




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, go to [www.mountainhealth.coop](http://www.mountainhealth.coop) or call 1-855-447-2900. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For <a href="#">network providers</a> : \$8,550 individual / \$17,100 family; for <a href="#">out-of-network providers</a> : \$17,100 individual / \$34,200 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> 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 deductibles for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> : \$8,550 individual / \$17,100 family; for <a href="#">out-of-network providers</a> : \$17,100 individual / \$34,200 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="#">Copayments</a> on certain services, <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="http://www.mountainhealth.coop">www.mountainhealth.coop</a> or call 1-855-447-2900 for information regarding <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
		Indian Health Care Provider (IHCP) (You will pay the least)	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	No charge	\$30.00 <a href="#">copayment</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	2 visits before deductible
	<a href="#">Specialist</a> visit	No charge	\$40.00 <a href="#">copayment</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	No Charge	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	This benefit does not include diagnostic services such as biopsies, which are services that are routinely covered under the Surgical Services Benefit.
	Imaging (CT/PET scans, MRIs)	No charge	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at plans/drug-list <a href="https://www.mountainhealth.coop/pharmacy">https://www.mountainhealth.coop/pharmacy</a>	Generic drugs	No charge	\$15.00 <a href="#">copayment</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30-day supply retail; 90-day supply mail order for 2x copay.
	Preferred brand drugs	No charge	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30-day supply retail; 90-day supply mail order. If you choose a higher Tier drug when a lower Tier drug is available, you must pay an ancillary charge in addition to the <a href="#">deductible</a> and/or <a href="#">coinsurance</a> , as

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.mountainhealth.coop](https://www.mountainhealth.coop).]

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
					applicable
	Non-preferred brand drugs	No charge	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30-day supply retail; 90-day supply mail order. If you choose a higher Tier drug when a lower Tier drug is available, you must pay an ancillary charge in addition to the <a href="#">deductible</a> and/or <a href="#">coinsurance</a> , as applicable
	<a href="#">Specialty drugs</a>	No charge	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30-day supply; Mail order not available. In-Network coverage limited to select pharmacies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Physician/surgeon fees	No charge	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	No charge	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Emergency medical transportation</a>	No charge	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Urgent care</a>	No charge	\$60.00 <a href="#">copayment</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Physician/surgeon fees	No charge	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you need mental health, behavioral	Outpatient services	No charge	\$30.00 <a href="#">copayment</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	2 visits before deductible

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
health, or substance abuse services					
	Inpatient services	No charge	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you are pregnant	Office visits	No charge	Included in delivery	Included in delivery	None
	Childbirth/delivery professional services	No charge	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Childbirth/delivery facility services	No charge	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	180 visit limit/year
	<a href="#">Rehabilitation services</a>	No charge	\$40.00 <a href="#">copayment</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	PT, OT, ST- 20 visits limit
	<a href="#">Habilitation services</a>	No charge	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Skilled nursing care</a>	No charge	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	60-day limit/year
	<a href="#">Durable medical equipment</a>	No charge	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Preauthorization is required for original purchase or replacement of Durable Medical Equipment over \$500
	<a href="#">Hospice services</a>	No charge	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If your child needs dental or eye care	Children's eye exam	No charge	\$0.00 <a href="#">copayment</a>	25% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Coverage is limited to one Vision Examination per Covered Dependent Child, under Age 19, per Calendar Year.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's glasses	No charge	\$0.00 <a href="#">copayment</a>	25% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Coverage is limited to one frame per Covered Dependent Child, under age 19, per Calendar Year.
	Children's dental check-up	Not Covered	Not Covered	Not Covered	None

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Abortion (except in the case of rape, incest, or when the life of the mother is endangered)</li> <li>• Bariatric surgery</li> <li>• Dental care and treatment</li> <li>• Hearing Aids, except pediatric</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Private-duty nursing</li> <li>• Religious counseling</li> <li>• Reversal of an elective sterilization</li> <li>• Rolfing therapy</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Self-help programs</li> <li>• Temporomandibular joint dysfunction</li> <li>• Transplants of non-human/artificial organs</li> <li>• Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Chiropractic care (Up to 20 visits/year)</li> <li>• Acupuncture (Up to 12 visits/year)</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic surgery (Only if medically necessary or for certain reconstructive surgeries)</li> <li>• Routine foot care provided to a member with Diabetes</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the United States. See <a href="http://www.mountainhealth.coop">www.mountainhealth.coop</a></li> </ul>

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [www.yourhealthidaho.org](http://www.yourhealthidaho.org), HHS, DOL, and/or other applicable agency contact information]. 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: [www.mountainhealth.coop](http://www.mountainhealth.coop) or call 1-855-447-2900 .

