Coverage Period: 01/01/2024-12/31/2024
Coverage for: Individual & Family | Plan Type: PPO

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 azblue.com/member. 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/ or call 1-844-899-4072 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|---|---|
| What is the overall deductible? | In-network: \$2,500/individual or \$5,000/family Out-of-network: \$7,500/individual or \$15,000/family | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , 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> . Unless a <u>copay</u> , fee, or other percent is shown, the <u>coinsurance</u> percent of the <u>allowed amount</u> that you pay for most services is 10% <u>in-network</u> and 40% <u>out-of-network</u> . |
| Are there services covered before you meet your deductible? | Yes. Certain in-network preventive services; in-network primary care and specialist visits; prescription drugs; emergency room care; in-network urgent care visits; hospice services. | 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ? | In-network: \$5,000/individual or \$10,000/family Out-of-network: \$15,000/individual or \$30,000/family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the out-of-pocket limit? | Premiums, out-of-network prior authorization charges, balance bills, and costs for health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |

| Important Questions | Answers | Why This Matters: |
|--|--|---|
| Will you pay less if you use a <u>network provider</u> ? | Yes. See www.azblue.com or call 1-844-899-4072 for a list of in-network providers. | 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</u> 's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |

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

| | | What Yo | u Will Pay | Limitations, Exceptions, & Other | |
|---|--|---|---|---|--|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Important Information | |
| | Primary care visit to treat an injury or illness | \$20 copay, deductible does not apply | 40% coinsurance & balance | <u>Prior authorization</u> may be required. \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. <u>Specialist copay</u> for most chiropractic services. | |
| If you visit a health | Specialist visit | \$35 <u>copay</u> , <u>deductible</u> does not apply | | \$10 copay for medical telehealth consultations through BlueCare Anywhere SM . | |
| care <u>provider's</u> office or clinic | Preventive care/screening/ immunization | No charge, <u>deductible</u> does not apply | bill bill | Preventive services not required to be covered by state or federal law are not covered. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. | |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | Office visit <u>copay</u> , <u>deductible</u> does not apply or no charge | 40% <u>coinsurance</u> & <u>balance</u> | Prior authorization may be required. \$500 charge if no prior authorization for out-of-network services. Cost share waived if lab or x-ray are the only | |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | <u>ын</u> тау арргу | services received during physician office visit. | |

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* For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.azblue.com/member</u>.

| | | What Yo | u Will Pay | limitations Expansions 9 Other | |
|---|--|--|---|---|--|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information | |
| | Level 1 | \$10 <u>copay</u> /30 day supply, <u>deductible</u> does not apply | \$10 copay/30 day supply & balance bill, deductible does not apply | Some drugs require prior authorization and won't | |
| If you need drugs to treat your illness or condition | Level 2 | \$35 <u>copay</u> /30 day supply, <u>deductible</u> does not apply | \$35 <u>copay</u> /30 day supply & <u>balance bill</u> , <u>deductible</u> does not apply | be covered without it. 90-day supply costs 3 <u>copays</u> for retail pharmacy and 2 <u>copays</u> for mail order. Mail order and 90-day retail supply not | |
| More information about prescription drug coverage is available at | Level 3 | \$55 <u>copay</u> /30 day supply, <u>deductible</u> does not apply | \$55 copay/30 day supply & balance bill, deductible does not apply | covered <u>out-of-network</u> . If a generic drug is available, pay the Level 1 (generic) <u>copay</u> + the price difference between the <u>allowed amount</u> for some brand drugs. | |
| www.azblue.com | Level 4 | 25% coinsurance | 25% <u>coinsurance</u> & <u>balance</u> <u>bill</u> | Some brand drugs. | |
| | Specialty drugs | 35% <u>coinsurance,</u> <u>deductible</u> does not apply | Not covered | Specialty <u>copay</u> covers up to a 30-day supply. No coverage without <u>prior authorization</u> . | |
| If you have outpatient | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 40% coinsurance & balance bill | Prior authorization may be required. \$500 charge if | |
| surgery | Physician/surgeon fees | 1070 <u>combarance</u> | 40% <u>coinsurance</u> & <u>balance</u> <u>bill</u> may apply | no <u>prior</u> <u>authorization</u> for <u>out-of-network</u> services. | |
| If you need immediate medical attention | Emergency room care | \$400 <u>copay,</u> <u>deductible</u> does not apply | | Copay is waived if you are admitted as an inpatient to the hospital and you pay inpatient deductible and coinsurance. Admittance for observation is not inpatient. Out-of-network providers can't balance bill for the difference between the allowed amount and the billed charge. | |
| | Emergency medical transportation | 10% coinsurance | | None | |
| | Urgent care | \$50 <u>copay</u> , <u>deductible</u> does not apply | 40% coinsurance & balance bill | <u>Copay</u> applies only to facilities specifically contracted for <u>urgent care</u> . | |

