




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. **This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-844-352-1706 or visit us at [www.amerihealthtpa.com](http://www.amerihealthtpa.com). For 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-844-352-1706 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	In-Network <b>\$0</b> person / <b>\$0</b> family, Out-of-Network <b>\$200</b> person / <b>\$500</b> family.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">In-Network preventive care</a> , emergency services, and services that require a <a href="#">copay</a> . There is no <a href="#">In-Network deductible</a> for this <a href="#">plan</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?	Yes. <b>\$500 deductible</b> for <a href="#">prescription drug</a> costs. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">In-Network coinsurance</a> limit: <b>\$800</b> person / <b>\$2,000</b> family. For <a href="#">In-Network providers</a> : <b>\$4,639</b> person / <b>\$8,878</b> family, for <a href="#">Out-of-Network</a> out-of-pocket limit: <b>\$5,000</b> person / <b>\$12,500</b> family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billed</a> charges, health care this <a href="#">plan</a> doesn't cover, and <a href="#">preauthorization</a> penalties.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.amerihealthtpa.com">www.amerihealthtpa.com</a> or call: <b>1-844-352-1706</b> for a list of In- <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 plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> per visit	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	<a href="#">Specialist</a> visit	\$30 <a href="#">copay</a> per visit	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Chiropractor: Limited to 30 visits per calendar year.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered except 30% <a href="#">coinsurance</a> for mammograms & gynecological exams.	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for. Age and frequency schedules may apply.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	---None---
	Imaging (CT/PET scans, MRIs)	No Charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required for some imaging services. If <a href="#">preauthorization</a> is not obtained, coverage may be denied.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.amerihealthtpa.com">www.amerihealthtpa.com</a>	Generic drugs	See separate <a href="#">prescription drug plan</a> SBC	See separate <a href="#">prescription drug plan</a> SBC	See separate <a href="#">prescription drug plan</a> SBC
	Preferred brand drugs	See separate <a href="#">prescription drug plan</a> SBC	See separate <a href="#">prescription drug plan</a> SBC	See separate <a href="#">prescription drug plan</a> SBC
	Non-preferred drugs	See separate <a href="#">prescription drug plan</a> SBC	See separate <a href="#">prescription drug plan</a> SBC	See separate <a href="#">prescription drug plan</a> SBC
	<a href="#">Specialty drugs</a>	See separate <a href="#">prescription drug plan</a> SBC	See separate <a href="#">prescription drug plan</a> SBC	See separate <a href="#">prescription drug plan</a> SBC
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	---None---
	Physician/surgeon fees	No Charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	---None---

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$125 <a href="#">copay</a> per visit	\$125 <a href="#">copay</a> per visit	If admitted within 24 hours, the <a href="#">copay</a> is waived. No coverage for non-emergency use.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a> <a href="#">Deductible</a> waived	Limited to local emergency transport to the nearest facility equipped to treat the emergency condition. No coverage for non-emergency use.
	<a href="#">Urgent care</a>	\$30 <a href="#">copay</a> per visit	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained, coverage may be denied. There is a separate \$500 <a href="#">deductible</a> per inpatient stay for Out-of-Network facilities.
	Physician/surgeon fees	No Charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained, coverage may be denied.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <a href="#">copay</a> per visit	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Some specialty outpatient services require <a href="#">preauthorization</a> . If <a href="#">preauthorization</a> is not obtained, coverage may be denied. No charge for substance abuse.
	Inpatient services	No Charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained, coverage may be denied. There is a separate \$500 <a href="#">deductible</a> per inpatient stay for Out-of-Network facilities.
If you are pregnant	Office visits	\$20 <a href="#">copay</a> per visit	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Copay</a> applies only to initial visit only.
	Childbirth/delivery professional services	No Charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained, coverage may be denied.
	Childbirth/delivery facility services	No Charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained, coverage may be denied. There is a separate \$500 <a href="#">deductible</a> per inpatient stay for Out-of-Network facilities.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No Charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained, coverage may be denied. Limited to one visit per day.
	<a href="#">Rehabilitation services</a>	\$30 <a href="#">copay</a> per visit	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> may be required for some therapies. If <a href="#">preauthorization</a> is not obtained, coverage may be denied.
	<a href="#">Habilitation services</a>	\$30 <a href="#">copay</a> per visit	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> may be required for some therapies. If <a href="#">preauthorization</a> is not obtained, coverage may be denied. Limited to treatment of Autism.
	<a href="#">Skilled nursing care</a>	No Charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained, coverage may be denied. Limited to a maximum of 120 days <a href="#">In-Network</a> and Out-of-Network combined for calendar year.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required for all rentals and some purchases. If <a href="#">preauthorization</a> is not obtained, coverage may be denied.
	<a href="#">Hospice services</a>	No Charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained, coverage may be denied. There is a separate \$500 <a href="#">deductible</a> per inpatient stay for Out-of-Network facilities
If your child needs dental or eye care	Children's eye exam	\$30 <a href="#">copay</a> per visit	Not Covered	Limited to one exam every calendar year.
	Children's glasses	\$200 Allowance	\$200 Allowance	Limited to \$200 every two calendar years combined <a href="#">In-Network</a> and Out-of- <a href="#">Network</a> .
	Children's dental check-up	Not Covered	Not Covered	---None---

