



## Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

**Coverage for:** Individual and/or Family | **Plan Type:** HMO



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

<http://www.fhcp.com/documents/coc/2026-large-group.pdf>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-877-615-4022 to request a copy.

| Important Questions                                                 | Answers                                                                                                                                                                   | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | <u>Network providers</u> : \$1,500 Individual/<br>\$4,500 Family<br><u>Out-of-network providers</u> : Not covered                                                         | 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. 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> .                                                                                                                                                               |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Preventive care</u> , and services not subject to the 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. For example, this <u>plan</u> covers certain <u>preventive</u> services without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive</u> services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                              |
| Are there other <u>deductibles</u> for specific services?           | No.                                                                                                                                                                       | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | <u>Network providers</u> : \$4,500 Individual/<br>\$9,000 Family<br><u>Out-of-network providers</u> : Not covered                                                         | The <u>out-of-pocket limit</u> 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.                                                                                                                                                                                                                                                                              |
| What is not included in the <u>out-of-pocket limit</u> ?            | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.                                                                         | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Will you pay less if you use a <u>network provider</u> ?            | Yes. See <a href="http://www.fhcp.com/find-providers/physician">www.fhcp.com/find-providers/physician</a> or call 1-877-615-4022 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 <u>provider</u> 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 <u>plan</u> pays ( <u>balance billing</u> ). 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. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?          | Yes.                                                                                                                                                                      | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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                                                                                                                                                                                                                                                                                                                                     |
|------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                        |                                                                  | <a href="#">Network Provider</a><br>(You will pay the least)                                                                                                                                                                                                                                                                                                               | <a href="#">Out-of-Network Provider</a><br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                            |
| If you visit a health care <a href="#">provider's</a> office or clinic | <a href="#">Primary Care</a> visit to treat an injury or illness | \$30 <a href="#">Copay</a> /Visit                                                                                                                                                                                                                                                                                                                                          | Not covered                                                        | Additional <a href="#">cost sharing</a> may apply for Allergy shots, Injections and Infusions. See schedule of benefits for telehealth benefit specific <a href="#">cost sharing</a> through designated <a href="#">provider</a> .                                                                                                                                                         |
|                                                                        | <a href="#">Specialist</a> visit                                 | \$55 <a href="#">Copay</a> /Visit                                                                                                                                                                                                                                                                                                                                          | Not covered                                                        | Additional <a href="#">cost sharing</a> may apply for Allergy shots, Injections and Infusions.                                                                                                                                                                                                                                                                                             |
|                                                                        | <a href="#">Preventive care/screening/immunization</a>           | No charge                                                                                                                                                                                                                                                                                                                                                                  | Not covered                                                        | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.                                                                                                                                                                |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)              | No Charge for laboratory & professional services at an independent clinical lab.<br><br>\$50 <a href="#">Copay</a> for x-ray & diagnostic imaging at an independent diagnostic testing center.<br><br>\$25 <a href="#">Copay</a> for laboratory & professional services and \$100 <a href="#">Copay</a> for x-ray & diagnostic imaging at an outpatient hospital facility. | Not covered                                                        | <a href="#">Prior authorization</a> is required.<br><br>Tests in hospitals, or facilities owned or operated by hospitals are subject to the outpatient hospital facility cost share.<br><br>Failure to obtain <a href="#">Prior authorization</a> for any service that requires <a href="#">prior authorization</a> will result in a denial of benefits. See your policy for more details. |
|                                                                        | Imaging (CT/PET scans, MRIs)                                     | \$200 <a href="#">Copay</a> at an independent facility / \$400 <a href="#">Copay</a> at an outpatient hospital facility.                                                                                                                                                                                                                                                   | Not covered                                                        |                                                                                                                                                                                                                                                                                                                                                                                            |

For more information about limitations and exceptions, see the plan or policy document at <http://www.fhcop.com/documents/coc/2026-large-group.pdf>

