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, please call **1-877-405-2926.** 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 **https://www.healthcare.gov/sbc-glossary** or by calling **1-877-405-2926** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1: $0 / $0; Tier 2 In-Network/Participating Providers: $5,000/person; $10,000/family; Tier 3 Out-of-Network/Non-participating Providers: Not Covered	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.
Are there services covered before you meet your deductible?	Yes. Preventive Care Services, and some services that charge a copayment, such as primary care, specialty care and prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance 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?	Tier 1 & 2 In-Network/Participating Providers: $10,000/person; $20,000/family Tier 3 Out-of-Network/Non-participating Providers: Not Covered	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. Out-of-network costs do not accumulate towards the out-of-pocket maximum.
What is not included in the out-of-pocket limit?	Penalties for non-compliance with plan provisions; premiums; balance-billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. https://medivi.6degreeshealth.com or call 877-405-2926 for a list of network providers.	You pay the least if you use Tier 1 providers to whom you are referred by your Care Coordination Team. Tier 1 benefits are not guaranteed. You pay more if you use a Tier 2 In-Network/Participating provider. You will pay the most if you use a non-participating/ 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).
Do you need a referral to see a specialist?	No, but it is highly recommended.	You can see the specialist you choose without permission from this plan.

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All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. If the deductible does not apply, neither does coinsurance.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge (through select partner)	$25 Copay/Office Visit	Not Covered	Other services performed in a physician's office setting (including but not limited to minor surgery or procedures) are subject to deductible and coinsurance.
	Specialist visit	Not applicable. See Tier 2 benefit.	$75 Copay/Office Visit	Not Covered	Other services performed in a physician's office setting (including but not limited to minor surgery or procedures) are subject to deductible and coinsurance. **Outpatient Hospital:** 30% Coinsurance after Annual Deductible
	Chiropractic Services	Not applicable. See Tier 2 benefit.	$45 Copay/Office Visit	Not Covered	Limited to 12 visits per calendar year.
	Preventive care/screening/ immunization	Not applicable. See Tier 2 benefit.	Covered in Full	Not Covered	Preventive Services are as outlined by the Patient Protection & Affordable Care Act. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (blood work)	Not applicable. See Tier 2 benefit.	30% Coinsurance after Annual Deductible	Not Covered	None.
	Imaging (X-Ray, CT/PET scans, MRIs)	No charge	30% Coinsurance after Annual Deductible	Not Covered	Preauthorization is a condition of benefit eligibility under this Plan. Except as provided below, services rendered without required Preauthorization are not covered benefits, and no payment will be made by the Plan. The Plan may require the use of a Designated Provider or Designated Site of

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	
					Care. In certain instances, services obtained elsewhere may not be covered. If Preauthorization is not obtained before services are rendered, the ordering or rendering provider may request a post-service authorization within 30 days of the date of service. If the post-service authorization is approved, the Plan's allowable amount for the covered service(s) will be reduced by 25%. The member is responsible for this reduction amount, which will not apply toward the deductible or out-of-pocket maximum. Post-service authorization requests received more than 30 days after the date of service will not be approved, and the service will remain a non-covered benefit. Tier 1 benefits are not guaranteed.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.writewise.com.	Generic drugs	Not applicable. See Tier 2 benefit.	$0 Copay/Prescription (30-day) $0 Copay/Prescription (90-day)	Not Covered.	Covers up to a 30-day supply (retail); 90-day supply (retail/mail order). Formulary: www.writewise.com/files/Premier-Plus-Plan.pdf Visit writewiserx.americaspharmacy.com/ to access Discount Card.
	Preferred brand drugs	Not applicable. See Tier 2 benefit.	$0 Copay/Prescription (30-day) $0 Copay/Prescription (90-day)	Not Covered.	
	Non-preferred brand drugs	Not applicable. See Tier 2 benefit.	Not Covered; Discount Card Available.	Not Covered.	
	Specialty drugs	Not applicable. See Tier 2 benefit.	Not Covered; Discount Card Available.	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% Coinsurance after Annual Deductible, plus amounts that exceed the Maximum Allowable Charge		Preauthorization is a condition of benefit eligibility under this Plan. Except as provided below, services rendered without required Preauthorization are not covered benefits, and no payment will be made by the Plan. The Plan may require the use of a Designated Provider or Designated Site of Care. In certain instances, services obtained elsewhere may not be covered. If Preauthorization is not obtained before services are rendered, the ordering or rendering provider may request a post-service authorization within 30 days of the date of service. If the post-service authorization is approved, the Plan's allowable amount for the covered service(s) will be reduced by 25%. The member is responsible for this reduction amount, which will not apply toward the deductible or out-of-pocket maximum. Post-service authorization requests received more than 30 days after the date of service will not be approved, and the service will remain a non-covered benefit. Tier 1 benefits are not guaranteed. For hospitals and facilities, the Maximum Allowable Charge paid by your plan is based on a reference-based price. Reference-based pricing works by reimbursing hospitals and facilities based
	Physician/surgeon fees	No charge	30% Coinsurance after Annual Deductible	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	Limitations, Exceptions, & Other Important Information
					on objective criteria. Most commonly, the criteria will be Medicare-published costs and pricing data, plus an additional percentage. This allows for a reasonable reimbursement that is fair to the hospital and facility, and a savings to the plan.
If you need immediate medical attention	Emergency room care	Not applicable. See Tier 2 benefit.	30% Coinsurance after Annual Deductible		If admitted, preauthorization must be requested within 48 hours of the service date or as soon as reasonably possible. If requested timely, no preauthorization reduction will apply. If not requested within 48 hours, the Plan may apply the 25% post-service reduction. For hospitals and facilities, the Maximum Allowable Charge paid by your plan is based on a reference-based price. Reference-based pricing works by reimbursing hospitals and facilities based on objective criteria. Most commonly, the criteria will be Medicare-published costs and pricing data, plus an additional percentage. This allows for a reasonable reimbursement that is fair to the hospital and facility, and a savings to the plan.

