



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, call 1-800-639-2227 or 1-401-459-5000 or TDD 711 or visit us at [www.BCBSRI.com](http://www.BCBSRI.com). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-800-639-2227 or TDD 711 to request a copy.

| Important Questions                                                 | Answers                                                                                                                                                                                                                                                                                                                                                                        | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | In-Network: <b>\$250</b> /individual; <b>\$500</b> / family<br>Out-of-Network: <b>\$200</b> /individual;<br><b>\$600</b> /family                                                                                                                                                                                                                                               | Generally, you must pay all of the costs from <u>providers</u> 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> , the family <u>deductible</u> is met by adding the total amount of <u>deductible</u> expenses paid by all family members; however, no one family member can contribute more than the individual <u>deductible</u> amount.                                                                       |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. In-network primary care and <u>specialist</u> office visits, in-network preventive care, in-network diagnostic tests and imaging, emergency room care, emergency medical transportation, in-network urgent care, prescription drugs, in-network outpatient mental health/substance abuse services, vision and dental are covered before you meet your <u>deductible</u> . | 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 preventive services without cost sharing and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://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> ?       | In-Network: <b>\$3,000</b> /individual;<br><b>\$9,000</b> /family<br>Out-of-Network: <b>\$3,000</b> /individual;<br><b>\$9,000</b> /family                                                                                                                                                                                                                                     | 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> ?            | Premiums, <u>balance billing</u> charges and health care this <u>plan</u> does not cover.                                                                                                                                                                                                                                                                                      | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                  |

| Important Questions                                        | Answers                                                                                                                                       | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Will you pay less if you use a <u>network provider</u> ?   | Yes. See <a href="http://www.BCBSRI.com">www.BCBSRI.com</a> or call 1-800-639-2227 or 1-401-459-5000 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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 <u>provider's</u> 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> ? | No                                                                                                                                            | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |



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

| Common Medical Event                                          | Services You May Need                            | What You Will Pay                                          |                                                                                                                                                                                         | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                               |
|---------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               |                                                  | <u>In-Network Provider</u><br>(You will pay the least)     | <u>Out-of-Network Provider</u><br>(You will pay the most)                                                                                                                               |                                                                                                                                                                                                                                                                                                                      |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$20 <u>copay</u> /visit; <u>deductible</u> does not apply | \$20 <u>copay</u> /visit plus 20% <u>coinsurance</u>                                                                                                                                    | No charge and <u>deductible</u> does not apply to <u>in-network</u> telemedicine services.                                                                                                                                                                                                                           |
|                                                               | <u>Specialist</u> visit                          | \$30 <u>copay</u> /visit; <u>deductible</u> does not apply | \$30 <u>copay</u> /visit plus 20% <u>coinsurance</u>                                                                                                                                    | Acupuncture Services: \$10 copay; <u>deductible</u> does not apply for <u>in-network</u> and <u>out-of-network</u> ; Acupuncture Services and Chiropractic Services are limited to 12 visits per year.                                                                                                               |
|                                                               | <u>Preventive care/screening/immunization</u>    | No charge; <u>deductible</u> does not apply                | 20% <u>coinsurance</u> for immunization/ <u>screenings</u> , contraceptives and breast pumps; \$20 or \$30 <u>copay</u> /certain <u>preventive services</u> plus 20% <u>coinsurance</u> | <u>Out-of-network copay</u> applies to annual physical exam and pediatric exam, well woman visit, and preventive counseling and education. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. 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; <u>deductible</u> does not apply                | 20% <u>coinsurance</u>                                                                                                                                                                  | <u>Preauthorization</u> is recommended for certain services                                                                                                                                                                                                                                                          |
|                                                               | Imaging (CT/PET scans, MRIs)                     | No charge; <u>deductible</u> does not apply                | 20% <u>coinsurance</u>                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                      |

