Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Coverage Period: 01/01/2025-12/31/2025 City of Chandler – White Medical Plan Coverage for: Individual & Family | Plan Type: HSA-qualified PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-595-5993 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	Coverage for Individual Only: <u>In-network</u> : \$1,750/individual <u>Out-of-network</u> : \$5,000/individual Coverage for Family: <u>In-network</u> : \$3,500/family <u>Out-of-network</u> : \$10,000/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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay. 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 15% <u>in-network</u> and 40% <u>out-of-network</u> . <u>In-network deductible</u> also accumulates to the <u>out-of-network deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Certain <u>in-network preventive</u> <u>services</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <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 <u>https://www.healthcare.gov/coverage/preventive- care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-network: \$3,500/individual or \$7,000/family Out-of-network: \$10,000/individual or \$20,000/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 <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

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 1-866- 595-5993 for a list of <u>in-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</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.

Common Medical Event	Services You May Need	What Yo Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	15% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u> & <u>balance</u> <u>bill</u>	denied or \$500 charge if no pr	<u>Prior authorization</u> may be required. Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Chiropractic services
If you visit a health care <u>provider's</u> office	<u>Specialist</u> visit	15% <u>coinsurance</u> after <u>deductible</u>		limited to 20 visits per year. Acupuncture has a \$500 maximum per year. Medical telehealth consultations are covered; Subject to a \$64 consultation fee then 15% coinsurance after deductible is met through BlueCare Anywhere SM . Telemedicine consultations are covered through your <u>network provider</u> .	
or clinic	Preventive care/screening/ immunization	No charge, <u>deductible</u> does not apply	Most services not covered. If covered, 40% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u>	<u>Preventive services</u> not required to be covered by state or federal law are not covered. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Only mammography (<u>deductible</u> is waived) and foreign travel immunizations are covered <u>out-of- network</u> .	

			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	
If you have a test	Diagnostic test (x-ray, blood work)	15% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after <u>deductible</u> & <u>balance</u> <u>bill</u>	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for	
	Imaging (CT/PET scans, MRIs)		may apply	out-of-network services.	
	Tier 1	\$10 <u>copay</u> /30 day supply, <u>copay</u> applies after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u>		
If you need drugs to treat your illness or condition	Tier 2	\$30 <u>copay</u> /30 day supply, <u>copay</u> applies after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u>	Some drugs require <u>prior authorization</u> and won't be covered without it. 90-day supply costs 2	
condition More information about prescription drug coverage is available at	Tier 3	\$50 <u>copay</u> /30 day supply, <u>copay</u> applies after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u>	<u>copays</u> for mail order. Mail order not covered <u>out</u> <u>of-network</u> .	
www.azblue.com	Tier 4	\$100 <u>copay</u> /30 day supply, <u>copay</u> applies after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u>		
	Specialty drugs	15% <u>coinsurance</u> after <u>deductible</u>	Not covered	Specialty covers up to a 30-day supply. No coverage without prior authorization.	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	15% coinsurance after	40% <u>coinsurance</u> after <u>deductible</u> & <u>balance</u> <u>bill</u>	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for	
If you need immediate medical attention	Physician/surgeon fees	deductible	40% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u> may apply	out-of-network services. Bariatric surgery subject to 50% coinsurance in-network and out-of- network.	
	Emergency room care	15% coinsurance after deductible		Out-of-network providers can't balance bill for the difference between the allowed amount and the billed charge.	
	Emergency medical transportation	15% coinsurance after deductible		None	
	Urgent care	15% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u> & <u>balance</u> <u>bill</u>	None	

		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
lf you have a hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fees	15% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after <u>deductible</u> & <u>balance</u> <u>bill</u> 40% <u>coinsurance</u> after <u>deductible</u> & <u>balance</u> <u>bill</u> may apply	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for out-of-network services. Bariatric surgery subject to 50% coinsurance in-network and out-of-network.
	Long-term acute care	15% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u> & <u>balance</u> <u>bill</u>	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for out-of-network services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u> may apply	Behavioral/Mental health visits in an office, or virtual (office) setting do not require <u>prior</u> <u>authorization</u> . Behavioral therapy (e.g. therapy for Autism and related services) provided in an outpatient setting does require <u>prior authorization</u> . <u>Prior authorization</u> is not required for emergency situations. Counseling and Psychiatric telehealth consultations are covered through BlueCare Anywhere SM subject to the following consultation fees then 15% coinsurance after deductible is met: Counseling (Master level): \$96 Counseling (Doctorate level): \$122 Psychiatric (Initial visit – 45 min): \$263 Psychiatric (Follow up visit – 30 min): \$145 <u>Prior authorization</u> may be required. Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
	Inpatient services	15% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u> may apply	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for out-of-network services.

		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	
	Office Visits	15% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u> & <u>balance</u> <u>bill</u>		
If you are pregnant	Childbirth/delivery professional services		40% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u> may apply	Maternity care may 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</u>	
	Childbirth/delivery facility services		40% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u>	preventive services.	
	Home health care/Home infusion therapy	15% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u> & <u>balance</u> <u>bill</u>	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for out-of-network services.	
If you need help recovering or	Rehabilitation services • EAR = Extended Active Rehabilitation Facility • PT/OT/ST = Physical Therapy, Occupational Therapy, Speech Therapy	15% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u> & <u>balance</u> <u>bill</u>	<u>Prior authorization</u> may be required. Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Limit of 60 combined visits for PT/OT/ST per member per calendar year. <u>Plan</u> does not cover	
have other	Habilitation services	Not covered	Not covered		
special health needs	<u>Skilled nursing care</u> In skilled nursing facility (SNF)	15% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u> & <u>balance</u> <u>bill</u>	group physical and occupational therapy. Limit of 240 days/calendar year for SNF.	
	Durable medical equipment	15% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u> & <u>balance</u> <u>bill</u>	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for out-of-network services.	
	Hospice services	15% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u> & <u>balance</u> <u>bill</u>	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for out-of-network services.	
If your shild reads	Children's eye exam	15% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u> & <u>balance</u> <u>bill</u>	No charge for member under age 5 in-network.	
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Excluded	
	Children's dental check-up	Not covered	Not covered	Excluded	

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.)