Page 3 of 10 * For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.azblue.com/member</u>.

| | | What You Will Pay | | Limitations Exceptions & Other |
|--|---|---|---|---|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| | Facility fee (e.g., hospital room) | 100/ 20:00:00 | 40% <u>coinsurance</u> & <u>balance</u> <u>bill</u> | Prior authorization may be required. \$500 charge if |
| If you have a hospital | Physician/surgeon fees | 10% <u>coinsurance</u> | 40% <u>coinsurance</u> & <u>balance</u> <u>bill</u> may apply | no prior authorization for out-of-network services. |
| stay | Long-term acute care | 10% <u>coinsurance</u> except 50% <u>coinsurance</u> days 101-365 | 40% coinsurance & balance bill except 50% coinsurance & balance bill for days 101- 365 | Prior authorization may be required. \$500 charge if no prior authorization for out-of-network services. Limit of 365 total LTAC days per member. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office visit copay, deductible does not apply or 10% coinsurance. Copay amount varies based on PCP/Specialist | 40% <u>coinsurance</u> & <u>balance</u> <u>bill</u> may apply | Prior authorization may be required. \$500 charge if no prior authorization for out-of-network services. Copay applies to office, home, walk-in clinic visits. Coinsurance applies to all other locations. \$20 copay for counseling and Psychiatric telehealth consultations through BlueCare Anywhere SM . |
| | Inpatient services | 10% coinsurance | 40% <u>coinsurance</u> & <u>balance</u> <u>bill</u> may apply | <u>Prior authorization</u> may be required. \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. |
| | Office Visits | Office visit <u>copay,</u> <u>deductible</u> does not apply | 40% <u>coinsurance</u> & <u>balance</u> <u>bill</u> | Only one <u>copay</u> is collected for services included in delivering physician's global charge. Depending |
| If you are pregnant | Childbirth/delivery professional services | or 10% coinsurance | 40% <u>coinsurance</u> & <u>balance</u> <u>bill</u> may apply | on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may |
| | Childbirth/delivery facility services | 10% coinsurance | 40% coinsurance & balance bill | include tests and services described elsewhere in the <u>SBC</u> (i.e. ultrasound). <u>Cost sharing</u> does not apply for <u>in-network preventive services</u> . |

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* For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.azblue.com/member</u>.

| | | What Yo | u Will Pay | Limitations, Exceptions, & Other |
|--|--|---|---|--|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Important Information |
| | Home health care/Home infusion therapy | 10% coinsurance | 40% coinsurance & balance bill | Prior authorization may be required. \$500 charge if no prior authorization for out-of-network services. Limit of 6 hours of care/member/day. Custodial care excluded. |
| If you need help recovering or have other special health | Rehabilitation services EAR = Extended Active Rehabilitation Facility PT/OT/ST/CT/AT= Physical therapy, occupational therapy, speech therapy, cognitive therapy, audiology therapy | EAR: 10% coinsurance PT/OT/ST/CT/AT: \$35 copay, deductible does not apply | 40% coinsurance & balance bill | Prior authorization may be required. \$500 charge if no prior authorization for out-of-network services. Limit of 60 days/calendar year for EAR and SNF combined. Limit of 60 visits/calendar year PT/OT/ST/CT/AT. Maximum of 10 visits/calendar year out-of-network PT/OT/ST/CT/AT. Habilitation limits combined with outpatient rehabilitation. Plan |
| needs | Habilitation services | \$35 <u>copay</u> , <u>deductible</u> does not apply | 40% <u>coinsurance</u> & <u>balance</u> <u>bill</u> | does not cover group physical and occupational therapy. |
| | Skilled nursing care In skilled nursing facility (SNF) | 10% coinsurance | 40% coinsurance & balance | |
| | Durable medical equipment | Office visit copay, deductible does not apply or 10% coinsurance. | 40% coinsurance & balance | Prior authorization may be required. \$500 charge if no prior authorization for out-of-network services. Cost share varies based on place of service and provider's network status. |
| | Hospice services | 10% coinsurance | 40% <u>coinsurance</u> & <u>balance</u> <u>bill</u> | <u>Prior authorization</u> may be required. \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. |
| If your child needs | Children's eye exam | Not covered | Not covered | Excluded. Screening for members under age 5 covered under "Preventive care / screening / immunization." |
| dental or eye care | Children's glasses | Not covered | Not covered | Excluded |
| | Children's dental check-up | Not covered | Not covered | Excluded |

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* For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.azblue.com/member</u>.

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.)