| Common Medical Event                                                                                                                                                                         | Services You May Need                                              | What You Will Pay                                                                                                                            |                                                                          | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                              |                                                                    | <u>In-Network Provider</u><br>(You will pay the least)                                                                                       | <u>Out-of-Network Provider</u><br>(You will pay the most)                |                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.BCBSRI.com">www.BCBSRI.com</a> . | Tier 1: generally low cost generic drugs                           | Retail: 20% <u>coinsurance</u> ;<br>\$100 maximum per prescription<br>Mail order: 20% <u>coinsurance</u> ;<br>\$250 maximum per prescription | Not covered                                                              | <u>Deductible</u> does not apply.<br>No charge for certain preventive drugs;<br>Maximum supply: Retail: 30 days or 100 units,<br>Mail order: 90 days or 300 units. Mail order pharmacy services provided by Amazon pharmacy.<br>Your cost for a 30-day supply of all insulin drugs is limited to \$40.<br>Maximums do not apply for infertility drugs.<br><u>Preauthorization</u> is required for certain drugs or no benefits provided. |
|                                                                                                                                                                                              | Tier 2: generally high cost generic and preferred brand name drugs |                                                                                                                                              |                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                              | Tier 3: non-preferred brand name drugs                             |                                                                                                                                              |                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                              | Tier 4: <u>specialty drugs</u>                                     | 20% <u>coinsurance</u> /\$100 maximum per prescription                                                                                       | 50% <u>coinsurance</u> ;<br>20% <u>coinsurance</u> for infertility drugs |                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>If you have outpatient surgery</b>                                                                                                                                                        | Facility fee (e.g., ambulatory surgery center)                     | No charge                                                                                                                                    | 20% <u>coinsurance</u>                                                   | <u>Preauthorization</u> is recommended; Some <u>in-network</u> services related to RI Mastectomy Treatment Mandate are covered at no charge, <u>deductible</u> does not apply.                                                                                                                                                                                                                                                           |
|                                                                                                                                                                                              | Physician/surgeon fees                                             | No charge                                                                                                                                    | 20% <u>coinsurance</u>                                                   | Some <u>in-network</u> services related to RI Mastectomy Treatment Mandate are covered at no charge, <u>deductible</u> does not apply.                                                                                                                                                                                                                                                                                                   |
| <b>If you need immediate medical attention</b>                                                                                                                                               | <u>Emergency room care</u>                                         | \$200 <u>copay</u> /visit; <u>deductible</u> does not apply                                                                                  | \$200 <u>copay</u> /visit; <u>deductible</u> does not apply              | <u>Copay</u> waived if admitted                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                              | <u>Emergency medical transportation</u>                            | \$50 <u>copay</u> /trip; <u>deductible</u> does not apply                                                                                    | \$50 <u>copay</u> /trip; <u>deductible</u> does not apply                | None                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                              | <u>Urgent care</u>                                                 | \$50 <u>copay</u> /visit; <u>deductible</u> does not apply                                                                                   | \$50 <u>copay</u> /visit plus 20% <u>coinsurance</u>                     | Applies to the visit only. If additional services are provided, additional <u>out-of-pocket</u> costs would apply based on services received.                                                                                                                                                                                                                                                                                            |
| <b>If you have a hospital stay</b>                                                                                                                                                           | Facility fee (e.g., hospital room)                                 | No charge                                                                                                                                    | 20% <u>coinsurance</u>                                                   | 45 days/year limit at an inpatient physical rehabilitation facility; <u>Preauthorization</u> is recommended; Some <u>in-network</u> services related to RI Mastectomy Treatment Mandate are covered at no charge, <u>deductible</u> does not apply.                                                                                                                                                                                      |

