



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.** Please read the FEHB Plan brochure (RI 71-005) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at [feblue.org/brochure](http://feblue.org/brochure), and view the Glossary at [www.opm.gov/healthcare-insurance/insurance-glossary/](http://www.opm.gov/healthcare-insurance/insurance-glossary/). You can call 1-800-411-2583 to request a copy of either document.

| Important Questions                                                       | Answers                                                                                                                                                                                                              | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <u>deductible</u>?</b>                             | \$ <u>350</u> /Self Only<br>\$ <u>700</u> /Self Plus One<br>\$ <u>700</u> /Self and Family                                                                                                                           | Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a <u>deductible</u> , only the Plan allowance for the service/supply counts toward the <u>deductible</u> . If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. Preventive care and primary care services are covered before you meet your deductible.                                                                                                                          | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No.                                                                                                                                                                                                                  | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | For <u>Preferred providers</u> \$6,000 Self Only /<br>\$12,000 Self Plus One / \$12,000 Self and Family; for <u>Non-preferred providers</u> \$8,000 Self Only /<br>\$16,000 Self Plus One / \$16,000 Self and Family | The <u>out-of-pocket limit</u> , or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                                                                                                           |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, and penalties for                                                                                                      | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

|                                                                  |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                  | failure to obtain preauthorization for services.                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Will you pay less if you use a <u>network provider</u>?</b>   | Yes. See provider.fepblue.org or call your local BCBS company for a list of <u>network providers</u> . | This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a provider in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b> | No.                                                                                                    | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                        |



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, plus you may be balance billed) |                                                                                                                                                                         |
| <b>If you visit a health care <u>provider's</u> office or clinic</b> | Primary care visit to treat an injury or illness | \$30/visit. <u>Deductible</u> does not apply. | 35% <u>coinsurance</u>                                                             | You pay nothing when you receive care in connection with, and within 72 hours after, an accidental injury.                                                              |
|                                                                      | <u>Specialist</u> visit                          | \$40/visit. <u>Deductible</u> does not apply. | 35% <u>coinsurance</u>                                                             | None                                                                                                                                                                    |
|                                                                      | <u>Preventive care/screening/immunization</u>    | No charge. <u>Deductible</u> does not apply.  | 35% <u>coinsurance</u>                                                             | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| <b>If you have a test</b>                                            | <u>Diagnostic test</u> (x-ray, blood work)       | 15% <u>coinsurance</u>                        | 35% <u>coinsurance</u>                                                             | None                                                                                                                                                                    |
|                                                                      | Imaging (CT/PET scans, MRIs)                     | 15% <u>coinsurance</u>                        | 35% <u>coinsurance</u>                                                             | 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, plus you may be balance billed) |                                                                                                                                                                       |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="https://www.fepblue.org/formulary">prescription drug coverage</a> is available at <a href="https://www.fepblue.org/formulary">fepblue.org/formulary</a> | Tier 1 (Generic drugs)                         | Retail: \$7.50/prescription (30-day supply)<br>Mail service: \$15/prescription.<br><u>Deductible</u> does not apply.                                                                     | 45% of the average wholesale price (AWP)<br><u>Deductible</u> does not apply.      | Retail: \$22.50/prescription for 31 to 90-day supply                                                                                                                  |
|                                                                                                                                                                                                                                                        | Tier 2 (Preferred brand drugs)                 | Retail: 30% <u>coinsurance</u><br>Mail service: 15%coinsurance / \$150 maximum. <u>Deductible</u> does not apply.                                                                        | 45% of the average wholesale price (AWP)<br><u>Deductible</u> does not apply.      | Retail: Up to a 90-day supply                                                                                                                                         |
|                                                                                                                                                                                                                                                        | Tier 3 (Non-preferred brand drugs)             | Retail: 50% <u>coinsurance</u><br>Mail service: 20% coinsurance / \$250 maximum. <u>Deductible</u> does not apply.                                                                       | 45% of the average wholesale price (AWP)<br><u>Deductible</u> does not apply.      | Retail: Up to a 90-day supply<br>Prior approval is required for certain prescription drugs.                                                                           |
|                                                                                                                                                                                                                                                        | Tier 4 ( Preferred <u>specialty drugs</u> )    | Retail: 30% <u>coinsurance</u> (30-day supply)<br>Specialty pharmacy: \$100/prescription (30-day supply); \$300/prescription (31 to 90-day supply).<br><u>Deductible</u> does not apply. | 45% of the average wholesale price (AWP)<br><u>Deductible</u> does not apply.      | Retail: One fill limit<br><br>Specialty pharmacy: 90-day supply can only be obtained after 3rd fill<br><br>Prior approval is required for certain prescription drugs. |
|                                                                                                                                                                                                                                                        | Tier 5 (Non-preferred <u>specialty drugs</u> ) | Retail: 30% <u>coinsurance</u> (30-day supply)<br>Specialty pharmacy: \$150/prescription (30-day supply); \$450/prescription (31 to 90-day supply).                                      | 45% of the average wholesale price (AWP)<br><u>Deductible</u> does not apply.      | Retail: One fill limit<br><br>Specialty pharmacy: 90-day supply can only be obtained after 3rd fill<br><br>Prior approval is required for certain prescription drugs. |

