



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 [www.cpg.org/mtdocs](http://www.cpg.org/mtdocs) or call (800) 480-9967. 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.cpg.org/uniform-glossary](http://www.cpg.org/uniform-glossary) or call (800) 480-9967 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                       | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | <u>Network:</u> <b>\$1,500</b> Individual / <b>\$3,000</b> Family<br><u>Out-of-Network:</u> <b>\$3,000</b> Individual / <b>\$6,000</b> Family                                                                                                                 | Generally, you must pay all of the costs from <a href="#">providers</a> 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 deductible. The network and out-of-network <a href="#">deductibles</a> accumulate separately.                                                                                                                           |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes, for example, network preventive care, emergency room care, urgent care, and certain telehealth services.                                                                                                                                                 | 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 preventive services at <a href="http://healthcare.gov/coverage/preventive-care-benefits">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> ? | <u>Network:</u> <b>\$5,000</b> Individual / <b>\$10,000</b> Family<br><u>Out-of-Network:</u> <b>\$10,000</b> Individual / <b>\$20,000</b> 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. The network and out-of-network <a href="#">out-of-pocket limits</a> accumulate separately.                                                                                                                                                                                                                                                  |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Contributions, ( <a href="#">premiums</a> ), <a href="#">balance-billing</a> charges, penalties, <a href="#">copays</a> for certain specialty pharmacy drugs considered non-essential health benefits and healthcare 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.anthem.com">www.anthem.com</a> or call (866) 871-0629 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 <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.cpg.org](http://www.cpg.org).

\*\*See Page 5 for important information about telehealth services.

 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 <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness       | \$35 copay/visit<br><a href="#">Deductible</a> does not apply                   | 50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a> | None.                                                                                                                                                                                                                                                                                                                                                   |
|                                                                        | <a href="#">Specialist</a> visit                       | \$50 copay/visit<br><a href="#">Deductible</a> does not apply                   | 50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a> | None.                                                                                                                                                                                                                                                                                                                                                   |
|                                                                        | <a href="#">Preventive care/screening/immunization</a> | No charge.                                                                      | 50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a> | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. See a list of preventive services at <a href="http://healthcare.gov/coverage/preventive-care-benefits">healthcare.gov/coverage/preventive-care-benefits</a> . |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 20% coinsurance<br><b>Outpatient:</b> <a href="#">Deductible</a> does not apply | 50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a> |                                                                                                                                                                                                                                                                                                                                                         |
|                                                                        | Imaging (CT/PET scans, MRIs)                           | 20% coinsurance<br><b>Outpatient:</b> <a href="#">Deductible</a> does not apply | 50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a> | Prior authorization is required for MRI/MRA and PET scans.                                                                                                                                                                                                                                                                                              |
| If you have outpatient surgery                                         | Facility fee (e.g., ambulatory surgery center)         | 20% coinsurance                                                                 | 50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a> | Prior authorization is required.                                                                                                                                                                                                                                                                                                                        |
|                                                                        | Physician/surgeon fees                                 | 20% coinsurance                                                                 | 50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a> | Prior authorization is required.                                                                                                                                                                                                                                                                                                                        |
| If you need immediate medical attention                                | <a href="#">Emergency room care</a>                    | \$250 copay/visit<br><a href="#">Deductible</a> does not apply                  | \$250 copay/visit<br><a href="#">Deductible</a> does not apply           | The \$250 <a href="#">copay</a> will be waived if you are admitted to the hospital as an inpatient within 24 hours.                                                                                                                                                                                                                                     |
|                                                                        | <a href="#">Emergency medical transportation</a>       | 20% coinsurance                                                                 | 20% coinsurance                                                          | None.                                                                                                                                                                                                                                                                                                                                                   |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.cpg.org](http://www.cpg.org).