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay                                                                                                 |                                                                                                                                     | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                               |
|----------------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                           | <u>In-Network Provider</u><br>(You will pay the least)                                                            | <u>Out-of-Network Provider</u><br>(You will pay the most)                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                  | Physician/surgeon fee                     | No charge                                                                                                         | 20% <u>coinsurance</u>                                                                                                              | Some <u>in-network</u> services related to RI Mastectomy Treatment Mandate are covered at no charge, <u>deductible</u> does not apply.                                                                                                                                                                                                                                                                                                                                               |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$20 <u>copay</u> / office visit;<br>No charge for other outpatient services;<br><u>deductible</u> does not apply | \$20 <u>copay</u> / office visit plus<br>20% <u>coinsurance</u><br>20% <u>coinsurance</u> for other outpatient services.            | <u>Preauthorization</u> is recommended for certain services. Notice of admission and discharge required for the following <u>out-of-network</u> services: non-urgent inpatient services, partial <u>hospitalization</u> , intensive outpatient services, transcranial magnetic stimulation, home- and community-based adult intensive services, and child and family intensive treatment. No charge and <u>deductible</u> does not apply to <u>in-network</u> telemedicine services. |
|                                                                                  | Inpatient services                        | No charge                                                                                                         | 20% <u>coinsurance</u>                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>If you are pregnant</b>                                                       | Office visits                             | No charge, except \$30 <u>copay</u> /office visit for initial office visit to diagnose pregnancy                  | 20% <u>coinsurance</u> , except \$30 <u>copay</u> /visit plus 20% <u>coinsurance</u> for initial office visit to diagnose pregnancy | Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Includes coverage for certified Doula services.<br><u>Preauthorization</u> is recommended for admissions exceeding 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.                                                                                                     |
|                                                                                  | Childbirth/delivery professional services | No charge                                                                                                         | 20% <u>coinsurance</u>                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                  | Childbirth/delivery facility services     | No charge                                                                                                         | 20% <u>coinsurance</u>                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>If you need help recovering or have other special health needs</b>            | <u>Home health care</u>                   | No charge                                                                                                         | 20% <u>coinsurance</u>                                                                                                              | Private Duty Nursing: 20% coinsurance. <u>Preauthorization</u> is recommended for Private Duty Nursing.                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                  | <u>Rehabilitation services</u>            | Inpatient: no charge<br>Outpatient: 20% <u>coinsurance</u>                                                        | 20% <u>coinsurance</u>                                                                                                              | Inpatient rehabilitation: limit 45 days/year. <u>Preauthorization</u> of physical, occupational and speech therapy is recommended.                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                  | <u>Habilitation services</u>              | No charge for services to treat autism spectrum disorder                                                          |                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                  | <u>Skilled nursing care</u>               | No charge                                                                                                         | 20% <u>coinsurance</u>                                                                                                              | Custodial care is not covered; <u>preauthorization</u> is recommended                                                                                                                                                                                                                                                                                                                                                                                                                |

| Common Medical Event                   | Services You May Need            | What You Will Pay                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                               | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                             |
|----------------------------------------|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                  | <u>In-Network Provider</u><br>(You will pay the least)                                                                                                                                                                                                                         | <u>Out-of-Network Provider</u><br>(You will pay the most)                                                                                                                                                                     |                                                                                                                                                                                                                                                    |
|                                        | <u>Durable medical equipment</u> | 20% <u>coinsurance</u>                                                                                                                                                                                                                                                         | 20% <u>coinsurance</u>                                                                                                                                                                                                        | <u>Preauthorization</u> is recommended for certain equipment                                                                                                                                                                                       |
|                                        | <u>Hospice service</u>           | No charge                                                                                                                                                                                                                                                                      | 20% <u>coinsurance</u>                                                                                                                                                                                                        | <u>None</u>                                                                                                                                                                                                                                        |
| If your child needs dental or eye care | Children's eye exam              | \$10 <u>copay</u> /visit through Davis Vision; \$30 <u>copay</u> /visit through BCBSRI. <u>Deductible</u> does not apply.                                                                                                                                                      | You pay 100% and apply for reimbursement through Davis Vision of up to \$40 <u>allowed amount</u> ; \$30 <u>copay</u> /visit plus 20% <u>coinsurance</u> through BCBSRI. <u>Deductible</u> does not apply under Davis Vision. | Limit: One routine eye exam/12 months under Davis Vision and one routine eye exam per <u>plan</u> year under BCBSRI.                                                                                                                               |
|                                        | Children's glasses               | \$10 <u>copay</u> /lenses. No charge up to \$200 for frames (\$250 for Visionworks), plus 20% discount on excess of <u>allowed amount</u> . No charge up to \$200 for contact lenses, plus 15% discount on excess of <u>allowed amount</u> . <u>Deductible</u> does not apply. | You pay 100% and apply for reimbursement up to <u>allowed amount</u> . <u>Deductible</u> does not apply.                                                                                                                      | Limit: 1 pair glasses/12 months or 4 disposable boxes of contact lenses/12 months or 2 boxes replacement contact lenses.<br>No charge if the frame is selected from Davis Vision Exclusive Collection.<br>Separately administered by Davis Vision. |
|                                        | Children's dental check-up       | Not covered                                                                                                                                                                                                                                                                    | Not covered                                                                                                                                                                                                                   | Not covered                                                                                                                                                                                                                                        |

### Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) |                                                                                               |                                                                                                                                                                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Children's dental check-up</li> <li>Cosmetic surgery</li> </ul>                                                                 | <ul style="list-style-type: none"> <li>Dental care (Adult)</li> <li>Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>Routine foot care (unless to treat diabetes or systemic conditions such as metabolic, neurologic, or peripheral vascular disease)</li> <li>Weight loss programs (except as required by ACA)</li> </ul> |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)                                 |                                                                                                                                                                                                                 |                                                                                                                                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Acupuncture (limit: 12 visits/year)</li> <li>Bariatric Surgery</li> <li>Chiropractic care (limit: 12 visits/year)</li> </ul> | <ul style="list-style-type: none"> <li>Hearing aids (limit: \$1,750 per hearing aid)</li> <li>Infertility treatment</li> <li>Non-emergency care when traveling outside the U.S. (see www.BCBSRI.com)</li> </ul> | <ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care (Adult) (limit: 1 exam/12 months and 1 pair glasses/12 months) (through Davis Vision)</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: 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). 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 on how 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: contact the [plan](#) at 1-800-639-2227 or 1-401-459-5000 or TDD 711. You may also contact 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). Additionally, a consumer assistance program can help you file your [appeal](#). Contact your state insurance department at 1-401-462-9520 or by email at [HealthInquiry@ohic.ri.gov](mailto:HealthInquiry@ohic.ri.gov).

**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:**

Para obtener asistencia en Español, llame al 1-800-639-2227.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-639-2227.

如果需要中文的帮助，请拨打这个号码 1-800-639-2227.

Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-639-2227.

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



## About these Coverage Examples:



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

### Peg is Having a Baby

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

|                                          |           |
|------------------------------------------|-----------|
| ■ The plan's overall <u>deductible</u>   | \$250     |
| ■ <u>Specialist copayment</u>            | \$30      |
| ■ Hospital (facility) <u>coinsurance</u> | No Charge |
| ■ Other <u>coinsurance</u>               | 20%       |

This **EXAMPLE** event includes services like:

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

|                    |          |
|--------------------|----------|
| Total Example Cost | \$12,700 |
|--------------------|----------|

In this example, Peg would pay:

| <u>Cost Sharing</u>               |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$250        |
| <u>Copayments</u>                 | \$30         |
| <u>Coinsurance</u>                | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$60         |
| <b>The total Peg would pay is</b> | <b>\$340</b> |

### Managing Joe's Type 2 Diabetes

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

|                                          |           |
|------------------------------------------|-----------|
| ■ The plan's overall <u>deductible</u>   | \$250     |
| ■ <u>Specialist copayment</u>            | \$30      |
| ■ Hospital (facility) <u>coinsurance</u> | No Charge |
| ■ Other <u>coinsurance</u>               | 20%       |

This **EXAMPLE** event includes services like:

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

|                    |         |
|--------------------|---------|
| Total Example Cost | \$5,600 |
|--------------------|---------|

In this example, Joe would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$250          |
| <u>Copayments</u>                 | \$100          |
| <u>Coinsurance</u>                | \$800          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,170</b> |

### Mia's Simple Fracture

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

|                                          |           |
|------------------------------------------|-----------|
| ■ The plan's overall <u>deductible</u>   | \$250     |
| ■ <u>Specialist copayment</u>            | \$30      |
| ■ Hospital (facility) <u>coinsurance</u> | No Charge |
| ■ Other <u>coinsurance</u>               | 20%       |

This **EXAMPLE** event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                    |         |
|--------------------|---------|
| Total Example Cost | \$2,800 |
|--------------------|---------|

In this example, Mia would pay:

| <u>Cost Sharing</u>               |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$250        |
| <u>Copayments</u>                 | \$300        |
| <u>Coinsurance</u>                | \$70         |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$620</b> |

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