



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 1-877-805-1970 or visit [welcometouhc.com](http://welcometouhc.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 [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-866-487-2365 to request a copy.

| Important Questions                                                       | Answers                                                                                                           | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
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| <b>What is the overall <u>deductible</u>?</b>                             | <u>Network</u> : <b>\$750</b> Individual / <b>\$1,500</b> Family<br>Per calendar year.                            | 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> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                                                               |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. <u>Preventive care</u> is 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 <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                     |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No.                                                                                                               | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | <u>Network</u> : <b>\$3,750</b> Individual / <b>\$7,500</b> Family<br>Per calendar year.                          | 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.                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.                 | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. See <a href="http://myuhc.com">myuhc.com</a> or call 1-877-805-1970 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. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>          | Yes.                                                                                                              | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .                                                                                                                                                                                                                                                                                                                                                                              |



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

| Common Medical Event                                   | Services You May Need                            | What You Will Pay                                              |                                                                |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                   |
|--------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                        |                                                  | Network Provider with Referral<br>(You will pay the least)     | Network Provider without Referral<br>(You may pay more)        | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                          |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$45 <u>copay</u> per visit, <u>deductible</u> does not apply. | \$45 <u>copay</u> per visit, <u>deductible</u> does not apply. | Not Covered                                        | <u>Primary Care Physician</u> must be assigned to member. Primary Care includes network OB/GYNs – no referral required. If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery. |
|                                                        | <u>Specialist</u> visit                          | \$55 <u>copay</u> per visit, <u>deductible</u> does not apply. | \$55 <u>copay</u> per visit, <u>deductible</u> does not apply. | Not Covered                                        | We only accept electronic referrals from the assigned PCP. If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.                                                              |
|                                                        | <u>Preventive care/screening/immunization</u>    | No Charge                                                      | Not Covered                                                    | Not Covered                                        | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.                                                                                                  |
| If you have a test                                     | <u>Diagnostic test</u> (x-ray, blood work)       | 20% <u>coinsurance</u>                                         | 20% <u>coinsurance</u>                                         | Not Covered                                        | None                                                                                                                                                                                                                                                                     |
|                                                        | Imaging (CT/PET scans, MRIs)                     | 20% <u>coinsurance</u>                                         | 20% <u>coinsurance</u>                                         | Not Covered                                        | None                                                                                                                                                                                                                                                                     |

| Common Medical Event                                                                                                                                                                     | Services You May Need               | What You Will Pay                                                                                                                                                                                            |                                                                                                                                                                                                              |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                          |                                     | Network Provider with Referral<br>(You will pay the least)                                                                                                                                                   | Network Provider without Referral<br>(You may pay more)                                                                                                                                                      | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <u>prescription drug coverage</u> is available at <a href="http://Caremark.com">Caremark.com</a> . | Tier 1 – Your Lowest Cost Option    | <b>Retail Up to 31-Day Supply</b><br>30% Coinsurance<br><b>Retail &amp; Mail Order Up to 90-Day Supply</b><br>25% Coinsurance<br><b>Specialty Drugs Up to 31-Day Supply</b><br>45% Coinsurance: \$75 Maximum | <b>Retail Up to 31-Day Supply</b><br>30% Coinsurance<br><b>Retail &amp; Mail Order Up to 90-Day Supply</b><br>25% Coinsurance<br><b>Specialty Drugs Up to 31-Day Supply</b><br>45% Coinsurance: \$75 Maximum | Not Covered                                        | No coverage for prescription drugs with UnitedHealthcare.<br><br>Prescription Drug Coverage is managed through CVS Caremark.<br><br>CVS Caremark Customer Service: 877-258-0105<br>CVS Caremark Specialty Pharmacy: 800-237-2767<br><br>Certain preventive medications (including certain contraceptives) are covered at No charge. To learn more about drug tiers and about <u>copays</u> for specific drugs, visit <a href="http://Caremark.com">Caremark.com</a> website. <u>Prior authorization</u> is required for certain drugs or there may be no coverage. <u>Specialty drugs</u> are not covered at a 90-day supply. <u>Prior authorization</u> is required for certain <u>specialty drugs</u> or there may be no coverage. |
|                                                                                                                                                                                          | Tier 2 – Your Mid-Range Cost Option | <b>Retail Up to 31-Day Supply</b><br>40% Coinsurance<br><b>Retail &amp; Mail Order Up to 90-Day Supply</b><br>35% Coinsurance<br><b>Specialty Drugs Up to 31-Day Supply</b><br>45% Coinsurance: \$75 Maximum | <b>Retail Up to 31-Day Supply</b><br>40% Coinsurance<br><b>Retail &amp; Mail Order Up to 90-Day Supply</b><br>35% Coinsurance<br><b>Specialty Drugs Up to 31-Day Supply</b><br>45% Coinsurance: \$75 Maximum | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                          | Tier 3 – Your Mid-Range Cost Option | <b>Retail Up to 31-Day Supply</b><br>50% Coinsurance<br><b>Retail &amp; Mail Order Up to</b>                                                                                                                 | <b>Retail Up to 31-Day Supply</b><br>50% Coinsurance<br><b>Retail &amp; Mail Order Up to</b>                                                                                                                 | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