\*\*See Page 5 for important information about telehealth services.

| 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="#">Urgent care</a>               | \$60 copay/visit<br><b>Deductible</b> does not apply                       | \$60 copay/visit plus any <a href="#">balance billing</a><br><b>Deductible</b> does not apply                | None.                                                                                                                                                                   |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 20% coinsurance                                                            | 50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>                                     | Prior authorization is required.                                                                                                                                        |
|                                                                           | Physician/surgeon fees                    | 20% coinsurance                                                            | 50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>                                     |                                                                                                                                                                         |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$35 copay/visit<br><b>Deductible</b> does not apply                       | 30% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a><br><b>Deductible</b> does not apply | Prior authorization required for Intensive Outpatient for Mental Health/Substance Use Disorders.                                                                        |
|                                                                           | Inpatient services                        | 20% coinsurance<br><b>Deductible</b> does not apply                        | 50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a><br><b>Deductible</b> does not apply | Prior authorization is required.                                                                                                                                        |
| If you are pregnant                                                       | Office visits                             | \$35 PCP / \$50 specialist copay/visit<br><b>Deductible</b> does not apply | 50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>                                     | <b>Copay</b> applies only to the initial visit to confirm pregnancy.                                                                                                    |
|                                                                           | Childbirth/delivery professional services | 20% coinsurance                                                            | 50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>                                     | Well-newborn care is covered. Newborn must be enrolled in the <a href="#">plan</a> within 30 days of birth.                                                             |
|                                                                           | Childbirth/delivery facility services     | 20% coinsurance                                                            | 50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>                                     |                                                                                                                                                                         |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | 20% coinsurance                                                            | 50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>                                     | Limited to 210 visits per plan year. Prior authorization is required.                                                                                                   |
|                                                                           | <a href="#">Rehabilitation services</a>   | \$35 PCP / \$50 specialist copay/visit<br><b>Deductible</b> does not apply | 50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>                                     | Benefits include speech/hearing, physical, and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies. |
|                                                                           | <a href="#">Habilitation services</a>     | \$35 PCP / \$50 specialist copay/visit<br><b>Deductible</b> does not       | 50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>                                     |                                                                                                                                                                         |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.cpg.org](http://www.cpg.org).

\*\*See Page 5 for important information about telehealth services.

| 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)                       |                                                                                                        |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                |                                           | apply                                        |                                                                          |                                                                                                        |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                | <a href="#">Skilled nursing care</a>      | 20% coinsurance                              | 50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a> | Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required. |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                | <a href="#">Durable medical equipment</a> | 20% coinsurance                              | 50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a> | Prior authorization required for all rentals and any purchase over \$1500.                             |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                | <a href="#">Hospice services</a>          | No charge.                                   | 50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a> | Prior authorization is required.                                                                       |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| If your child needs dental or eye care                                                                                                                                                                         | Children’s eye exam                       | Not covered.                                 | Not covered.                                                             | Vision benefits are available through EyeMed Vision Care                                               |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                | Children’s glasses                        | Not covered.                                 | Not covered.                                                             |                                                                                                        |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                | Children’s dental check-up                | Not covered.                                 | Not covered.                                                             |                                                                                                        |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Common Medical Event                                                                                                                                                                                           | Services You May Need                     | What You Will Pay                            |                                                                          |                                                                                                        |               | Limitations, Exceptions, & Other Important Information*                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                |                                           | Standard Prescription Plan                   |                                                                          | Premium Prescription Plan                                                                              |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> | Generic drugs                             | Retail                                       | Home Delivery                                                            | Retail                                                                                                 | Home Delivery | <a href="#">Deductible</a> does not apply.<br><br>You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using home delivery (up to a 30-day supply for <a href="#">specialty drugs</a> ). <sup>1</sup> See “Important Questions” regarding the Plan’s out-of-pocket limit on page 1.<br><br>No charge for contraceptives.<br><br>For a complete list of non-essential specialty medications, see <a href="http://SaveonSP.com/cpg">SaveonSP.com/cpg</a> . |
|                                                                                                                                                                                                                |                                           | Up to \$10                                   | Up to \$25                                                               | Up to \$5                                                                                              | Up to \$12    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                | Preferred brand drugs                     | 25%; up to \$40 min / \$120 max              | 25%; up to \$100 min / \$300 max                                         | Up to \$35                                                                                             | Up to \$87    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                | Non-preferred brand drugs                 | 40%; up to \$80 min / \$160 max              | 40%; up to \$200 min / \$400 max                                         | Up to \$70                                                                                             | Up to \$175   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                | <a href="#">Specialty drugs</a>           | 50%; up to \$250 min / \$500 max             | 50%; up to \$250 min / \$500 max                                         | Up to \$90                                                                                             | Up to \$90    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                    |                        |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------|--|--|--|
| • Cosmetic surgery                                                                                                                                                                                | • Dental care (Adult)                              | • Long-term care       |  |  |  |
| • Routine eye care (Adult)                                                                                                                                                                        | • Routine foot care (unless related to diabetes or | • Weight loss programs |  |  |  |

