



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> \$500 individual / \$1,500 family; for <a href="#">out-of-network providers</a> \$500 individual / \$1,500 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> , 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. Examples of some services: In-network office visits for the first four primary care, <a href="#">specialist</a> and <a href="#">urgent care</a> , virtual care visits, <a href="#">preventive care</a> , office visits for outpatient behavioral health services, outpatient <a href="#">diagnostic tests</a> , chronic condition visits, and diabetes services, maternity professional services, nutritional therapy, breastfeeding support, as well as in and out of network hospice care, routine nursery care, diabetic supplies, and breastfeeding supplies 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>             | Yes. \$50 individual / \$150 family for generic and brand prescription drugs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these 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> \$1,500 individual / \$4,500 family; for <a href="#">out-of-network providers</a> \$4,000 individual / \$12,000 family ; \$1,000 individual / \$3,000 family for prescription drugs.<br>Maximum cost share: for <a href="#">network providers</a> \$6,850 individual / \$13,700 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.                                                                                                                                                                                                                                                                                       |
| <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:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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)                                              |                                                                                                                                                                                           |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness                           | \$10 <a href="#">copay</a> /visits; <a href="#">deductible</a> does not apply to first 4 visits<br>No charge for chronic condition or virtual visits<br>No charge/CirrusMD virtual visit; <a href="#">deductible</a> does not apply | 30% <a href="#">coinsurance</a>                                                                 | None                                                                                                                                                                                      |
|                                                                        | <a href="#">Specialist</a> visit                                           | \$10 <a href="#">copay</a> /visit for massage therapy<br>\$25 <a href="#">copay</a> /visit for all other visits<br>No charge/CirrusMD virtual visit                                                                                 | 30% <a href="#">coinsurance</a>                                                                 | Office visits by naturopathic physicians, massage therapists, acupuncturists and chiropractors are specialist visits.<br>\$1,000 calendar year maximum for massage therapy.               |
|                                                                        | <a href="#">Preventive care</a> / <a href="#">screening</a> / immunization | No charge                                                                                                                                                                                                                           | 30% <a href="#">coinsurance</a> ,<br>15% <a href="#">coinsurance</a> tobacco cessation supplies | 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. |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)                        | No charge                                                                                                                                                                                                                           | 30% <a href="#">coinsurance</a>                                                                 | Includes other tests such as EKG, allergy testing and sleep study.                                                                                                                        |
|                                                                        | Imaging (CT/PET scans, MRIs)                                               | \$100 <a href="#">copay</a> /per service                                                                                                                                                                                            | \$100 <a href="#">copay</a> /per service, then 30% <a href="#">coinsurance</a>                  | <a href="#">Preauthorization</a> may be required. Failure to get <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 need drugs to treat your illness or condition</b><br>More information about <a href="https://www.judi.health">prescription drug coverage</a> is available at <a href="https://www.judi.health">https://www.judi.health</a> | Value tier                                       | No charge                                                                                                                                                            | No charge                                                                                     | See Judi Rx summary for more details                                                                                                                                                                     |
|                                                                                                                                                                                                                                      | Generic tier                                     | \$10 <a href="#">copay</a> /retail,<br>\$25 <a href="#">copay</a> /mail-order<br>\$10 <a href="#">copay</a> /specialty <a href="#">deductible</a> does not apply     | \$10 <a href="#">copay</a> /retail prescription,<br><a href="#">deductible</a> does not apply |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                      | Brand tier                                       | \$30 <a href="#">copay</a> /retail,<br>\$75 <a href="#">copay</a> mail-order,<br>\$100 <a href="#">copay</a> and specialty <a href="#">deductible</a> does not apply | \$30 <a href="#">copay</a> /retail prescription,<br><a href="#">deductible</a> does not apply |                                                                                                                                                                                                          |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                | Facility fee (e.g., ambulatory surgery center)   | \$25 <a href="#">copay</a> /visit                                                                                                                                    | \$100 <a href="#">copay</a> /per service then 40% <a href="#">coinsurance</a>                 | <a href="#">Preauthorization</a> may be required. Failure to get <a href="#">preauthorization</a> results in denial.<br><a href="#">Out-of-network</a> bariatric surgery is not covered.                 |
|                                                                                                                                                                                                                                      | Physician/surgeon fees                           | \$25 <a href="#">copay</a> /visit                                                                                                                                    | 30% <a href="#">coinsurance</a>                                                               |                                                                                                                                                                                                          |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                       | <a href="#">Emergency room care</a>              | \$150 <a href="#">copay</a> /visit                                                                                                                                   | \$150 <a href="#">copay</a> /visit                                                            | In-network <a href="#">deductible</a> and maximum cost share apply. <a href="#">Copay</a> waived if hospital admission immediately follows. Plan <a href="#">coinsurance</a> may apply to some services. |
|                                                                                                                                                                                                                                      | <a href="#">Emergency medical transportation</a> | \$75 <a href="#">copay</a> /per trip                                                                                                                                 | \$75 <a href="#">copay</a> /per trip                                                          | None                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                      | <a href="#">Urgent care</a>                      | \$25 <a href="#">copay</a> /office visit,<br>No charge/CirrusMD virtual visit                                                                                        | \$25 <a href="#">copay</a> /office visit                                                      | None                                                                                                                                                                                                     |
| <b>If you have a hospital stay</b>                                                                                                                                                                                                   | Facility fee (e.g., hospital room)               | \$50 <a href="#">copay</a> per day / \$250 <a href="#">copay</a> per admission                                                                                       | \$500 <a href="#">copay</a> per admission then 40% <a href="#">coinsurance</a>                | <a href="#">Preauthorization</a> may be required. Failure to get <a href="#">preauthorization</a> results in denial.<br><a href="#">Out-of-network</a> bariatric surgery is not covered.                 |
|                                                                                                                                                                                                                                      | Physician/surgeon fees                           | No charge                                                                                                                                                            | 30% <a href="#">coinsurance</a>                                                               |                                                                                                                                                                                                          |