Common Medical Event	Services You May Need	What You Will Pay Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	Limitations, Exceptions, & Other Important Information
	Emergency medical transportation	Not applicable. See Tier 2 benefit.	30% Coinsurance after Annual Deductible		ALS and Air Ambulance are only covered when medically necessary and the only option. For hospitals and facilities, the Maximum Allowable Charge paid by your plan is based on a reference-based price. Reference-based pricing works by reimbursing hospitals and facilities based on objective criteria. Most commonly, the criteria will be Medicare-published costs and pricing data, plus an additional percentage. This allows for a reasonable reimbursement that is fair to the hospital and facility, and a savings to the plan.
	Urgent care	No charge (through select partner)	$100 Copay/Office Visit (standalone clinic)	Not Covered	**Outpatient Hospital:** 30% Coinsurance after Annual Deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable. See Tier 2 benefit.	30% Coinsurance after Annual Deductible, plus amounts that exceed the Maximum Allowable Charge		Preauthorization is a condition of benefit eligibility under this Plan. Except as provided below, services rendered without required Preauthorization are not covered benefits, and no payment will be made by the Plan. The Plan may require the use of a Designated Provider or Designated Site of Care. In certain instances, services obtained elsewhere may not be covered. If Preauthorization is not obtained before services are rendered, the ordering or rendering provider may request a post-service authorization within 30 days of the date of service. If the post-service
	Physician/surgeon fees	Not applicable. See Tier 2 benefit.	30% Coinsurance after Annual Deductible	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	
					authorization is approved, the Plan's allowable amount for the covered service(s) will be reduced by 25%. The member is responsible for this reduction amount, which will not apply toward the deductible or out-of-pocket maximum. Post-service authorization requests received more than 30 days after the date of service will not be approved, and the service will remain a non-covered benefit. Tier 1 benefits are not guaranteed. For hospitals and facilities, the Maximum Allowable Charge paid by your plan is based on a reference-based price. Reference-based pricing works by reimbursing hospitals and facilities based on objective criteria. Most commonly, the criteria will be Medicare-published costs and pricing data, plus an additional percentage. This allows for a reasonable reimbursement that is fair to the hospital and facility, and a savings to the plan.

Common Medical Event	Services You May Need	What You Will Pay: Tier 1 (Preferred)	What You Will Pay: Tier 2 (In-Network/Participating Provider)	What You Will Pay: Tier 3 (Out-of-Network/Non-Participating Provider)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge (through select partner)	$25 Copay/Office Visit (Provider's Office) 30% Coinsurance after Annual Deductible (Outpatient hospital)	Not Covered	**Inpatient Services:** Preauthorization is a condition of benefit eligibility under this Plan. Except as provided below, services rendered without required Preauthorization are not covered benefits, and no payment will be made by the Plan. The Plan may require the use of a Designated Provider or Designated Site of Care. In certain instances, services obtained elsewhere may not be covered. If Preauthorization is not obtained before services are rendered, the ordering or rendering provider may request a post-service authorization within 30 days of the date of service. If the post-service authorization is approved, the Plan's allowable amount for the covered service(s) will be reduced by 25%. The member is responsible for this reduction amount, which will not apply toward the deductible or out-of-pocket maximum. Post-service authorization requests received more than 30 days after the date of service will not be approved, and the service will remain a non-covered benefit. Tier 1 benefits are not guaranteed. For hospitals and facilities, the Maximum Allowable Charge paid by your plan is based on a reference-based price. Reference-based pricing works by
	Inpatient services	No charge	30% Coinsurance after Annual Deductible, plus amounts that exceed the Maximum Allowable Charge		