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.mountainhealth.coop](http://www.mountainhealth.coop).]

### 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](#).

**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: [www.HealthCare.gov](http://www.HealthCare.gov), HHS, DOL, and/or other applicable agency contact information]. 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: [WWW.healthcare.gov applicable contact information from instructions].

### Language Access Services:

SPANISH: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-447-2900.

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 1-855-447-2900。

SERBO-CROATION: U ovom obavještenju su sadržane važne informacije. U ovom obavještenju su sadržane važne informacije o

Vašoj prijavi ili osiguranju preko MHC. Pogledajte

nalaze li se u ovom obavještenju nekiključni datumi. Možda ćete morati poduzeti određene radnje u datom roku kako biste i dalje zadržali svoje osiguranje ili pomoć pri plaćanju. Imate pravo da ove informacije, kao i pomoć, dobijete besplatno na svom jeziku. Nazovite 1-855-447-2900.

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx)번으로 전화해 주십시오. 1-855-447-2900

VIETNAMESE: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-447-2900.

ARABIC: يحوي هذا إشعار معلومات هامة. يحوي هذا شعار معلومات مهمة بخصوص طلبك للحصول على التغطية من قبل ابحت عن التواريخ ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة

(. اللغوية تتوافر لك بالمجان. اتصل برقم 1 - 2900-447-855 (رقم هاتف الصم والبكم: 1 - 2900-447-855)

GERMAN: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-447-2900.

TAGALOG: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-447-2900.

RUSSIAN: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-447-2900.

FRENCH: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-447-2900.

ITALIAN: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-447-2900.

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。1-855-447-2900（TTY:1-855-447-2900）まで、お電話にてご連絡ください。



THAI: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-447-2900 (TTY: 1-855-447-2900).

ROMANIAN: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-855-447-2900.

SUDANIC-FULFULDE: Anndinoore nde'e e woodi habaru kimminiidum. TAnndinoore nde'e e woodi habaru kimminiidum dow dereewol tefal maadamaada malla ko yaali dow laawol MHC. Maanda nyalaade lewru nder anndinoorende'e. Teema a gideteedo ngada goddum bako godde nyalaade ngam ko yaali njamu maada malla walla dow njobdi. Hakke maada annda habaru ngu'u ewalliinde nder wolde maada naa maa a yobii. Noddu 1-855-447-2900.

UKRAINIAN: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.

Телефонуйте за номером 1-855-447-2900 (телетайп: 1-855-447-2900).

NEPALI: धधधध धधधधधधध: धधधधधधध धधधधध धधधधधधधधध धध धधधधधधध धधधधध धधध धधधधध धधधधधधध धधधधधधध धधधधध धधधधध ध ध धधध धधधधधधधध 1-855-447-2900 (धधधधधधध: 1-855-447-2900)

SERBO-CROATIAN: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-447-2900 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-855-447-2900).

BANTU: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-855-447-2900 (TTY: 1-855-447-2900).

FARSI: 2900-447-855-1 تماس بگ ریید (TTY: 1-855-447-2900) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

NORWEGIAN: MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-855-447-2900.

PENNSYLVANIA DUTCH: Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-447-2900.

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

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

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [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>	\$8,550
■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]	\$40
■ Hospital (facility) [ <a href="#">cost sharing</a> ]	0%
■ Other [ <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:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$8,550
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$8,610</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>	\$8,550
■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]	\$40
■ Hospital (facility) [ <a href="#">cost sharing</a> ]	0%
■ Other [ <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:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$5,100
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$5,220</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>	\$8,550
■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]	\$40
■ Hospital (facility) [ <a href="#">cost sharing</a> ]	0%
■ Other [ <a href="#">cost sharing</a> ]	0%

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>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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