- Care that is not <u>medically necessary</u>
- 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 except as stated in <u>plan</u>

- Genetic and chromosomal testing except as stated
 in <u>plan</u>
- Habilitation services
- Hearing aids
- Inpatient SNF treatment exceeding 240 days per calendar year
- Long-term care, except long-term acute care
- Massage therapy other than allowed under evidence-based criteria
- Out-of-network preventive care except
 mammography and foreign travel immunizations
- <u>Out-of-network</u> Mail Order drugs and <u>out-of-network</u> <u>Specialty</u> drugs

- Physical, occupational and speech therapy exceeding 60 visits per year
- <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
- Services, tests and procedures that are excluded under medical coverage guidelines
- Sexual dysfunction treatment and services except as stated in <u>plan</u>
- Weight loss programs

(Other Covered Services (Limitations may apply	to these services. This isn't a complete list. Please services	ee your <u>plan</u> document.)
•	Alternative medicine (acupuncture services limited to \$500 maximum) Bariatric surgery	 Chiropractic care limited to 20 visits per year Non-emergency care when traveling outside the U.S 	Routine eye care

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 <u>www.cciio.cms.gov</u>.
- 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 <u>Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your Grievance 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 <u>group health</u> coverage subject to ERISA, contact Blue Cross Blue Shield of Arizona at 1-866-595-5993. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>www.dol.gov/ebsa/healthreform</u>. 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 1-866-595-5993. 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 or 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 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.

Page 7 of 10 * 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 nílínigií Blue Cross Blue Shield of Arizona haada yit'éego bína'ídíłkidgo éí doodago Háida bíjá anilyeedígií 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'ígií kojí' bich'i' 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 المتحدث مع مترجم اتصل ب 479-475-877.

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 .4799-475-877 تماس حاصل نمایید.

Assyrian:

، بَا سَمَهُ، بَا سَةِ فَحَيْمَةًا دَشِمَةُمَ مَعْدَدُهُ، المَكْمَمَةُ حَمَّة حَمَّة عَمَّة مَعْمَرُ مَعْمَرُ مُعَمَّة مَعْمَدُ مَعْمَرُ مَعْمَرُ مَعْمَرُ عَدَيَّة حَكَيْتُهُ اللَّهُ العَالَي فَعَيْمُ المَا عَلَيْ مَعْمَدُ مُعْمَرُ عَدَى اللَّهُ العَامَة مُعْمَدًا مَعْمَرُ عَدَيَّة حَكَيْتُهُ المُعْمَد المُعْمَد مُعْمَرُ مُعْمَرُ عَدَيَّة حَكَيْتُهُ اللَّهُ و كفوموج بِحَدَيَة مُعْمَدُهُ عَنْ مَدْ عَدَى مَدْ عَدَى مَدْ عَدَى مُعْمَدُهُ مُعْمَدُهُ مُعْمَدُهُ مُعْمَدُهُ م

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.

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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)

■ The plan's overall deductible	\$1,750
■ <u>Specialist</u> <u>coinsurance</u>	15%
Hospital (facility) coinsurance	15%

■ Hospital (facility) <u>coinsurance</u> 15% ■ Other coinsurance 15%

This EXAMPLE event includes services like: <u>Specialist</u> office visits (*prenatal care*) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (*ultrasounds and blood work*) <u>Specialist</u> visit (*anesthesia*)

Total Example Cost	\$12,700

In this example, Peg would pay:

Cost Sharing		
Deductibles	\$1,750	
Copayments	\$0	
Coinsurance	\$1,620	
What isn't covered		
Limits or exclusions	\$50	
The total Peg would pay is	\$3,420	

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>	\$1,750
■ <u>Specialist</u> <u>coinsurance</u>	15%
Hospital (facility) <u>coinsurance</u>	15%
■ Other <i>coinsurance</i>	15%

This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (*including disease education*) <u>Diagnostic tests</u> (*blood work*) <u>Prescription drugs</u> <u>Durable medical equipment</u> (*glucose meter*)

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In this example, Joe would pay:

Cost Sharing		
Deductibles	\$1,750	
Copayments	\$0	
Coinsurance	\$550	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$2,320	

Mia's Simple Fracture (in-network emergency room visit and follow up

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The <u>plan's</u> overall <u>deductible</u>	\$1,750
Specialist <u>coinsurance</u>	15%
Hospital (facility) <u>coinsurance</u>	15%
Other <u>coinsurance</u>	15%
This EXAMPLE event includes service	s like:

This EXAMPLE event includes services like <u>Emergency room care</u> (including medical supplies) <u>Diagnostic test</u> (x-ray) <u>Durable medical equipment</u> (crutches) <u>Rehabilitation services</u> (physical therapy)

Total Example Cost	\$2,800

In this example, Mia would pay:

Cost Sharing		
Deductibles	\$1,750	
Copayments	\$0	
Coinsurance	\$160	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$1,910	

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

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