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay                                                                                                                             |                                                                                                                                                          | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|----------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                           | Network Provider<br>(You will pay the least)                                                                                                  | Out-of-Network Provider<br>(You will pay the most)                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$10 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply.<br>No charge for substance use disorder                         | 30% <a href="#">coinsurance</a>                                                                                                                          | <a href="#">Preauthorization</a> may be required. Failure to obtain <a href="#">preauthorization</a> results in denial.                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                  | Inpatient services                        | \$50 <a href="#">copay</a> per day / \$250 <a href="#">copay</a> per admission<br>No charge for substance use disorder                        | \$500 <a href="#">copay</a> and 40% <a href="#">coinsurance</a> for inpatient mental health services, 40% <a href="#">coinsurance</a> for other services |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>If you are pregnant</b>                                                       | Office visits                             | No charge                                                                                                                                     | 30% <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 | No charge                                                                                                                                     | 30% <a href="#">coinsurance</a>                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                  | Childbirth/delivery facility services     | \$50 <a href="#">copay</a> per day / \$250 <a href="#">copay</a> per admission                                                                | \$500 <a href="#">copay</a> per admission then 40% <a href="#">coinsurance</a>                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | \$25 <a href="#">copay</a> /visit                                                                                                             | 30% <a href="#">coinsurance</a>                                                                                                                          | Limited to 180 visits per calendar year.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                  | <a href="#">Rehabilitation services</a>   | \$25 <a href="#">copay</a> /visit outpatient;<br>\$50 <a href="#">copay</a> per day / \$250 <a href="#">copay</a> per admission for inpatient | 30% <a href="#">coinsurance</a> for outpatient;<br>40% <a href="#">coinsurance</a> for inpatient                                                         | Calendar year maximum of 30 days for inpatient and 60 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. <a href="#">Habilitation services</a> 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>     | \$25 <a href="#">copay</a> /visit outpatient;<br>\$50 <a href="#">copay</a> per day / \$250 <a href="#">copay</a> per admission for inpatient | 30% <a href="#">coinsurance</a> for outpatient;<br>40% <a href="#">coinsurance</a> for inpatient                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                  | <a href="#">Skilled nursing care</a>      | \$50 <a href="#">copay</a> per day / \$250 <a href="#">copay</a> per admission for inpatient                                                  | 40% <a href="#">coinsurance</a>                                                                                                                          | Limited to 180 days per calendar year.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                  | <a href="#">Durable medical equipment</a> | 15% <a href="#">coinsurance</a>                                                                                                               | 30% <a href="#">coinsurance</a>                                                                                                                          | Includes supplies and prosthetics. Frequency limits apply to some durable medical equipment (DME). <a href="#">Preauthorization</a> may be required. Failure to obtain <a href="#">preauthorization</a> results in denial.                                                                                                                                                                                                                                                                                                                                             |
|                                                                                  | <a href="#">Hospice services</a>          | No charge                                                                                                                                     | No charge                                                                                                                                                | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