- Acupuncture
- Alternative medicine
- Bariatric surgery
- Care that is not medically necessary
- Cosmetic surgery, cosmetic services & supplies
- Custodial care
- Dental care except dental accidents
- <u>DME</u> rental/repair charges that exceed <u>DME</u> purchase price
- Experimental and investigational treatments except as stated in <u>plan</u>
- Eyewear except after cataract surgery
- Fertility and infertility medication and treatment
- Flat feet treatment and services

- Genetic and chromosomal testing except as stated in plan
- Hearing aids
- Home health care and infusion therapy exceeding 6 hours of care per member per day
- Inpatient EAR and SNF treatment exceeding a combined limit of 60 days per <u>calendar year</u>
- Long-term care, except long-term acute care up to a 365 days benefit <u>plan</u> maximum
- Massage therapy other than allowed under evidence-based criteria
- <u>Out-of-network</u> Mail Order drugs, <u>out-of-network</u> <u>Specialty</u> drugs, and <u>out-of-network</u> 90-day retail supply of drugs

- PT/OT/ST/CT/AT exceeding 60 visits per <u>calendar</u> <u>year</u> and 10 visits <u>out-of-network</u> per <u>calendar year</u>
- <u>Preventive services</u> not required to be covered by state or federal law
- Private-duty nursing
- Respite care except as stated in plan
- Routine foot care
- Routine vision exams
- Services, tests and procedures that are excluded under medical coverage guidelines
- Sexual dysfunction treatment and services
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)

Chiropractic care

Non-emergency care when traveling outside the U.S.

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.azblue.com/member</u>.

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:

- For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Church <u>plans</u> are not covered by the Federal <u>COBRA</u> continuation coverage rules. If the coverage is insured, individuals should contact the Arizona Department of Insurance (602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area) regarding their possible rights to continuation coverage under State law.

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 or call 1-800-318- 2596.

Your <u>Grievance</u> and <u>Appeals</u> Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

- For group health coverage subject to ERISA, contact Blue Cross Blue Shield of Arizona at 1-844-899-4072. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. If your coverage is insured, you may also contact the Arizona Department of Insurance at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area.
- For non-federal governmental group health plans and church plans that are group health plans, contact Blue Cross Blue Shield of Arizona at 1-844-899-4072. If your coverage is insured, you may also contact the Arizona Department of Insurance at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area https://difi.az.gov/consumer/i/health.

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 <u>plan</u> meet the <u>Minimum Value Standards</u>? 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.

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.azblue.com/member</u>.

Multi-language Interpreter Services

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe'é atah nílínigíí Blue Cross Blue Shield of Arizona haada yit'éego bína'ídíłkidgo éí doodago Háida bíjá anilyeedígíí t'áadoo le'é yína'ídíłkidgo beehaz'áanii hóló díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'á doo bááh ílínígóó. Ata' halne'ígíí kojí' bich'j' hodíilnih 877-475-4799.

Chinese: 如果您,或是您正在協助的對象,有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題,您有權利免費以您的 母語得到幫助和訊息。洽詢一位翻譯員,請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

Arabic:

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة للتحدث مع مترجم اتصل ب 4799-475-877.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 877-475-4799.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799 로 전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、877-475-4799 までお電話ください。

Farsi:

اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Arizona ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. 877-475-778 تماس حاصل نمایید.

Assvrian

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

Thai: หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีค่าถามเกี่ยวกับ Blue Cross Blue Shield of Arizona คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 877-475-4799

To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

About These Coverage Examples

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

| 500 |
|------|
| \$35 |
| 0% |
| 0% |
| l |

This EXAMPLE event includes services like:

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

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

In this example, Peg would pay:

| Cost Sharing | | |
|----------------------------|---------|--|
| <u>Deductibles</u> | \$2,500 | |
| Copayments | \$50 | |
| <u>Coinsurance</u> | \$750 | |
| What isn't covered | | |
| Limits or exclusions | \$50 | |
| The total Peg would pay is | \$3,350 | |

Managing Joe's Type 2 Diabetes

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

| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,500 |
|---|---------|
| ■ Specialist copayment | \$35 |
| ■ Hospital (facility) coinsurance | 10% |
| ■ Other coinsurance | 10% |

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (*including disease education*)

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (*glucose meter*)

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

In this example, Joe would pay:

| Cost Sharing | |
|----------------------------|-------|
| <u>Deductibles</u> | \$50 |
| Copayments | \$710 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$780 |

Mia's Simple Fracture

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

| ■ The plan's overall deductible | \$2,500 |
|-----------------------------------|---------|
| ■ Specialist copayment | \$35 |
| ■ Hospital (facility) coinsurance | 10% |
| ■ Other coinsurance | 10% |

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

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

In this example, Mia would pay:

| Cost Sharing | |
|----------------------------|---------|
| <u>Deductibles</u> | \$1,940 |
| <u>Copayments</u> | \$430 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,370 |

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

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