### 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](#).)

- |                       |                        |                        |
|-----------------------|------------------------|------------------------|
| • Cosmetic surgery    | • Long Term Care       | • Routine foot care    |
| • Dental care (Adult) | • Private-duty nursing | • Weight loss programs |

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

- |  |   |  |
|--|---|--|
| • Acupuncture (For pain management only)                         | • Hearing Aids (Only covered for members age 15 or younger, maximums apply) | • Non-emergency care when traveling outside the U.S. (Subject to deductible/ <a href="#">coinsurance</a> and <a href="#">balance billing</a> ) |
| • Bariatric surgery (Requires <a href="#">preauthorization</a> ) | • Infertility Treatment (Requires <a href="#">preauthorization</a> )        | • Routine eye care (Adult)   |
| • Chiropractic care (30 visits per calendar year)                |   |  |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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: 1-844-352-1706 or [www.amerihelthtpa.com](http://www.amerihelthtpa.com). 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](http://www.dol.gov/ebsa/healthreform).

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

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

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

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

### **Nondiscrimination Notice and Notice of Availability of Auxiliary Aids and Services**

AmeriHealth Administrators complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AmeriHealth Administrators does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AmeriHealth Administrators:

- Provides free aids and services to people with disabilities to communicate effectively with us and written information in other formats, such as large print
- Provides free language services to people whose primary language is not English and information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that AmeriHealth Administrators has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator.

There are four ways to file a grievance directly with AmeriHealth Administrators:

- by mail: AmeriHealth Administrators,  
ATTN: Civil Rights Coordinator, 1900 Market Street, Philadelphia, PA 19103;
- by phone: 844-352-1706 (TTY 711);
- by fax: 215-761-0920; or
- by email: [AHACivilRightsCoordinator@ahatpa.com](mailto:AHACivilRightsCoordinator@ahatpa.com).

If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



## Language Access Services:

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-352-1706 (TTY: 711).

Spanish: ATENCIÓN: Si usted habla inglés, tiene a su disposición servicios de asistencia de idiomas sin costo. Llame al 1-844-352-1706 (TTY: 711).

Chinese: 请注意：如果您说[中文]，则可以免费使用语言协助服务。请致电 1-844-352-1706 (TTY: 711)。

Hmong: LUS CEEB TOOM: Yog tias koj hais LUS HMOOB, ces yuav muaj kev pab cuam txhais lus pub dawb rau koj. Hu rau tus xov tooj 1-844-352-1706 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói [người việt nam], bạn sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí. Gọi 1-844-352-1706 (TTY: 711).

Somali: FIIRO GAAR AH: Haddii aad ku hadashid luuqada Soomaaliga, adeegyada caawinta luuqada, oo bilaash ah, ayaa lagu helayaa. Soo wac 1-844-352-1706 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги переводчика. Позвоните 1-844-352-1706 (TTY: 711).

Arabic: انتبه: إذا كنت تتحدث اللغة العربية، تم توفير خدمات المساعدة اللغوية مجاناً، اتصل بالرقم ١٧٠٦-٣٥٢-٨٤٤-١ (TTY: ٧١١).

French : ATTENTION : Si vous parlez le français, des services d'assistance linguistique gratuits, vous sont proposés. Appelez le 1-844-352-1706 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen ein kostenloser Sprachassistent zur Verfügung. Rufen Sie unter der Nummer 1-844-352-1706 (TTY: 711) an.

