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, visit www.MyAmeriBen.com or call 1-877-635-2909. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.MyAmeriBen.com or call 1-877-635-2909 to request a copy.

Important Questions	Answers			Why This Matters:
What is the overall deductible?		**Network**	**Non-Network**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
	Per participant:	$1,400	$1,400	
	Per family:	$2,800	$2,800	
Are there services covered before you meet your deductible?	Yes. Preventive care from a participating provider.			This plan covers some items and services even if you haven't yet met the deductible amount. But a co-payment or co-insurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.			You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?		**Network**	**Non-Network**	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
	Per participant:	$3,000	Unlimited	
	Per family:	$6,000	Unlimited	
What is not included in the out-of-pocket limit?	Premiums, balance billing charges (unless balance billing is prohibited), healthcare this plan doesn't cover, and penalties for failure to obtain pre-certification for services.			Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. **Medical:** See www.MyAmeriBen.com or call 1-877-635-2909 for a list of participating providers. **Prescription Drugs:** See www.Navitus.com for prescription drug coverage.			This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.			You can see the specialist you choose without a referral.

All **co-payment** and **co-insurance** 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 (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	50% co-insurance	BlueCare Anywhere consultations are paid at no charge.
	Specialist visit	20% co-insurance	50% co-insurance	
	ACA required preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive or required by the ACA. Ask your provider if the services needed are preventive. Then check what your plan will pay for. On-site screenings are covered at no charge.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	50% co-insurance	**Pre-certification is required for imaging over $1,000.**
	Imaging (CT/PET scans, MRIs)	20% co-insurance	50% co-insurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.navitus.com**	Generic drugs	20% co-insurance		Covers a 30-day and up to a 90-day supply at retail pharmacy; up to a 90-day supply at mail order pharmacy. Specialty drugs are only available in a 30-day supply at a retail pharmacy. Preventive medication and contraceptives are covered at no charge as required by law. This includes preventive medications on the IRS Safe Harbor list. Brand-name drug penalty: if generic is available but you choose the brand name, you pay the actual cost difference plus the brand name co-payment. Quantity limits, prior authorizations, and step therapy may be required. Purchases at a non-participating pharmacy require you to pay in full then submit a claim form for reimbursement.
	Preferred brand drugs	20% co-insurance		
	Non-preferred brand drugs	75% co-insurance		
	Specialty drugs	20% co-insurance		
If you have outpatient	Facility fee (e.g., ambulatory	20% co-insurance	50% co-insurance	**Pre-certification is required for surgical**

* For more information about limitations and exceptions, see the plan or policy document at www.MyAmeriBen.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
surgery	surgery center)			**procedures over $1,000.**
	Physician/surgeon fees	20% co-insurance	50% co-insurance	——————none——————
If you need immediate medical attention	Emergency room care	20% co-insurance	20% co-insurance	Rates listed are for emergency services. Services for a non-emergency are not covered.
	Emergency medical transportation	20% co-insurance	20% co-insurance	**Pre-certification is required for fixed wing air ambulance.**
	Urgent care	20% co-insurance	50% co-insurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	50% co-insurance	**Pre-certification is required for inpatient stays.** Room & board is limited to the semi-private room rate, or if the hospital has private rooms only, 100% of the lowest private room rate. ICU as billed.
	Physician/surgeon fees	20% co-insurance	50% co-insurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance	50% co-insurance	——————none——————
	Inpatient services	20% co-insurance	50% co-insurance	**Pre-certification is required for inpatient stays.**
If you are pregnant	Office visits	20% co-insurance	50% co-insurance	Cost sharing does not apply for preventive services rendered by a network provider.
	Childbirth/delivery professional services	20% co-insurance	50% co-insurance	——————none——————
	Childbirth/delivery facility services	20% co-insurance	50% co-insurance	**Pre-certification is required for an inpatient stay that is in excess of forty-eight (48) hours (vaginal delivery) or (96) hours (caesarean delivery).**
If you need help recovering or have other special needs	Home health care	20% co-insurance	50% co-insurance	**Pre-certification is required for visits and injectable medication over $1,000.** **Benefit Year Maximum:** Sixty (60) visits per plan participant.

