



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 us at 1-844-282-3025 or visit us on the web at <https://www.christushealthplan.org/member-resources/forms-documents/individual-and-family-plans/>. 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 <http://www.healthcare.gov/sbc-glossary> or call 1-844-282-3025 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                               | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$6,900/individual or \$13,800/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 <a href="#">deductible</a> .                                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .                                                                          | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                                   | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$10,350/individual or \$20,700/family                                                                                                                                                                | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.                                                                          | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="https://www.christushealthplan.org/find-a-provider">https://www.christushealthplan.org/find-a-provider</a> or call 1-844-282-3025 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's 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 <a href="#">provider's</a> 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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |



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       | \$5 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply         | Not covered                                        | Telemedicine and telehealth services have the same <a href="#">cost sharing</a> .                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                   | <a href="#">Specialist</a> visit                       | \$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply        | Not covered                                        | Including office services, other than those specifically shown below.<br><br>Telemedicine and telehealth services have the same <a href="#">cost sharing</a> .                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                   | <a href="#">Preventive care/screening/immunization</a> | No charge; <a href="#">deductible</a> does not apply                                    | Not covered                                        | 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.                                                                                                                                                                                                  |
| If you have a test                                                                                                                                                                                                                                                                                                                | <a href="#">Diagnostic test</a> (x-ray, blood work)    | \$60 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply        | Not covered                                        | None.                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                   | Imaging (CT/PET scans, MRIs)                           | \$400 <a href="#">copayment</a> /visit                                                  | Not covered                                        | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.                                                                                                                                                                                                                                                                 |
| 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="https://chppayment.christushealth.org/documents/hix/formulary/TXHIXFormulary2027.pdf">https://chppayment.christushealth.org/documents/hix/formulary/TXHIXFormulary2027.pdf</a> | Preferred generic drugs                                | No charge; <a href="#">deductible</a> does not apply                                    | Not covered                                        | <a href="#">Cost sharing</a> for a 90-day supply by mail order is triple the <a href="#">cost sharing</a> for a standard 30-day supply. Prescriptions for birth control are not subject to <a href="#">deductible</a> , and do not have a <a href="#">copayment</a> . <a href="#">Preauthorization</a> is needed for certain <a href="#">prescription drugs</a> and intravenous infusions. |
|                                                                                                                                                                                                                                                                                                                                   | Non-preferred generic drugs                            | \$10 <a href="#">copayment</a> /prescription; <a href="#">deductible</a> does not apply | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                   | Preferred brand drugs                                  | \$60 <a href="#">copayment</a> /prescription; <a href="#">deductible</a> does not apply | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                   | Non-preferred brand drugs                              | \$80 <a href="#">copayment</a> /prescription                                            | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                   | <a href="#">Specialty drugs</a>                        | \$350 <a href="#">copayment</a> /prescription                                           | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                            |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                                                                                      |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                 |
|---------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Network Provider<br>(You will pay the least)                                                                                                           | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                        |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | 50% <a href="#">coinsurance</a>                                                                                                                        | Not covered                                        | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.                                                             |
|                                                                           | Physician/surgeon fees                           | 50% <a href="#">coinsurance</a>                                                                                                                        | Not covered                                        | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.                                                             |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$950 <a href="#">copayment</a> /visit                                                                                                                 | \$950 <a href="#">copayment</a> /visit             | No charge for virtual urgent care through CHRISTUS Health System.                                                                                                                      |
|                                                                           | <a href="#">Emergency medical transportation</a> | 50% <a href="#">coinsurance</a>                                                                                                                        | 50% <a href="#">coinsurance</a>                    |                                                                                                                                                                                        |
|                                                                           | <a href="#">Urgent care</a>                      | \$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply                                                                       | Not covered                                        |                                                                                                                                                                                        |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | \$950 <a href="#">copayment</a> /stay                                                                                                                  | Not covered                                        | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.                                                             |
|                                                                           | Physician/surgeon fees                           | No charge                                                                                                                                              | Not covered                                        | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.                                                             |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Office visit: \$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply<br>Outpatient facility: 50% <a href="#">coinsurance</a> | Not covered                                        | Office visits are subject to the listed <a href="#">cost sharing</a> , while facility outpatient treatments are subject to the outpatient facility <a href="#">coinsurance</a> .       |
|                                                                           | Inpatient services                               | \$950 <a href="#">copayment</a> /stay                                                                                                                  | Not covered                                        | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.                                                             |
| If you are pregnant                                                       | Office visits                                    | \$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply                                                                       | Not covered                                        | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |

| 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) |                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                       | Childbirth/delivery professional services | No charge                                                                        | Not covered                                        | None.                                                                                                                                                                                                                                                                                                                                                              |
|                                                                       | Childbirth/delivery facility services     | \$950 <a href="#">copayment</a> /stay                                            | Not covered                                        | <a href="#">Preauthorization</a> is required for inpatient care, except for: (1) forty-eight (48) hours of Inpatient care following an uncomplicated vaginal delivery or ninety-six (96) hours of Inpatient care following an uncomplicated Cesarean section or (2) Post-Partum Care. If you don't get <a href="#">preauthorization</a> , benefits will be denied. |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | 50% <a href="#">coinsurance</a>                                                  | Not covered                                        | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied. Limited to 60 visits/calendar year.                                                                                                                                                                                                     |
|                                                                       | <a href="#">Rehabilitation services</a>   | \$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply | Not covered                                        | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied. Limited to 35 visits/calendar year, combined with chiropractic care.                                                                                                                                                                    |
|                                                                       | <a href="#">Habilitation services</a>     | \$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply | Not covered                                        | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.                                                                                                                                                                                                                                         |
|                                                                       | <a href="#">Skilled nursing care</a>      | 50% <a href="#">coinsurance</a>                                                  | Not covered                                        | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied. Limited to 25 days/calendar year.                                                                                                                                                                                                       |
|                                                                       | <a href="#">Durable medical equipment</a> | 50% <a href="#">coinsurance</a>                                                  | Not covered                                        | <a href="#">Preauthorization</a> is required for some <a href="#">durable medical equipment</a> . If you don't get <a href="#">preauthorization</a> , benefits will be denied.                                                                                                                                                                                     |
|                                                                       | <a href="#">Hospice services</a>          | 50% <a href="#">coinsurance</a>                                                  | Not covered                                        | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.                                                                                                                                                                                                                                         |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | No charge; <a href="#">deductible</a> does not apply                             | Not covered                                        | Limited to one exam per year.                                                                                                                                                                                                                                                                                                                                      |