| Common Medical Event                                                                                                                                                                                                                                                                                                                                            | Services You May Need                                                                     | What You Will Pay                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                 |                                                                                           | Network Provider<br>(You will pay the least)                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                               |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="https://fm.formularynavigator.com/FBO/126/2026_NGF_Formulary.pdf">prescription drug coverage</a> is available at <a href="https://fm.formularynavigator.com/FBO/126/2026_NGF_Formulary.pdf">https://fm.formularynavigator.com/FBO/126/2026_NGF_Formulary.pdf</a> | Generic drugs – preferred / non-preferred                                                 | Retail: \$3 <a href="#">Copay</a> per <a href="#">prescription</a> for Preferred at FHCP / Mail Order: \$6 <a href="#">Copay</a> per <a href="#">prescription</a> for Preferred / Retail: \$10 <a href="#">Copay</a> per <a href="#">prescription</a> for Non-Preferred at FHCP / Mail Order: \$27 <a href="#">Copay</a> per <a href="#">prescription</a> for Non-Preferred / Retail: \$15 <a href="#">Copay</a> per <a href="#">prescription</a> at select Non-Preferred Retail Pharmacies.. | Not covered                                        | 31 Days per Benefit Period. Available at Preferred-FHCP and select Non-Preferred Retail Pharmacies Only. Up to 93-day Mail Order available through FHCP Only. Refer to the schedule of benefits for <a href="#">cost sharing</a> at Non-Preferred Pharmacies. |
|                                                                                                                                                                                                                                                                                                                                                                 | Preferred brand drugs                                                                     | Retail: \$30 <a href="#">Copay</a> per <a href="#">prescription</a> at FHCP / Mail Order: \$87 <a href="#">Copay</a> per <a href="#">prescription</a> / Retail: \$35 <a href="#">Copay</a> per <a href="#">prescription</a> at select Non-Preferred Retail Pharmacies.                                                                                                                                                                                                                        | Not covered                                        |                                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                 | Non-preferred brand drugs                                                                 | Retail: \$55 <a href="#">Copay</a> per <a href="#">prescription</a> at FHCP / Mail Order: \$162 <a href="#">Copay</a> per <a href="#">prescription</a> / Retail: \$60 <a href="#">Copay</a> per <a href="#">prescription</a> at select Non-Preferred Retail Pharmacies.                                                                                                                                                                                                                       | Not covered                                        |                                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                 | <a href="#">Specialty drugs</a> – preferred / non-preferred                               | Retail: 15% <a href="#">Coinsurance</a> for Preferred <a href="#">Specialty drugs</a> at FHCP. 25% <a href="#">Coinsurance</a> for Non-Preferred <a href="#">Specialty drugs</a> at FHCP.                                                                                                                                                                                                                                                                                                     | Not covered                                        | 31 Days per Benefit Period. Available at FHCP Pharmacy Only. Mail Order not available.                                                                                                                                                                        |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                                                                                                                           | Facility fee (e.g., ambulatory surgery center (ASC) / outpatient hospital facility (OHF)) | \$200 <a href="#">Copay</a> – ASC / \$400 <a href="#">Copay</a> – OHF                                                                                                                                                                                                                                                                                                                                                                                                                         | Not covered                                        | <a href="#">Pre-certification/Pre-authorization</a> of coverage required for non-emergency outpatient surgical care. Your benefits / services may be denied.                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                 | Physician/surgeon fees                                                                    | No charge                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Not covered                                        | <a href="#">Prior approval</a> required. Your benefits /                                                                                                                                                                                                      |

For more information about limitations and exceptions, see the plan or policy document at <http://www.fhcp.com/documents/coc/2026-large-group.pdf>

| 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)           |                                                                                                                                                |
|                                                                           |                                                  |                                                              |                                                              | services may be denied.                                                                                                                        |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$250 <a href="#">Copay</a> /Visit                           | \$250 <a href="#">Copay</a> /Visit                           | Waived if admitted.                                                                                                                            |
|                                                                           | <a href="#">Emergency medical transportation</a> | <a href="#">Deductible</a> + 20% <a href="#">Coinsurance</a> | <a href="#">Deductible</a> + 20% <a href="#">Coinsurance</a> | None                                                                                                                                           |
|                                                                           | <a href="#">Urgent care</a>                      | \$60 <a href="#">Copay</a> /Visit                            | \$60 <a href="#">Copay</a> /Visit                            | None                                                                                                                                           |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | <a href="#">Deductible</a> + 20% <a href="#">Coinsurance</a> | Not covered                                                  | <a href="#">Pre-certification/Pre-authorization</a> of coverage required for non-emergency admissions. Your benefits / services may be denied. |
|                                                                           | Physician/surgeon fees                           | <a href="#">Deductible</a> + 20% <a href="#">Coinsurance</a> | Not covered                                                  | None                                                                                                                                           |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$55 <a href="#">Copay</a> /Visit                            | Not covered                                                  | The cost share displayed applies to outpatient office visits only, other outpatient services may be subject to additional cost share.          |
|                                                                           | Inpatient services                               | <a href="#">Deductible</a> + 20% <a href="#">Coinsurance</a> | Not covered                                                  | <a href="#">Pre-certification/Pre-authorization</a> of coverage required for non-emergency admissions. Your benefits / services may be denied. |
| If you are pregnant                                                       | Office visits                                    | \$55 <a href="#">Copay</a> /Visit                            | Not covered                                                  | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)                                                |
|                                                                           | Childbirth/delivery professional services        | <a href="#">Deductible</a> + 20% <a href="#">Coinsurance</a> | Not covered                                                  | <a href="#">Pre-certification/Pre-authorization</a> of coverage required for non-emergency admissions. Your benefits / services may be denied. |
|                                                                           | Childbirth/delivery facility services            | <a href="#">Deductible</a> + 20% <a href="#">Coinsurance</a> | Not covered                                                  | <a href="#">Pre-certification/Pre-authorization</a> of coverage required for non-emergency admissions. Your benefits / services may be denied. |
| If you need help recovering or have other special health                  | <a href="#">Home health care</a>                 | <a href="#">Deductible</a> + 20% <a href="#">Coinsurance</a> | Not covered                                                  | <a href="#">Prior approval</a> required. Your benefits / services may be denied. Prior approval required. Coverage limited to 60 days.         |