* For more information about limitations and exceptions, see the plan or policy document at www.MyAmeriBen.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Rehabilitation services	20% co-insurance	50% co-insurance	**Benefit Year Maximum:** Cardiac rehab, physical, occupational, speech, and vision therapy are limited to a combined forty (40) visits per plan participant, combined with the habilitation maximum.
	Habilitation services	20% co-insurance	50% co-insurance	**Benefit Year Maximum:** Forty (40) visits per plan participant, combined with the rehabilitation maximum.
	Skilled nursing care	20% co-insurance	50% co-insurance	**Pre-certification is required for inpatient stays.** **Benefit Year Maximum:** Ninety (90) days per plan participant, including inpatient rehab facility.
	Durable medical equipment	20% co-insurance	50% co-insurance	**Pre-certification is required for durable medical equipment over $1,000.**
	Hospice services	20% co-insurance	50% co-insurance	**Pre-certification is required for hospice care.** **Lifetime Benefit Maximum:** One hundred-eighty (180) days per plan participant. Bereavement counseling must be done within two (2) months of the immediate family member's death.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	none
	Children's glasses	Not Covered	Not Covered	none
	Children's dental check-up	Not Covered	Not Covered	none

* For more information about limitations and exceptions, see the plan or policy document at www.MyAmeriBen.com.

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.)		
• Acupuncture • Cosmetic surgery • Dental care (Adult/Child) • Hearing aids	• Infertility treatment • Long-term care • Non-emergency care in an emergency room • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine eye care (Adult/Child) • Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Chiropractic care (40 visits/plan year)	• Habilitation services (40 visits/plan year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Plan's COBRA Administrator at AmeriBen, P.O. Box 7186, Boise, ID 83707, 1-877-635-2909. 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 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, you may contact the third party administrator (TPA) to assist the plan administrator with claims adjudication. The TPA's name, address, and telephone number are:

AmeriBen
Attention: Appeals Coordination
P.O. Box 7186
Boise, ID 83707
1-877-635-2909

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-877-635-2909.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-635-2909.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-635-2909.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-635-2909.
* For more information about limitations and exceptions, see the plan or policy document at www.MyAmeriBen.com.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

* For more information about limitations and exceptions, see the plan or policy document at www.MyAmeriBen.com.

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, co-payments and co-insurance) 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 plan's overall deductible	**$1,400**
Specialist cost sharing	**20%**
Hospital (facility) cost sharing	**20%**
Other cost sharing	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,400
Co-payments	$0
Co-insurance	$1,600
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$3,020**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,400**
Specialist cost sharing	**20%**
Hospital (facility) cost sharing	**20%**
Other cost sharing	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,400
Co-payments	$0
Co-insurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,600**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,400**
Specialist cost sharing	**20%**
Hospital (facility) cost sharing	**20%**
Other cost sharing	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,400
Co-payments	$0
Co-insurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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Important Questions	Answers			Why This Matters:
What is the overall deductible?		**Network**	**Non-Network**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
	Per participant:	$750	N/A	
	Per family:	$2,250	N/A	
Are there services covered before you meet your deductible?	Yes. Services paid with a co-payment (except emergency room care) and services paid at no charge.			This plan covers some items and services even if you haven't yet met the deductible amount. But a co-payment or co-insurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.			You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?		**Network**	**Non-Network**	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
	Per participant:	$8,700	N/A	
	Per family:	$17,400	N/A	
What is not included in the out-of-pocket limit?	Premiums, balance billing charges (unless balance billing is prohibited), healthcare this plan doesn't cover, and penalties for failure to obtain pre-certification for services.			Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. **Medical:** See www.MyAmeriBen.com or call 1-877-635-2909 for a list of participating providers. **Prescription Drugs:** See www.Navitus.com for prescription drug coverage.			This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-payment/visit, deductible waived	Not Covered	BlueCare Anywhere consultations are paid at no charge.
	Specialist visit	$50 co-payment/visit, deductible waived	Not Covered	
	ACA required preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive or required by the ACA. Ask your provider if the services needed are preventive. Then check what your plan will pay for. On-site screenings are covered at no charge.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	Not Covered	**Pre-certification is required for imaging over $1,000.**
	Imaging (CT/PET scans, MRIs)	20% co-insurance	Not Covered	Independent labs are paid at no charge.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.navitus.com**	Generic drugs	**30-day supply:** $10/prescription **Up to 90-day supply:** $20/prescription		Covers a 30-day and up to a 90-day supply at retail pharmacy; up to a 90-day supply at mail order pharmacy. Specialty drugs are only available in a 30-day supply at a retail pharmacy. Preventive medication and contraceptives are covered at no charge as required by law. Brand-name drug penalty: if generic is available but you choose the brand name, you pay the actual cost difference plus the brand name co-payment. Quantity limits, prior authorizations, and step therapy may be required. Purchases at a non-participating pharmacy require you to pay in full then submit a claim
	Preferred brand drugs	**30-day supply:** $30/prescription **Up to 90-day supply:** $60/prescription		
	Non-preferred brand drugs	**30-day supply:** 75% of the cost of the drug **Up to 90-day supply:** 75% of the cost of the drug		