Common Medical Event	Services You May Need	What You Will Pay Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	Limitations, Exceptions, & Other Important Information
					reimbursing hospitals and facilities based on objective criteria. Most commonly, the criteria will be Medicare-published costs and pricing data, plus an additional percentage. This allows for a reasonable reimbursement that is fair to the hospital and facility, and a savings to the plan.
If you are pregnant	Office visits	No charge	Initial visit: $75 Copay/Office Visit Subsequent visits: No charge	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Tier 1 benefits are not guaranteed.
	Childbirth/delivery professional services	No charge	30% Coinsurance after Annual Deductible	Not Covered	
	Childbirth/delivery facility services	No charge	30% Coinsurance after Annual Deductible, plus amounts that exceed the Maximum Allowable Charge		Prior authorization may be required for stays exceeding 48 hours (vaginal deliveries) or 96 hours (caesarian deliveries). Preauthorization is a condition of benefit eligibility under this Plan. Except as provided below, services rendered without required Preauthorization are not covered benefits, and no payment will be made by the Plan. The Plan may require the use of a Designated Provider or Designated Site of Care. In certain instances, services obtained elsewhere may not be covered. If Preauthorization is not obtained before services are rendered, the ordering or rendering provider may request a post-service authorization within 30 days of the

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	
					date of service. If the post-service authorization is approved, the Plan's allowable amount for the covered service(s) will be reduced by 25%. The member is responsible for this reduction amount, which will not apply toward the deductible or out-of-pocket maximum. Post-service authorization requests received more than 30 days after the date of service will not be approved, and the service will remain a non-covered benefit. Tier 1 benefits are not guaranteed. For hospitals and facilities, the Maximum Allowable Charge paid by your plan is based on a reference-based price. Reference-based pricing works by reimbursing hospitals and facilities based on objective criteria. Most commonly, the criteria will be Medicare-published costs and pricing data, plus an additional percentage. This allows for a reasonable reimbursement that is fair to the hospital and facility, and a savings to the plan.

Common Medical Event	Services You May Need	What You Will Pay Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge	30% Coinsurance after Annual Deductible	Not Covered	Limited to 180 visits per calendar year. Preauthorization is a condition of benefit eligibility under this Plan. Except as provided below, services rendered without required Preauthorization are not covered benefits, and no payment will be made by the Plan. The Plan may require the use of a Designated Provider or Designated Site of Care. In certain instances, services obtained elsewhere may not be covered. If Preauthorization is not obtained before services are rendered, the ordering or rendering provider may request a post-service authorization within 30 days of the date of service. If the post-service authorization is approved, the Plan's allowable amount for the covered service(s) will be reduced by 25%. The member is responsible for this reduction amount, which will not apply toward the deductible or out-of-pocket maximum. Post-service authorization requests received more than 30 days after the date of service will not be approved, and the service will remain a non-covered benefit. Tier 1 benefits are not guaranteed.
	Rehabilitation services Habilitation services	No charge	$75 Copay	Not Covered	Rehabilitation & Habilitation: combined limit of 30 days per calendar year. Preauthorization is a condition of benefit

Common Medical Event	Services You May Need	What You Will Pay Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	Limitations, Exceptions, & Other Important Information
					eligibility under this Plan. Except as provided below, services rendered without required Preauthorization are not covered benefits, and no payment will be made by the Plan. The Plan may require the use of a Designated Provider or Designated Site of Care. In certain instances, services obtained elsewhere may not be covered. If Preauthorization is not obtained before services are rendered, the ordering or rendering provider may request a post-service authorization within 30 days of the date of service. If the post-service authorization is approved, the Plan's allowable amount for the covered service(s) will be reduced by 25%. The member is responsible for this reduction amount, which will not apply toward the deductible or out-of-pocket maximum. Post-service authorization requests received more than 30 days after the date of service will not be approved, and the service will remain a non-covered benefit. Tier 1 benefits are not guaranteed.
	Skilled nursing care	No charge	30% Coinsurance after Annual Deductible, plus amounts that exceed the Maximum Allowable Charge		Limit of 30 days per calendar year. Preauthorization is a condition of benefit eligibility under this Plan. Except as provided below, services rendered without required Preauthorization are not covered benefits, and no payment will be made by

