / CirrusMD virtual visit | 50% <a href="#">coinsurance</a>                    | First 3 visits combined with virtual care, PCP and naturopathic physicians office visits.<br><br><a href="#">Preauthorization</a> is required for some outpatient behavioral health services. Failure to obtain <a href="#">preauthorization</a> results in denial.                      |
|                                                                                                                                                                                                                     | Inpatient services                               | 50% <a href="#">coinsurance</a>                                                                                                                                      | 50% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required. Failure to obtain <a href="#">preauthorization</a> 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 are pregnant</b>                                            | Office visits                             | No charge/office visits for routine services, 0% <a href="#">coinsurance</a> for non-routine prenatal services | 50% <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 | 50% <a href="#">coinsurance</a>                                                                                | 50% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                       | Childbirth/delivery facility services     | 50% <a href="#">coinsurance</a>                                                                                | 50% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | 50% <a href="#">coinsurance</a>                                                                                | 50% <a href="#">coinsurance</a>                    | Calendar year maximum of 140 visits.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                       | <a href="#">Rehabilitation services</a>   | 50% <a href="#">coinsurance</a>                                                                                | 50% <a href="#">coinsurance</a>                    | Calendar year maximum of 30 days for inpatient and 30 sessions for outpatient rehabilitation except as required for mental health parity. May be eligible for 60 days for inpatient and 60 sessions for outpatient rehabilitation for acute head or spinal cord injury. Habilitation services are limited to services that qualify under rehabilitation guidelines and medically necessary to treat a mental health condition. <a href="#">Preauthorization</a> may be required. Failure to obtain <a href="#">preauthorization</a> results in denial. |
|                                                                       | <a href="#">Habilitation services</a>     | 50% <a href="#">coinsurance</a>                                                                                | 50% <a href="#">coinsurance</a>                    | Calendar year maximum of 60 days.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                       | <a href="#">Skilled nursing care</a>      | 50% <a href="#">coinsurance</a>                                                                                | 50% <a href="#">coinsurance</a>                    | Includes supplies and prosthetics. Frequency limits apply to some DME. <a href="#">Preauthorization</a> may be required. Failure to obtain <a href="#">preauthorization</a> results in denial.                                                                                                                                                                                                                                                                                                                                                         |
|                                                                       | <a href="#">Durable medical equipment</a> | 50% <a href="#">coinsurance</a>                                                                                | 50% <a href="#">coinsurance</a>                    | Calendar year maximum of 12 days for inpatient care and 170 hours for respite care.                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                       | <a href="#">Hospice services</a>          | 50% <a href="#">coinsurance</a>                                                                                | 50% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | No charge                                                                                                      | No charge                                          | Vision exam and supplies paid once every calendar year for members under age 19. Additional vision <a href="#">screening</a> covered in-network under preventive care for children age 3 to 5. \$400 every calendar year for members age 19 and over for combined vision services.                                                                                                                                                                                                                                                                     |
|                                                                       | Children's glasses                        | No charge                                                                                                      | No charge                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                       | 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                                           | • Infertility treatment                              | • Private-duty nursing                   |
| • Cosmetic surgery, except as required for certain situations | • Long-term care                                     | • Routine foot care, except for diabetes |
| • Dental care (Adult), except for accident related injuries   | • Naturopathic supplies                              | • Weight loss programs                   |
|                                                               | • Non-emergency care when traveling outside the U.S. |                                          |

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

- |               |                     |                            |
|---------------|---------------------|----------------------------|
| • Abortion    | • Chiropractic care | • Hearing aids             |
| • Acupuncture |                     | • Routine eye care (Adult) |

**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 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. For group health coverage subject to ERISA, 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> | \$1,700 |
| ■ <a href="#">Specialist coinsurance</a>                        | 50%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 50%     |
| ■ Other <a href="#">coinsurance</a>                             | 50%     |

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:

| <i>Cost Sharing</i>         |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$1,700 |
| <a href="#">Copayments</a>  | \$0     |
| <a href="#">Coinsurance</a> | \$3,300 |

*What isn't covered*

|                      |      |
|----------------------|------|
| Limits or exclusions | \$50 |
|----------------------|------|

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Peg would pay is</b> | <b>\$5,050</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> | \$1,700 |
| ■ <a href="#">Specialist coinsurance</a>                        | 50%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 50%     |
| ■ Other <a href="#">coinsurance</a>                             | 50%     |

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:

| <i>Cost Sharing</i>           |         |
|-------------------------------|---------|
| <a href="#">Deductibles</a> * | \$1,700 |
| <a href="#">Copayments</a>    | \$0     |
| <a href="#">Coinsurance</a>   | \$1,900 |

*What isn't covered*

|                      |      |
|----------------------|------|
| Limits or exclusions | \$20 |
|----------------------|------|

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Joe would pay is</b> | <b>\$3,620</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> | \$1,700 |
| ■ <a href="#">Specialist coinsurance</a>                        | 50%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 50%     |
| ■ Other <a href="#">coinsurance</a>                             | 50%     |

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:

| <i>Cost Sharing</i>           |         |
|-------------------------------|---------|
| <a href="#">Deductibles</a> * | \$1,700 |
| <a href="#">Copayments</a>    | \$0     |
| <a href="#">Coinsurance</a>   | \$600   |

*What isn't covered*

|                      |     |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Mia would pay is</b> | <b>\$2,300</b> |
|-----------------------------------|----------------|

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