



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

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



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/2027-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 <a href="#">deductible</a> ?                                | <a href="#">Network providers</a> : \$2,000 Individual/ \$4,000 Family<br><a href="#">Out-of-network providers</a> : \$3,000 Individual /\$6,000 Family                            | Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. In-Network <a href="#">preventive care</a> , and services not subject to the deductible                                                                                       | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | <a href="#">Network providers</a> : \$4,000 Individual/\$8,000 Family.<br><a href="#">Out-of-network providers</a> : \$6,000 Individual/\$12,000 Family                            | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.                                                       | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | 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 <a href="#">network providers</a> . | This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.                                                                                                                                                                                | You can see the <a href="#">Specialist</a> you choose without a referral.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event                                   | Services You May Need                                   | What You Will Pay                                                                                                                                                                                                                                                                                                                                                                        |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------------------------|---------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                        |                                                         | Network Provider<br>(You will pay the least)                                                                                                                                                                                                                                                                                                                                             | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                         |
| If you visit a health care provider's office or clinic | <u>Primary Care</u> visit to treat an injury or illness | \$20 <u>Copay</u> /Visit. <u>Deductible</u> does not apply.                                                                                                                                                                                                                                                                                                                              | <u>Deductible</u> + 40% <u>Coinsurance</u>         | Additional <u>cost share</u> may apply for Allergy shots, Injections and Infusions. See schedule of benefits for telehealth benefit specific <u>cost sharing</u> through designated <u>provider</u> .                                                                                                                                                                   |
|                                                        | <u>Specialist</u> visit                                 | \$35 <u>Copay</u> /Visit. <u>Deductible</u> does not apply.                                                                                                                                                                                                                                                                                                                              | <u>Deductible</u> + 40% <u>Coinsurance</u>         | Additional <u>cost share</u> may apply for Allergy shots, Injections and Infusions.                                                                                                                                                                                                                                                                                     |
|                                                        | <u>Preventive care/screening/immunization</u>           | No charge                                                                                                                                                                                                                                                                                                                                                                                | <u>Deductible</u> + 40% <u>Coinsurance</u>         | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.                                                                                                                                                                                 |
| If you have a test                                     | <u>Diagnostic test</u> (x-ray, blood work)              | No charge for laboratory & professional services at an independent clinical lab.<br><br>No charge for x-ray & diagnostic imaging at an independent diagnostic testing center.<br><br><u>Deductible</u> + 30% <u>Coinsurance</u> for laboratory & professional services and <u>Deductible</u> + 30% <u>Coinsurance</u> for x-ray & diagnostic imaging at an outpatient hospital facility. | <u>Deductible</u> + 40% <u>Coinsurance</u>         | <u>Prior authorization</u> is required.<br><br>Tests in hospitals, or facilities owned or operated by hospitals are subject to the outpatient hospital facility <u>cost share</u> .<br><br>Failure to obtain <u>prior authorization</u> for any service that requires <u>prior authorization</u> will result in a denial of benefits. See your policy for more details. |
|                                                        | Imaging (CT/PET scans, MRIs)                            | <u>Deductible</u> + 30% <u>Coinsurance</u> at an independent facility or outpatient hospital facility.                                                                                                                                                                                                                                                                                   | <u>Deductible</u> + 40% <u>Coinsurance</u>         |                                                                                                                                                                                                                                                                                                                                                                         |