For more information about limitations and exceptions, see the plan or policy document at <http://www.fhcp.com/documents/coc/2026-large-group.pdf>

| 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) |                                                                                                                                                |
| needs                                  | <a href="#">Rehabilitation services</a>   | <a href="#">Deductible</a> + 20% <a href="#">Coinsurance</a> | Not covered                                        | Coverage limited to 20 visits. Includes Physical, Speech, Occupational Therapy                                                                 |
|                                        | <a href="#">Habilitation services</a>     | Not covered                                                  | Not covered                                        |                                                                                                                                                |
|                                        | <a href="#">Skilled nursing care</a>      | <a href="#">Deductible</a> + 20% <a href="#">Coinsurance</a> | Not covered                                        | <a href="#">Pre-certification/Pre-authorization</a> of coverage required. Your benefits / services may be denied. Coverage limited to 20 days. |
|                                        | <a href="#">Durable medical equipment</a> | <a href="#">Deductible</a> + 20% <a href="#">Coinsurance</a> | Not covered                                        | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. <a href="#">Prior authorization</a> is required.         |
|                                        | <a href="#">Hospice services</a>          | <a href="#">Deductible</a> + 20% <a href="#">Coinsurance</a> | Not covered                                        | None                                                                                                                                           |
| If your child needs dental or eye care | Children's eye exam                       | Not covered                                                  | Not covered                                        |                                                                                                                                                |
|                                        | Children's glasses                        | Not covered                                                  | Not covered                                        |                                                                                                                                                |
|                                        | Children's dental check-up                | Not covered                                                  | Not covered                                        |                                                                                                                                                |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)                                    |                                                                                                                                                                                                                                            |                                                                                                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Abortion with the Exception of Limited Services</li> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Dental care (Child)</li> </ul> | <ul style="list-style-type: none"> <li>• <a href="#">Habilitation services</a></li> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine eye care (Child)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                                         |                                                                                                                                                                                                                                            |                                                                                                                                                                                                               |
| <ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul>                                                                                                                                                | <ul style="list-style-type: none"> <li>• Bariatric surgery</li> </ul>                                                                                                                                                                      |                                                                                                                                                                                                               |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or

For more information about limitations and exceptions, see the plan or policy document at <http://www.fhcp.com/documents/coc/2026-large-group.pdf>

[www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the [Health insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the insurer at 1-877-615-4022. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health [plans](#) and church [plans](#) that are group health [plans](#) contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your [appeal](#). Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

**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 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 1-877-615-4022.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-615-4022.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-877-615-4022.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-615-4022.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*



## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|                                                                 |        |
|-----------------------------------------------------------------|--------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1500 |
| ■ <a href="#">Specialist copayment</a>                          | \$55   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%    |
| ■ Other <a href="#">copayment</a>                               | \$50   |

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic test](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,500        |
| <a href="#">Copayment</a>         | \$200          |
| <a href="#">Coinsurance</a>       | \$1,400        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,160</b> |

### Managing Joe's type 2 Diabetes

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

|                                                                 |        |
|-----------------------------------------------------------------|--------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1500 |
| ■ <a href="#">Specialist copayment</a>                          | \$55   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%    |
| ■ Other <a href="#">coinsurance</a>                             | 20%    |

This EXAMPLE event includes services like:

[Primary Care physician](#) office visits (*including disease education*)  
[Diagnostic test](#) (*blood work*)  
[Prescription Drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayment</a>         | \$1,100        |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,120</b> |

### Mia's Simple Fracture

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

|                                                                 |        |
|-----------------------------------------------------------------|--------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1500 |
| ■ <a href="#">Specialist copayment</a>                          | \$55   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%    |
| ■ Other <a href="#">copayment</a>                               | \$250  |

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:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,500        |
| <a href="#">Copayment</a>         | \$500          |
| <a href="#">Coinsurance</a>       | \$20           |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,020</b> |

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