* For more information about limitations and exceptions, see the plan or policy document at www.MyAmeriBen.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Specialty drugs	**30-day supply:** 20% co-insurance up to $150		form for reimbursement. Deductible does not apply to prescription drug expenses.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	Not Covered	**Pre-certification is required for surgical procedures over $1,000.**
	Physician/surgeon fees	20% co-insurance	Not Covered	——————none——————
If you need immediate medical attention	Emergency room care	$500 co-payment/visit, then 20% co-insurance, deductible does apply	$500 co-payment/visit, then 20% co-insurance, deductible does apply	Rates listed are for emergency services. Services for a non-emergency are not covered. Co-payment is waived if admitted.
	Emergency medical transportation	20% co-insurance	20% co-insurance	**Pre-certification is required for fixed wing air ambulance.**
	Urgent care	$50 co-payment	Not Covered	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	Not Covered	**Pre-certification is required for inpatient stays.** Room & board is limited to the semi-private room rate, or if the hospital has private rooms only, 100% of the lowest private room rate. ICU as billed.
	Physician/surgeon fees	20% co-insurance	Not Covered	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Primary care physician: $30 co-payment/office visit, deductible waived Specialist: $50 co-payment/office visit, deductible waived	Not Covered	——————none——————
	Inpatient services	20% co-insurance	Not Covered	**Pre-certification is required for inpatient stays.**
If you are pregnant	Office visits	20% co-insurance	Not Covered	If maternity charges are billed separately rather than globally, applicable office visit co-payments will apply. Cost sharing does not apply for preventive services rendered by a network provider.
	Childbirth/delivery professional services	20% co-insurance	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at www.MyAmeriBen.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	20% co-insurance	Not Covered	**Pre-certification is required for an inpatient stay that is in excess of forty-eight (48) hours (vaginal delivery) or ninety-six (96) hours (caesarean delivery).**
If you need help recovering or have other special needs	Home health care	20% co-insurance	Not Covered	**Pre-certification is required for visits and injectable medication over $1,000.** **Benefit Year Maximum:** Sixty (60) visits per plan participant.
	Rehabilitation services	20% co-insurance	Not Covered	**Benefit Year Maximum:** Cardiac rehab, physical, occupational, speech, and vision therapy are limited to a combined forty (40) visits per plan participant, combined with the habilitation maximum.
	Habilitation services	Primary care physician: $30 co-payment/office visit, deductible waived Specialist: $50 co-payment/office visit, deductible waived	Not Covered	**Benefit Year Maximum:** Forty (40) visits per plan participant, combined with the rehabilitation maximum.
	Skilled nursing care	20% co-insurance	Not Covered	**Pre-certification is required for inpatient stays.** **Benefit Year Maximum:** Ninety (90) days per plan participant, including inpatient rehab facility.
	Durable medical equipment	20% co-insurance	Not Covered	**Pre-certification is required for durable medical equipment over $1,000.**
	Hospice services	20% co-insurance	Not Covered	**Pre-certification is required for hospice care.** **Lifetime Benefit Maximum:** One hundred-eighty (180) days per plan participant. Bereavement counseling must be done within two (2) months of the immediate family member's death.
If your child needs	Children's eye exam	Not Covered	Not Covered	none

* For more information about limitations and exceptions, see the plan or policy document at www.MyAmeriBen.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
dental or eye care	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult/Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care in an emergency room
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult/Child)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care (40 visits/plan year)
- Habilitation services (40 visits/plan year)

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AmeriBen
Attention: Appeals Coordination
P.O. Box 7186
Boise, ID 83707
1-877-635-2909

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.

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Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-635-2909.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-635-2909.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-635-2909.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-635-2909.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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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, co-payments and co-insurance) 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 plan's overall deductible	**$750**
Specialist co-payment	**$50**
Hospital (facility) cost sharing	**20%**
Other cost sharing	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Co-payments	$20
Co-insurance	$2,400
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$3,170**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$750**
Specialist co-payment	**$50**
Hospital (facility) cost sharing	**20%**
Other cost sharing	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Co-payments	$700
Co-insurance	$10
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,510**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$750**
Specialist co-payment	**$50**
Hospital (facility) cost sharing	**20%**
Other cost sharing	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Co-payments	$500
Co-insurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.