| 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, plus you may be balance billed)                                            |                                                                                                                                                                         |
|                                                                           |                                                | <u>Deductible</u> does not apply.                                                                                            |                                                                                                                               |                                                                                                                                                                         |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center) | 15% <u>coinsurance</u>                                                                                                       | 35% <u>coinsurance</u> for member and non-member facilities                                                                   | Prior approval is required for certain surgical services                                                                                                                |
|                                                                           | Physician/surgeon fees                         | 15% <u>coinsurance</u>                                                                                                       | 35% <u>coinsurance</u>                                                                                                        | Prior approval is required for certain surgical services                                                                                                                |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                     | 15% <u>coinsurance</u>                                                                                                       | 15% coinsurance                                                                                                               | You pay nothing when you receive care for your accidental injury within 72 hours.                                                                                       |
|                                                                           | <u>Emergency medical transportation</u>        | \$100/day. <u>Deductible</u> does not apply.                                                                                 | \$100/day. <u>Deductible</u> does not apply.                                                                                  | Air or sea ambulance: \$150/day<br>You pay nothing when you receive care for your accidental injury within 72 hours.                                                    |
|                                                                           | <u>Urgent care</u>                             | \$30/visit. <u>Deductible</u> does not apply.                                                                                | 35% <u>coinsurance</u>                                                                                                        | You pay nothing when you receive care for your accidental injury within 72 hours.                                                                                       |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)             | \$350/admission. <u>Deductible</u> does not apply.                                                                           | \$450/admission and 35% coinsurance. <u>Deductible</u> does not apply.                                                        | Precertification is required for inpatient hospital stays. We will reduce benefits for the inpatient hospital stay by \$500 if no one contacts us for precertification. |
|                                                                           | Physician/surgeon fees                         | 15% <u>coinsurance</u>                                                                                                       | 35% <u>coinsurance</u>                                                                                                        | Prior approval is required for certain surgical services                                                                                                                |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                            | \$30/visit for professional services. <u>Deductible</u> does not apply. 15% <u>coinsurance</u> for other outpatient services | 35% <u>coinsurance</u>                                                                                                        | None                                                                                                                                                                    |
|                                                                           | Inpatient services                             | No charge for professional services; \$350/admission for facility care. <u>Deductible</u> does not apply.                    | 35% <u>coinsurance</u> for professional services; 35% <u>coinsurance</u> for facility care. <u>Deductible</u> does not apply. | Precertification is required for inpatient hospital stays. We will reduce benefits for the inpatient hospital stay by \$500 if no one contacts us for precertification. |
| If you are pregnant                                                       | Office visits                                  | No charge. <u>Deductible</u> does not apply.                                                                                 | 35% <u>coinsurance</u>                                                                                                        | Cost sharing does not apply for preventive services. Maternity care may include tests and                                                                               |

| 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, plus you may be balance billed)                                                                                                                                 |                                                                                                                                                   |
|                                                                       |                                           |                                                                                                                                                                                                              |                                                                                                                                                                                                                    | services described elsewhere in the SBC (i.e., ultrasound).                                                                                       |
|                                                                       | Childbirth/delivery professional services | No charge. <u>Deductible</u> does not apply.                                                                                                                                                                 | 35% <u>coinsurance</u>                                                                                                                                                                                             | None                                                                                                                                              |
|                                                                       | Childbirth/delivery facility services     | No charge. <u>Deductible</u> does not apply.                                                                                                                                                                 | 35% <u>coinsurance</u>                                                                                                                                                                                             | None                                                                                                                                              |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>                   | 15% <u>coinsurance</u>                                                                                                                                                                                       | 35% <u>coinsurance</u>                                                                                                                                                                                             | 50 visit limit/calendar year                                                                                                                      |
|                                                                       | <u>Rehabilitation services</u>            | Outpatient cardiac rehab: 15% <u>coinsurance</u><br>Physical, occupational, speech and cognitive therapies: \$30/visit for primary care provider, \$40/visit (specialist). <u>Deductible</u> does not apply. | 35% <u>coinsurance</u>                                                                                                                                                                                             | 75 visit limit/calendar year. Includes physical, occupational and speech therapies.                                                               |
|                                                                       | <u>Habilitation services</u>              | \$30/visit for primary care provider, \$40/visit (specialist). <u>Deductible</u> does not apply.                                                                                                             | 35% <u>coinsurance</u>                                                                                                                                                                                             | 75 visit limit/calendar year. Coverage is limited to physical, occupational and speech therapies.                                                 |
|                                                                       | <u>Skilled nursing care</u>               | \$175. <u>Deductible</u> does not apply.                                                                                                                                                                     | \$275 plus 35% <u>coinsurance</u> . <u>Deductible</u> does not apply.                                                                                                                                              | 30 day visit limit for members who do not have Medicare Part A. Precertification is required prior to admission. Additional criteria must be met. |
|                                                                       | <u>Durable medical equipment</u>          | 15% <u>coinsurance</u>                                                                                                                                                                                       | 35% <u>coinsurance</u>                                                                                                                                                                                             | None                                                                                                                                              |
|                                                                       | <u>Hospice services</u>                   | No charge. <u>Deductible</u> does not apply.                                                                                                                                                                 | Traditional Home (Member/Non-member facilities): \$450 copayment/episode. <u>Deductible</u> does not apply.<br>Continuous Home and Inpatient (Member facilities): \$450/episode. <u>Deductible</u> does not apply. | Benefits are provided for up to 30 consecutive days in a facility licensed as an inpatient hospice facility.                                      |