| 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/126/2027_NGF_Formulary.pdf">prescription drug coverage</a> is available at <a href="https://fm.formularynavigator.com/FBO/126/2027_NGF_Formulary.pdf">https://fm.formularynavigator.com/FBO/126/2027_NGF_Formulary.pdf</a> | Generic drugs – preferred / non-preferred                   | Preferred Generic: \$3 <a href="#">Copay</a> at Preferred Retail Pharmacy / Mail Order: \$9 <a href="#">Copay</a> . Non-Preferred Generic: \$10 <a href="#">Copay</a> at Preferred Retail Pharmacy / Mail Order: \$30 <a href="#">Copay</a> . Non-Preferred Retail Pharmacy: \$15 <a href="#">Copay</a> . | Not covered                                                                    | 31 Days per Benefit Period. Available at Preferred and Non-Preferred Retail Pharmacies only. Up to 93-day Mail Order is only available through a Preferred Pharmacy.<br><br><a href="#">Copay</a> is per prescription order up to the day supply limit listed above.<br><br>Go to <a href="http://www.fhcp.com">www.fhcp.com</a> and click find a pharmacy to locate Preferred and Non-Preferred pharmacy locations. |
|                                                                                                                                                                                                                                                                                                                                                                 | Preferred brand drugs                                       | \$30 <a href="#">Copay</a> at Preferred Retail Pharmacy / Mail Order: \$90 <a href="#">Copay</a> . \$35 <a href="#">Copay</a> at Non-Preferred Retail Pharmacies.                                                                                                                                         | Not covered                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                 | Non-preferred brand drugs                                   | \$55 <a href="#">Copay</a> at Preferred Retail Pharmacy / Mail Order: \$165 <a href="#">Copay</a> . \$60 <a href="#">Copay</a> at Non-Preferred Retail Pharmacies.                                                                                                                                        | Not covered                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                 | <a href="#">Specialty drugs</a> – preferred / non-preferred | Preferred Specialty: 15% <a href="#">Coinsurance</a> at Preferred Retail Pharmacy. Non-Preferred Specialty: 25% <a href="#">Coinsurance</a> at Preferred Retail Pharmacy.                                                                                                                                 | Not covered                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                                                                                                                           | Facility fee (e.g., ambulatory surgery center)              | <a href="#">Deductible</a> + 30% <a href="#">Coinsurance</a>                                                                                                                                                                                                                                              | <a href="#">Deductible</a> + 40% <a href="#">Coinsurance</a>                   | <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                                      | <a href="#">Deductible</a> + 30% <a href="#">Coinsurance</a>                                                                                                                                                                                                                                              | <a href="#">Deductible</a> + 40% <a href="#">Coinsurance</a>                   | <a href="#">Prior approval</a> required. Your benefits / services may be denied.                                                                                                                                                                                                                                                                                                                                     |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                                                                                                                                                  | <a href="#">Emergency room care</a>                         | \$100 <a href="#">Copay</a> /Visit. <a href="#">Deductible</a> does not apply.                                                                                                                                                                                                                            | \$100 <a href="#">Copay</a> /Visit. <a href="#">Deductible</a> does not apply. | Waived if admitted.                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                 | <a href="#">Emergency medical transportation</a>            | <a href="#">Deductible</a> + 30% <a href="#">Coinsurance</a>                                                                                                                                                                                                                                              | In-Network <a href="#">Deductible</a> + 30% <a href="#">Coinsurance</a>        | None                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                 | <a href="#">Urgent care</a>                                 | \$50 <a href="#">Copay</a> /Visit. <a href="#">Deductible</a> does not apply.                                                                                                                                                                                                                             | \$50 <a href="#">Copay</a> /Visit. <a href="#">Deductible</a> does not apply.  | None                                                                                                                                                                                                                                                                                                                                                                                                                 |