Amharic: ትኩረት: [አማርኛ] የሚናገሩ ከሆነ ከክፍያ ነፃ የሆነ የቋንቋ አገልግሎት ስለሚገኝ 1-844-352-1706 (TTY: 711) ላይ ይዘሉ።

Korean: 주의: [한국어]를 사용하는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 1-844-352-1706로 전화해주십시오. (TTY: 711).

Lao: ສັງຄົມນີ້: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອທາງດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າ. ໂທ 1-844-352-1706 (TTY: 711).

Tagalog: PANSININ: Kung nagsasalita ka ng Tagalog, libre na available sa iyo ang mga serbisyo sa tulong sa wika. Tumawag sa 1-844-352-1706 (TTY: 711).

Navajo: Áhéhee': T'áá a'nííł nígíí bizaad yádaaltí'í nisin, yá'át'éehá ánída'áł nisin, ákót'éego bee hółó, bizaad yádaaltí'í nisin dah nishlį́, yaaltsoh da t'ááji'ígíí ashkíí. 1-844-352-1706 t'áá baa yáshtí'. (TTY: 711).

Khmer: ប្រុងប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយភាសា [ខ្មែរ] មានផ្តល់សេវាកម្មជំនួយភាសាដោយឥតគិតថ្លៃជូនអ្នក។ ហៅទូរសព្ទទៅលេខ 1-844-352-1706 (TTY: 711)។

Italian: ATTENZIONE: Per coloro che parlano italiano, sono disponibili i servizi di assistenza linguistica gratuiti. Chiamare al numero 1-844-352-1706 (TTY: 711).

Guajarati: ધ્યાન આપી: જો તમે ગુજરાતી બોલો છો, તો ભાષા સહાય સેવાઓ, તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. 1-844-352-1706 (TTY: 711) પર કોલ કરો.

Polish: UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnych usług pomocy językowej. Zadzwoń pod numer 1-844-352-1706 (telefon tekstowy: 711).

Creole: ATANSYON: Si ou pale kreyòl, sèvis asistans lang yo gratis, e yo disponib pou ou. Rele nan 1-844-352-1706 (TTY: 711).

Portuguese: ATENÇÃO: Se você fala português, os serviços de assistência linguística, gratuitos, estão disponíveis para você. Ligue 1-844-352-1706 (TTY: 711).

Japanese: 注記：[日本語] 話者向けの無料の言語支援サービスを利用できます。電話 1-844-352-1706 (TTY: 711)。

Farsi: توجه: اگر زبان شما فارسی است، خدمات کمک زبانی، به صورت رایگان در دسترس شما است. با شماره ١٧٠٦-٣٥٢-٨٤٤ تماس بگیرید (TTY: ٧١١).

Urdu: متوجہ ہوں: اگر آپ اردو بولتے ہیں، تو زبان کی معاونت کی خدمات، آپ کے لیے مفت دستیاب ہیں۔ ١٧٠٦-٣٥٢-٨٤٤-١ (TTY: ٧١١) پر کال کریں۔

Hindi: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-352-1706 (TY: 711) पर कॉल करें।

Telugu: ధ్యాన పెట్టండి: మీరు తెలుగు మాట్లాడగలిగితే, భాషా సహాయక సేవలు మీకు ఉచితంగా లభిస్తాయి. 1-844-352-1706 (TTY: 711)కు కాల్ చేయండి.

Swahili: KUMBUKA: Iwapo unazungumza Kiswahili, utapata huduma za usaidizi wa lugha bila malipo. Piga simu kwa 1-844-352-1706 (TTY: 711).

Ojibwe: AMBE: Giishipin wii'wiidookaagooyan ii-noondam Ojibwemowin. qanoozhishinaam 1-844-352-1706 (TTY: 711) Gawain gidaw-diba'anziin.

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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>	\$0
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) no <a href="#">cost sharing</a>	\$0
■ Other no <a href="#">cost sharing</a>	\$0

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>
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$20
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$90</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>	\$0
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) no <a href="#">cost sharing</a>	\$0
■ Other no <a href="#">cost sharing</a>	\$0

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>
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$3,500
<b>The total Joe would pay is</b>	<b>\$3,780</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>	\$0
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) no <a href="#">cost sharing</a>	\$0
■ Other no <a href="#">cost sharing</a>	\$0

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic tests](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$510</b>

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