<sup>1</sup> The prescription drug plan maintains a retail refill limit policy. The retail refill limit requires that you use home delivery if you are prescribed a maintenance medication. In some circumstances, you may not be required to use home delivery. See the plan document at [www.cpg.org](http://www.cpg.org).

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.cpg.org](http://www.cpg.org).

\*\*See Page 5 for important information about telehealth 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](#).)**

certain other conditions)

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Acupuncture (limit 20 visits per year)
- Hearing aids (limit \$3,000 every three years)
- Private duty nursing (only through home healthcare benefit)
- Bariatric surgery (if Medically Necessary)
- Infertility treatment (\$50,000 lifetime maximum)
- Chiropractic care (limit 20 visits per year)
- Non-emergency care when traveling outside the U.S.<sup>2</sup>

**Telehealth Services:** The Medical Trust will waive all [copays](#), [deductibles](#), and [coinsurance](#) for all telehealth services received through Quantum Health's telehealth platform, Teladoc. The Medical Trust will also allow claims for virtual visits with [network](#) and [out-of-network providers](#) who do not use Teladoc through Quantum Health, but standard [deductibles](#), [copays](#), and [coinsurance](#) will apply.

**Your Rights to Continue Coverage:** The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as COBRA) for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements<sup>3</sup>. Nonetheless, subscribers and/or their enrolled dependents will have the opportunity to continue benefits for a limited time in certain instances when coverage through the health plan would otherwise cease. Individuals who elect to continue coverage must pay for the coverage. Call (800) 480-9967 for more information.

**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 Anthem Blue Cross and Blue Shield or Express Scripts, as appropriate.

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al (800) 480-9967.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 480-9967.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(800) 480-9967.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 480-9967.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf (800) 480-9967 uff.

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

<sup>2</sup> Coverage for non-emergency care when traveling outside the U.S. applies only to services available through the medical benefit administered by Anthem Blue Cross and Blue Shield. Non-emergency services outside the U.S. are not available through the prescription drug benefit administered by Express Scripts.

<sup>3</sup> Under Section 4980B(d) of the Code and Treasury Regulation Section 54.4980 B-2, Q. and A. No. 4.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.cpg.org](http://www.cpg.org).

\*\*See Page 5 for important information about telehealth services.

## 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> | \$1,500 |
| ■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]   | \$50    |
| ■ Hospital (facility) [ <a href="#">cost sharing</a> ]          | 20%     |
| ■ Other [ <a href="#">cost sharing</a> ]                        | 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*)

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

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,500        |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$2,200        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,770</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> | \$1,500 |
| ■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]   | \$50    |
| ■ Hospital (facility) [ <a href="#">cost sharing</a> ]          | 20%     |
| ■ Other [ <a href="#">cost sharing</a> ]                        | 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*)

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

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,100        |
| <a href="#">Copayments</a>        | \$2,000        |
| <a href="#">Coinsurance</a>       | \$20           |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$3,140</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> | \$1,500 |
| ■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]   | \$50    |
| ■ Hospital (facility) [ <a href="#">cost sharing</a> ]          | 20%     |
| ■ Other [ <a href="#">cost sharing</a> ]                        | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,500        |
| <a href="#">Copayments</a>        | \$500          |
| <a href="#">Coinsurance</a>       | \$40           |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,040</b> |

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