For more information about limitations and exceptions, see the plan or policy document at <http://www.fhcp.com/documents/coc/2027-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) |                                                                                                                                                      |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | <u>Deductible</u> + 30% <u>Coinsurance</u>                  | <u>Deductible</u> + 40% <u>Coinsurance</u>         | <u>Pre-certification/pre-authorization</u> of coverage required for non-emergency admissions. Your benefits / services may be denied.                |
|                                                                           | Physician/surgeon fees                    | <u>Deductible</u> + 30% <u>Coinsurance</u>                  | <u>Deductible</u> + 40% <u>Coinsurance</u>         | None                                                                                                                                                 |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$35 <u>Copay</u> /Visit. <u>Deductible</u> does not apply. | <u>Deductible</u> + 40% <u>Coinsurance</u>         | The <u>cost share</u> displayed applies to outpatient office visits only, other outpatient services may be subject to additional <u>cost share</u> . |
|                                                                           | Inpatient services                        | <u>Deductible</u> + 30% <u>Coinsurance</u>                  | <u>Deductible</u> + 40% <u>Coinsurance</u>         | <u>Pre-certification/pre-authorization</u> of coverage required for non-emergency admissions. Your benefits / services may be denied.                |
| If you are pregnant                                                       | Office visits                             | \$35 <u>Copay</u> /Visit. <u>Deductible</u> does not apply. | <u>Deductible</u> + 40% <u>Coinsurance</u>         | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)                                                      |
|                                                                           | Childbirth/delivery professional services | <u>Deductible</u> + 30% <u>Coinsurance</u>                  | <u>Deductible</u> + 40% <u>Coinsurance</u>         | <u>Pre-certification/pre-authorization</u> of coverage required for non-emergency admissions. Your benefits / services may be denied.                |
|                                                                           | Childbirth/delivery facility services     | <u>Deductible</u> + 30% <u>Coinsurance</u>                  | <u>Deductible</u> + 40% <u>Coinsurance</u>         | <u>Pre-certification/pre-authorization</u> of coverage required for non-emergency admissions. Your benefits / services may be denied.                |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | <u>Deductible</u> + 30% <u>Coinsurance</u>                  | <u>Deductible</u> + 40% <u>Coinsurance</u>         | <a href="#">Prior approval</a> required. Your benefits / services may be denied. Coverage limited to 60 days.                                        |
|                                                                           | <a href="#">Rehabilitation services</a>   | <u>Deductible</u> + 30% <u>Coinsurance</u>                  | <u>Deductible</u> + 40% <u>Coinsurance</u>         | Coverage limited to 20 visits. Includes Physical, Speech, Occupational Therapy                                                                       |
|                                                                           | <a href="#">Habilitation services</a>     | Not covered                                                 | Not covered                                        |                                                                                                                                                      |

| 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) |                                                                                                                                        |
|                                        | <a href="#">Skilled nursing care</a>      | <u>Deductible</u> + 30% <u>Coinsurance</u>   | <u>Deductible</u> + 40% <u>Coinsurance</u>         | Pre-certification/pre-authorization of coverage required. Your benefits / services may be denied. Coverage limited to 20 days.         |
|                                        | <a href="#">Durable medical equipment</a> | <u>Deductible</u> + 30% <u>Coinsurance</u>   | <u>Deductible</u> + 40% <u>Coinsurance</u>         | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. <a href="#">Prior authorization</a> is required. |
|                                        | <a href="#">Hospice services</a>          | <u>Deductible</u> + 30% <u>Coinsurance</u>   | <u>Deductible</u> + 40% <u>Coinsurance</u>         | 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 [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- |                                                                                                                                                                                                                      |                                                                                                                                                                                                                                            |                                                                                                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <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 [plan](#) 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 [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> | \$2000 |
| ■ <a href="#">Specialist</a> <a href="#">copayment</a>          | \$35   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%    |
| ■ Other <a href="#">copayment</a>                               | \$0    |

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:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,000        |
| <a href="#">Copayments</a>        | \$50           |
| <a href="#">Coinsurance</a>       | \$1,900        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,010</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> | \$2000 |
| ■ <a href="#">Specialist</a> <a href="#">copayment</a>          | \$35   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%    |
| ■ Other <a href="#">coinsurance</a>                             | 30%    |

This **EXAMPLE** event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

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

In this example, Joe would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$1,000        |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,020</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> | \$2000 |
| ■ <a href="#">Specialist</a> <a href="#">copayment</a>          | \$35   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%    |
| ■ Other <a href="#">copayment</a>                               | \$100  |

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:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,600        |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,800</b> |

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