|                                                |                                                |                                                                                                                                                                                                      |                                                                                                                                                                                                      |                                                            |                                     |
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|                                                |                                                | <b>90-Day Supply</b><br>45% Coinsurance<br><b>Specialty Drugs Up to 31-Day Supply</b><br>45% Coinsurance: \$75 Maximum                                                                               | <b>90-Day Supply</b><br>45% Coinsurance<br><b>Specialty Drugs Up to 31-Day Supply</b><br>45% Coinsurance: \$75 Maximum                                                                               |                                                            |                                     |
|                                                | Tier 4 – Your Highest Cost Option              | <b>Retail Up to 31-Day Supply</b><br>Not Covered<br><b>Retail &amp; Mail Order Up to 90-Day Supply</b><br>Not Covered<br><b>Specialty Drugs Up to 31-Day Supply</b><br>45% Coinsurance: \$75 Maximum | <b>Retail Up to 31-Day Supply</b><br>Not Covered<br><b>Retail &amp; Mail Order Up to 90-Day Supply</b><br>Not Covered<br><b>Specialty Drugs Up to 31-Day Supply</b><br>45% Coinsurance: \$75 Maximum | Not Applicable                                             |                                     |
| <b>If you have outpatient surgery</b>          | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u>                                                                                                                                                                               | 20% <u>coinsurance</u>                                                                                                                                                                               | Not Covered                                                | None                                |
|                                                | Physician/surgeon fees                         | 20% <u>coinsurance</u>                                                                                                                                                                               | 20% <u>coinsurance</u>                                                                                                                                                                               | Not Covered                                                | None                                |
| <b>If you need immediate medical attention</b> | <u>Emergency room care</u>                     | \$300 <u>copay</u> per visit, then 20% <u>coinsurance</u>                                                                                                                                            | \$300 <u>copay</u> per visit, then 20% <u>coinsurance</u>                                                                                                                                            | *\$300 <u>copay</u> per visit, then 20% <u>coinsurance</u> | * <u>Network deductible</u> applies |
|                                                | <u>Emergency medical transportation</u>        | 20% <u>coinsurance</u>                                                                                                                                                                               | 20% <u>coinsurance</u>                                                                                                                                                                               | *20% <u>coinsurance</u>                                    | * <u>Network deductible</u> applies |

|                             |                                    |                                                                |                                                                |             |      |
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|                             | <u>Urgent care</u>                 | \$75 <u>copay</u> per visit, <u>deductible</u> does not apply. | \$75 <u>copay</u> per visit, <u>deductible</u> does not apply. | Not Covered | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u>                                         | 20% <u>coinsurance</u>                                         | Not Covered | None |
|                             | Physician/surgeon fees             | 20% <u>coinsurance</u>                                         | 20% <u>coinsurance</u>                                         | Not Covered | None |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                              |                                                                |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | Network Provider with Referral<br>(You will pay the least)     | Network Provider without Referral<br>(You may pay more)        | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                              |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$45 <u>copay</u> per visit, <u>deductible</u> does not apply. | \$45 <u>copay</u> per visit, <u>deductible</u> does not apply. | Not Covered                                        | Network Partial hospitalization/intensive outpatient treatment: 20% <u>coinsurance</u>                                                                                                                                                                                       |
|                                                                           | Inpatient services                        | 20% <u>coinsurance</u>                                         | 20% <u>coinsurance</u>                                         | Not Covered                                        | None                                                                                                                                                                                                                                                                         |
| If you are pregnant                                                       | Office visits                             | No Charge                                                      | No Charge                                                      | Not Covered                                        | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
|                                                                           | Childbirth/delivery professional services | 20% <u>coinsurance</u>                                         | 20% <u>coinsurance</u>                                         | Not Covered                                        |                                                                                                                                                                                                                                                                              |
|                                                                           | Childbirth/delivery facility services     | 20% <u>coinsurance</u>                                         | 20% <u>coinsurance</u>                                         | Not Covered                                        | None                                                                                                                                                                                                                                                                         |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                   | 20% <u>coinsurance</u>                                         | 20% <u>coinsurance</u>                                         | Not Covered                                        | Limited to 60 visits per calendar year.                                                                                                                                                                                                                                      |
|                                                                           | <u>Rehabilitation services</u>            | \$55 <u>copay</u> per visit, <u>deductible</u> does not apply. | \$55 <u>copay</u> per visit, <u>deductible</u> does not apply. | Not Covered                                        | Limits per calendar year: Physical, Speech, Occupational, Pulmonary: 30 visits each; Cardiac: 36 visits.<br>Visit limits do not apply for the treatment of mental illness or substance-related & addictive disorders.                                                        |