| Common Medical Event                   | Services You May Need      | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information |
|----------------------------------------|----------------------------|----------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
|                                        |                            | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                        |
| If your child needs dental or eye care | Children's eye exam        | No charge                                    | Not covered                                        | None.                                                  |
|                                        | Children's glasses         | Not covered                                  | Not covered                                        | None.                                                  |
|                                        | Children's dental check-up | Not covered                                  | Not covered                                        | None.                                                  |

### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                                                             |                                                                                                                                                                                        |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <ul style="list-style-type: none"> <li>Cosmetic surgery, except as required for certain situations</li> <li>Dental care (Adult), except for accident related injuries</li> </ul>                  | <ul style="list-style-type: none"> <li>Long-term care</li> <li>Naturopathic supplies</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</li> <li>Routine foot care, except for diabetes</li> <li>Weight loss programs</li> </ul> |  |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                      |                                                                                                                                                             |                                                                                                                                                                                        |  |
| <ul style="list-style-type: none"> <li>Abortion</li> <li>Acupuncture, limited to 12 visits per year</li> </ul>                                                                                    | <ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Chiropractic care, limited to 20 visits per year</li> </ul>                               | <ul style="list-style-type: none"> <li>Hearing aids, one per ear every 3 years</li> <li>Infertility treatment</li> </ul>                                                               |  |

**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> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$25  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$50  |
| ■ Other <a href="#">coinsurance</a>                             | 15%   |

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> | \$250   |
| <a href="#">Copayments</a>  | \$10    |
| <a href="#">Coinsurance</a> | \$1,300 |

| <i>What isn't covered</i> |      |
|---------------------------|------|
| Limits or exclusions      | \$50 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Peg would pay is</b> | <b>\$1,610</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> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$25  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$50  |
| ■ Other <a href="#">coinsurance</a>                             | 15%   |

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> | \$200 |
| <a href="#">Copayments</a>  | \$900 |
| <a href="#">Coinsurance</a> | \$100 |

| <i>What isn't covered</i> |      |
|---------------------------|------|
| Limits or exclusions      | \$20 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Joe would pay is</b> | <b>\$1,220</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> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$25  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$50  |
| ■ Other <a href="#">coinsurance</a>                             | 15%   |

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> | \$250 |
| <a href="#">Copayments</a>  | \$200 |
| <a href="#">Coinsurance</a> | \$400 |

| <i>What isn't covered</i> |     |
|---------------------------|-----|
| Limits or exclusions      | \$0 |

|                                   |              |
|-----------------------------------|--------------|
| <b>The total Mia would pay is</b> | <b>\$850</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.