Common Medical Event	Services You May Need	What You Will Pay Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	Limitations, Exceptions, & Other Important Information
					the Plan. The Plan may require the use of a Designated Provider or Designated Site of Care. In certain instances, services obtained elsewhere may not be covered. If Preauthorization is not obtained before services are rendered, the ordering or rendering provider may request a post-service authorization within 30 days of the date of service. If the post-service authorization is approved, the Plan's allowable amount for the covered service(s) will be reduced by 25%. The member is responsible for this reduction amount, which will not apply toward the deductible or out-of-pocket maximum. Post-service authorization requests received more than 30 days after the date of service will not be approved, and the service will remain a non-covered benefit. For hospitals and facilities, the Maximum Allowable Charge paid by your plan is based on a reference-based price. Reference-based pricing works by reimbursing hospitals and facilities based on objective criteria. Most commonly, the criteria will be Medicare-published costs and pricing data, plus an additional percentage. This allows for a reasonable reimbursement that is fair to the hospital and facility, and a savings to the plan.
	Durable medical	No charge	30% Coinsurance after Annual	Not Covered	Preauthorization is a condition of benefit

Common Medical Event	Services You May Need	What You Will Pay Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	Limitations, Exceptions, & Other Important Information
	equipment		Deductible		eligibility under this Plan. Except as provided below, services rendered without required Preauthorization are not covered benefits, and no payment will be made by the Plan. The Plan may require the use of a Designated Provider or Designated Site of Care. In certain instances, services obtained elsewhere may not be covered. If Preauthorization is not obtained before services are rendered, the ordering or rendering provider may request a post-service authorization within 30 days of the date of service. If the post-service authorization is approved, the Plan's allowable amount for the covered service(s) will be reduced by 25%. The member is responsible for this reduction amount, which will not apply toward the deductible or out-of-pocket maximum. Post-service authorization requests received more than 30 days after the date of service will not be approved, and the service will remain a non-covered benefit. Tier 1 benefits are not guaranteed.
	Hospice services	No charge	30% Coinsurance after Annual Deductible	Not Covered	Benefits limited to 30 days per calendar year. Preauthorization is a condition of benefit eligibility under this Plan. Except as provided below, services rendered without required Preauthorization are not covered

Common Medical Event	Services You May Need	What You Will Pay Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	Limitations, Exceptions, & Other Important Information
					benefits, and no payment will be made by the Plan. The Plan may require the use of a Designated Provider or Designated Site of Care. In certain instances, services obtained elsewhere may not be covered. If Preauthorization is not obtained before services are rendered, the ordering or rendering provider may request a post-service authorization within 30 days of the date of service. If the post-service authorization is approved, the Plan's allowable amount for the covered service(s) will be reduced by 25%. The member is responsible for this reduction amount, which will not apply toward the deductible or out-of-pocket maximum. Post-service authorization requests received more than 30 days after the date of service will not be approved, and the service will remain a non-covered benefit. Tier 1 benefits are not guaranteed.
If your child needs dental or eye care	Children's eye exam	Covered in Full	Covered in Full	Not Covered	Preventive care includes visual screening assessment, as covered under preventive services. (Recommended by Bright Futures Project).
	Children's glasses	Not Covered	Not Covered	Not Covered	Excluded Service.
	Children's dental check-up	Covered in Full	Covered in Full	Not Covered	Preventive care includes oral health risk assessment, as covered under preventive services. (Recommended by Bright Futures Project).

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
- Bariatric surgery
- Cosmetic Surgery
- Dental care (except for treatment to sound natural teeth required due to injury.)
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine Eye Exam (Adult)
- 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.)

- Chiropractic Care
- Dialysis
- Routine Hearing Exam
- Specialty Drugs

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 www.dol.gov/ebsa. 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, contact: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-877-405-2926.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-405-2926.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-405-2926.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-405-2926..

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 plan's overall deductible** **$5,000**
- **Specialist *Copayment*** **$75**
- **Hospital (facility) *Coinsurance*** **30%**
- **Other *Coinsurance**** **30%**

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	$5,000
Copayments	$0
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,360**

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

- **The plan's overall deductible** **$5,000**
- **Specialist *Copayment*** **$75**
- **Hospital (facility) *Coinsurance*** **30%**
- **Other *Coinsurance**** **30%**

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	$900
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

- **The plan's overall deductible** **$5,000**
- **Specialist *Copayment*** **$75**
- **Hospital (facility) *Coinsurance*** **30%**
- **Other *Coinsurance**** **30%**

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	$2,100
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,600**

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