|                                               |                                  |                                                                |                                                                |             |                                                                                                |
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|                                               | <u>Habilitative services</u>     | \$55 <u>copay</u> per visit, <u>deductible</u> does not apply. | \$55 <u>copay</u> per visit, <u>deductible</u> does not apply. | Not Covered | Services are provided under and limits are combined with <u>Rehabilitation Services</u> above. |
|                                               | <u>Skilled nursing care</u>      | 20% <u>coinsurance</u>                                         | 20% <u>coinsurance</u>                                         | Not Covered | Limited to 60 days per calendar year (combined with inpatient rehabilitation).                 |
|                                               | <u>Durable medical equipment</u> | 20% <u>coinsurance</u>                                         | 20% <u>coinsurance</u>                                         | Not Covered | Covers 1 per type of DME (including repair/replacement) every 3 years.                         |
|                                               | <u>7 services</u>                | 20% <u>coinsurance</u>                                         | 20% <u>coinsurance</u>                                         | Not Covered | None                                                                                           |
| <b>If your child needs dental or eye care</b> | Children's eye exam              | Not Covered                                                    | Not Covered                                                    | Not Covered | No coverage for Children's eye exams.                                                          |
|                                               | Children's glasses               | Not Covered                                                    | Not Covered                                                    | Not Covered | No coverage for Children's glasses.                                                            |
|                                               | Children's dental check-up       | Not Covered                                                    | Not Covered                                                    | Not Covered | No coverage for Children's Dental check-up.                                                    |

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- |                                                                                                                                                              |                                                                                                                                                                                               |                                                                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Cosmetic surgery</li><li>• Dental care</li><li>• Glasses</li></ul> | <ul style="list-style-type: none"><li>• Infertility treatment</li><li>• Long-term care</li><li>• Non-emergency care when travelling outside - the U.S.</li><li>• Prescription drugs</li></ul> | <ul style="list-style-type: none"><li>• Private duty nursing</li><li>• Routine eye care</li><li>• Weight loss programs</li></ul> |
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### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- |                                                                                                                  |                                                                                      |                                                                                                      |
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| <ul style="list-style-type: none"><li>• Chiropractic (Manipulative care) – 20 visits per calendar year</li></ul> | <ul style="list-style-type: none"><li>• Hearing aids - \$5,000 per 3 years</li></ul> | <ul style="list-style-type: none"><li>• Routine foot care (covered for certain conditions)</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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information 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: the Member Service number listed on the back of your ID card or [myuhc.com](http://myuhc.com).

Additionally, a consumer assistance program may help you file your appeal. Contact [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform).

### 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 1-877-805-1970.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-805-1970.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-805-1970.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-877-805-1970 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-805-1970.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-877-805-1970.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-877-805-1970.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang 1-877-805-1970.