| 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, plus you may be balance billed)                                                     |                                                                                                |
|                                        |                            |                                                                                                                                                                                                                   | Continuous Home and Inpatient (Non-member facilities): \$450/admission plus 35% <u>coinsurance</u> . <u>Deductible</u> does not apply. |                                                                                                |
| If your child needs dental or eye care | Children's eye exam        | \$30/visit (primary care). <u>Deductible</u> does not apply.<br>\$40/visit (specialist). <u>Deductible</u> does not apply.                                                                                        | 35% <u>coinsurance</u>                                                                                                                 | Coverage limited to exams related to treatment of a specific medical condition.                |
|                                        | Children's glasses         | 15% <u>coinsurance</u>                                                                                                                                                                                            | 35% <u>coinsurance</u>                                                                                                                 | Coverage limited to one pair of glasses per incident prescribed for certain medical conditions |
|                                        | Children's dental check-up | Up to age 13: The difference between \$12 and the Maximum Allowable Charge (MAC). <u>Deductible</u> does not apply.<br>Age 13 and over: The difference between \$8 and the MAC. <u>Deductible</u> does not apply. | All charges above the fee schedule amount. <u>Deductible</u> does not apply.                                                           | Coverage limited to two per person per calendar year.                                          |

#### Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your FEHB Plan brochure for more information and a list of any other <u>excluded services</u> .) |                                                                                                  |                                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Cosmetic surgery</li> <li>Long-term care</li> </ul>                                                          | <ul style="list-style-type: none"> <li>Private duty nursing</li> <li>Routine eye care</li> </ul> | <ul style="list-style-type: none"> <li>Commercial weight loss programs</li> </ul>                    |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)                   |                                                                                                  |                                                                                                      |
| <ul style="list-style-type: none"> <li>Acupuncture (24 visit limit/calendar year)</li> <li>Bariatric surgery</li> </ul>                             | <ul style="list-style-type: none"> <li>Dental care</li> <li>Hearing aids</li> </ul>              | <ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> </ul> |

- Chiropractic care (12 visit limit/calendar year)
- Infertility treatment
- Routine foot care if you are under active treatment for a metabolic or peripheral vascular disease

**Your Rights to Continue Coverage:** You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at the number on the back of your ID card or visit [www.opm.gov/insure/health/](http://www.opm.gov/insure/health/). Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or temporary continuation of coverage (TCC). 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:** If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, “How you get care,” and Section 8 “The disputed claims process,” in your FEHB Plan brochure. If you need assistance, you can contact your local BCBS company at the customer service number on the back of your member ID card.

#### **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 servicio de atención al cliente al número que aparece en su tarjeta de identificación.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.]

[Chinese (中文): 請撥打您 ID 卡上的客服號碼以尋求中文協助。]

[Navajo (Dine): Diné k'ehjí yá'áti' bee shíká'adoowoł nohsingo naaltsoos nihaa halne'go nidaahtinígíí bine'déé' Customer Service bibéesh bee hane'é biká'ígíí bich'í dahodoolnih.]

*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 <u>deductible</u>      | \$350 |
| ■ <u>Specialist [cost sharing]</u>          | \$40  |
| ■ <u>Hospital (facility) [cost sharing]</u> | \$350 |
| ■ <u>Other [cost sharing]</u>               | 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>               |             |
|-----------------------------------|-------------|
| <u>Deductibles</u>                | \$0         |
| <u>Copayments</u>                 | \$30        |
| <u>Coinsurance</u>                | \$0         |
| <i>What isn't covered</i>         |             |
| Limits or exclusions              | \$60        |
| <b>The total Peg would pay is</b> | <b>\$90</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                             |       |
|---------------------------------------------|-------|
| ■ The plan's overall <u>deductible</u>      | \$350 |
| ■ <u>Specialist [cost sharing]</u>          | \$40  |
| ■ <u>Hospital (facility) [cost sharing]</u> | \$350 |
| ■ <u>Other [cost sharing]</u>               | 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>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$350          |
| <u>Copayments</u>                 | \$1,300        |
| <u>Coinsurance</u>                | \$400          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,070</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                             |       |
|---------------------------------------------|-------|
| ■ The plan's overall <u>deductible</u>      | \$350 |
| ■ <u>Specialist [cost sharing]</u>          | \$40  |
| ■ <u>Hospital (facility) [cost sharing]</u> | \$350 |
| ■ <u>Other [cost sharing]</u>               | 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>               |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$0          |
| <u>Copayments</u>                 | \$ 360       |
| <u>Coinsurance</u>                | \$60         |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$420</b> |