| 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) |                                                        |
|                      | Children's glasses         | No charge; <a href="#">deductible</a> does not apply | Not covered                                        | Limited to one pair of glasses per year.               |
|                      | Children's dental check-up | No charge; <a href="#">deductible</a> does not apply | Not covered                                        | Limited to one cleaning and exam per six months.       |

## 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](#).)

- |                                                                                            |                                                      |                                                                              |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------------------|
| • Abortion (Except in cases of rape, incest, or when the life of the mother is endangered) | • Dental care (Adult)                                | • Private-duty nursing (Except medically necessary or authorized by the PCP) |
| • Acupuncture                                                                              | • Infertility treatment                              | • Routine eye care (Adult)                                                   |
| • Bariatric surgery                                                                        | • Long-term care                                     | • Routine foot care                                                          |
| • Cosmetic surgery                                                                         | • Non-emergency care when traveling outside the U.S. | • Weight loss programs                                                       |

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

- |                                                                                                  |                                                                                                        |
|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| • Chiropractic care (35 visits per year, combined with <a href="#">rehabilitation services</a> ) | • Hearing aids (1 hearing aid in each ear every 3 years limited to \$2,000 benefit maximum per device) |
|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|

**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: CHRISTUS Health Plan Customer Service at 1-844-282-3025; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>; Texas Health and Human Services Commission at 1-800-252-8263 or <https://hhs.texas.gov/services/health/medicaid-chip>. 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: Texas Department of Insurance at 1-800-578-4677 or <http://www.tdi.texas.gov/index.html>.

### 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? Not Applicable.

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): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-282-3025 (TTY: 1-800-735-2989).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-282-3025 (TTY: 1-800-735-2989).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-844-282-3025 (TTY: 1-800-735-2989)。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-282-3025 (TTY: 1-800-735-2989)번으로 전화해 주십시오.

Arabic: ملحوظة: إذا ذكر تتحدث كنت إذا، اذكر تتحدث خدمات فإن اللغة، بالمجان لك تتوافر اللغوية المساعدة خدمات فإن اللغة، اذكر تتحدث كنت إذا (1-800-735-2989: والبكم الصم هاتف رقم) 1-844-282-3025 برقم اتصل.

Urdu: 1-844-282-3025 (TTY: 1-800-735-2989) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں۔

Tagalog : PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-282-3025 (TTY: 1-800-735-2989).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne '1-844-282-3025 (TTY: 1-800-735-2989).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-282-3025 (ATS : 1-800-735-2989).

Persian: هستند شما دسترس در کنند، می صحبت رایگان زبان، کمک خدمات فارسی، شما اگر 1-844-282-3025 (TTY: 1-800-735-2989).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-282-3025 (TTY: 1-800-735-2989).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-282-3025 (телетайп: 1-800-735-2989).

Japanese: 注意事項 : 日本語を話される場合、無料の言語支援をご利用いただけます。1-844-282-3025 (TTY: 1-800-735-2989) まで、お電話にてご連絡ください。

Laotian: ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-844-282-3025 (TTY: 1-800-735-2989).

Hindi: हंद: सावधानी: यदि आप हिंदी बोलते हैं, तो आप मुफ्त भाषा सहायता सेवाओं से लाभ उठा सकते हैं। 1-844-282-3025 पर कॉल करें (टीटीवी: 1-800-735-2989)

Gujarati: જરાત: સાવધાન: જો તમે ગુજરાતી બોલતા હોવ તો, તમે મફત ભાષા સહાય સેવાઓમાંથી લાભ મેળવી શકો છો. 1-844-282-3025 પર કોલ કરો (TTY: 1-800-735-2989)

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

## About these Coverage Examples:



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

### Peg is Having a Baby

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$6,900 |
| ■ <a href="#">Specialist copayment</a>                          | \$50    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$950   |
| ■ Other <a href="#">coinsurance</a>                             | 50%     |

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:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$6,900        |
| <a href="#">Copayments</a>        | \$1,600        |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$8,560</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> | \$6,900 |
| ■ <a href="#">Specialist copayment</a>                          | \$50    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$950   |
| ■ Other <a href="#">coinsurance</a>                             | 50%     |

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:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$800          |
| <a href="#">Copayments</a>        | \$1,200        |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,020</b> |

### Mia's Simple Fracture

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$6,900 |
| ■ <a href="#">Specialist copayment</a>                          | \$50    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$950   |
| ■ Other <a href="#">coinsurance</a>                             | 50%     |

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:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,000        |
| <a href="#">Copayments</a>        | \$500          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,500</b> |

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