*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<br>(9 months of in-network pre-natal care and a hospital delivery)                                                                                                                                                                                                                                |                 | Managing Joe's type 2 Diabetes<br>(a year of routine in-network care of a well-controlled condition)                                                                                                                                                                               |                | Mia's Simple Fracture<br>(in-network emergency room visit and follow up care)                                                                                                                                                                                                          |                |
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| ■ The plan's overall <u>deductible</u>                                                                                                                                                                                                                                                                                 | \$750           | ■ The plan's overall <u>deductible</u>                                                                                                                                                                                                                                             | \$750          | ■ The plan's overall <u>deductible</u>                                                                                                                                                                                                                                                 | \$750          |
| ■ <u>Specialist copay</u>                                                                                                                                                                                                                                                                                              | \$55            | ■ <u>Specialist copay</u>                                                                                                                                                                                                                                                          | \$55           | ■ <u>Specialist copay</u>                                                                                                                                                                                                                                                              | \$55           |
| ■ Hospital (facility) <u>coinsurance</u>                                                                                                                                                                                                                                                                               | 20%             | ■ Hospital (facility) <u>coinsurance</u>                                                                                                                                                                                                                                           | 20%            | ■ Hospital (facility) <u>coinsurance</u>                                                                                                                                                                                                                                               | 20%            |
| ■ Other <u>coinsurance</u>                                                                                                                                                                                                                                                                                             | 20%             | ■ Other <u>coinsurance</u>                                                                                                                                                                                                                                                         | 20%            | ■ Other <u>coinsurance</u>                                                                                                                                                                                                                                                             | 20%            |
| <b>This EXAMPLE event includes services like:</b><br><u>Specialist</u> office visits ( <i>pre-natal care</i> )<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br><u>Diagnostic tests</u> ( <i>ultrasounds and blood work</i> )<br><u>Specialist</u> visit ( <i>anesthesia</i> ) |                 | <b>This EXAMPLE event includes services like:</b><br><u>Primary care physician</u> office visits ( <i>including disease education</i> )<br><u>Diagnostic tests</u> ( <i>blood work</i> )<br><u>Prescription drugs</u><br><u>Durable medical equipment</u> ( <i>glucose meter</i> ) |                | <b>This EXAMPLE event includes services like:</b><br><u>Emergency room care</u> ( <i>including medical supplies</i> )<br><u>Diagnostic test</u> ( <i>x-ray</i> )<br><u>Durable medical equipment</u> ( <i>crutches</i> )<br><u>Rehabilitation services</u> ( <i>physical therapy</i> ) |                |
| <b>Total Example Cost</b>                                                                                                                                                                                                                                                                                              | <b>\$12,700</b> | <b>Total Example Cost</b>                                                                                                                                                                                                                                                          | <b>\$5,600</b> | <b>Total Example Cost</b>                                                                                                                                                                                                                                                              | <b>\$2,800</b> |
| <b>In this example, Peg would pay:</b>                                                                                                                                                                                                                                                                                 |                 | <b>In this example, Joe would pay:</b>                                                                                                                                                                                                                                             |                | <b>In this example, Mia would pay:</b>                                                                                                                                                                                                                                                 |                |
| <i>Cost Sharing</i>                                                                                                                                                                                                                                                                                                    |                 | <i>Cost Sharing</i>                                                                                                                                                                                                                                                                |                | <i>Cost Sharing</i>                                                                                                                                                                                                                                                                    |                |
| <u>Deductibles</u>                                                                                                                                                                                                                                                                                                     | \$750           | <u>Deductibles</u>                                                                                                                                                                                                                                                                 | \$250          | <u>Deductibles</u>                                                                                                                                                                                                                                                                     | \$750          |
| <u>Copayments</u>                                                                                                                                                                                                                                                                                                      | \$0             | <u>Copayments</u>                                                                                                                                                                                                                                                                  | \$300          | <u>Copayments</u>                                                                                                                                                                                                                                                                      | \$600          |
| <u>Coinsurance</u>                                                                                                                                                                                                                                                                                                     | \$2,100         | <u>Coinsurance</u>                                                                                                                                                                                                                                                                 | \$0            | <u>Coinsurance</u>                                                                                                                                                                                                                                                                     | \$100          |
| <i>What isn't covered</i>                                                                                                                                                                                                                                                                                              |                 | <i>What isn't covered</i>                                                                                                                                                                                                                                                          |                | <i>What isn't covered</i>                                                                                                                                                                                                                                                              |                |
| Limits or exclusions                                                                                                                                                                                                                                                                                                   | \$70            | Limits or exclusions                                                                                                                                                                                                                                                               | \$4,300        | Limits or exclusions                                                                                                                                                                                                                                                                   | \$10           |
| <b>The total Peg would pay is</b>                                                                                                                                                                                                                                                                                      | <b>\$2,920</b>  | <b>The total Joe would pay is</b>                                                                                                                                                                                                                                                  | <b>\$4,850</b> | <b>The total Mia would pay is</b>                                                                                                                                                                                                                                                      | <b>\$1,460</b> |

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