HIGHMARK. Delaware

Summary of Shared Cost PPO $1000/100 *Benefits*

On the chart below, you'll see what your plan pays for specific services.

Benefit	In-Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (per benefit period)(2) Individual Family	 $1,000 $2,000	 $2,000 $4,000
Plan Pays (unless otherwise specified) – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Includes deductible, coinsurance and copayments. Once met, plan pays 100% coinsurance for the rest of the benefit period.) Individual Family - Aggregate	 $8,550 $17,100	 $17,100 $34,200
Office/Clinic/Urgent Care Visits		
Primary Care Provider Office Visits	100% after $25 copay	80% after deductible
Virtual Primary Care Program	100%	Not Covered
Specialist Office Visits	100% after $50 copay	80% after deductible
Urgent Care Center Visits	100% after $60 copay	80% after deductible
Telemedicine Service(3)	100% after $20 copay	Not Covered
Preventive Care(4)		
Routine Adult		
Adult immunizations	100%	80% after deductible
Colorectal cancer screening	100%	80% after deductible
Diagnostic services and procedures	100%	80% after deductible
Routine mammograms	100%	80% after deductible
Physical exams	100%	80% after deductible
Routine gynecological exams, including a Pap test	100%	80% after deductible
Routine adult vision exam **-** Health Care Reform Vision Network (8)	Not Covered	Not Covered
Routine Pediatric		
Pediatric immunizations	100%	80% after deductible
Physical exams	100%	80% after deductible
Pediatric Vision(5) - Health Care Reform Vision Network (8)		
Exam (including dilation, as professionally indicated)	100%	Not Covered
Pediatric frame selection	100%	Not Covered
Standard eyeglass lenses (per pair)	100%	Not Covered
Pediatric Dental(5) - United Concordia Advantage Plus 2.0 Network		
Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants)	100%	Not Covered
Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings))	50%	Not Covered
Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.))	50%	Not Covered
Orthodontics(6) (Medically necessary with prior approval)	50%	Not Covered
Hospital and Medical/Surgical Expenses (including maternity)		
Anesthesia	100% after deductible	
Hospital Inpatient(7) (professional & facility)	100% after deductible	80% after deductible
Hospital Outpatient(7) (Non-Surgical)	100% after deductible	80% after deductible
Outpatient Surgery(7) (9)	100% after deductible and $130 copay	80% after deductible
Maternity(7) (non-preventive facility & professional services) including dependent daughter	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations) **/Surgical Expenses**	100% after deductible	80% after deductible
Emergency Services		
Emergency Room Services	100% after $300 copay (waived if admitted)	
Ambulance (11)	100% after in-network deductible	
Therapy, Rehabilitative and Habilitative Services		
Chiropractic	100% after deductible	80% after deductible
	Limit: 30 visits/benefit period SB#225 services related to the treatment of back pain are excluded from visit limits	
Cardiac Rehab	100% after deductible	80% after deductible
	Limited to 3 sessions per week and 12 weeks of treatment. Care beyond this limit requires medical review and approval.	
Chemotherapy and Radiation Therapy	100% after deductible	80% after deductible
Physical & Occupational Therapy (combined) (Rehabilitative and Habilitative)	100% after $15 copay	80% after deductible
	Limit: 30 Rehabilitative and 30 Habilitative visits /benefit period - Limit does not apply to Habilitative services for the treatment of a Mental Health or Substance Abuse diagnosis SB#225 services related to the treatment of back pain are excluded from visit limits	
Respiratory Therapy	100% after deductible	80% after deductible

Benefit	In-Network	Out-of-Network
Speech Therapy (Rehabilitative and Habilitative)	100% after $50 copay	80% after deductible
	Limit: 30 Rehabilitative and 30 Habilitative visits /benefit period - Limit does not apply to Habilitative services for the treatment of a Mental Health or Substance Abuse diagnosis	
Mental Health/Substance Abuse		
Inpatient(7) (professional & facility)	100% after deductible	80% after deductible
Inpatient Detoxification/Rehabilitation(7)	100% after deductible	80% after deductible
Outpatient(7) (professional & facility)	100% after $25 copay	80% after deductible
Other Services		
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after $250 copay	80% after deductible
Diagnostic X-ray	100% after $35 copay	80% after deductible
Laboratory	100% after $25 copay	80% after deductible
Durable Medical Equipment	100% after deductible	80% after deductible
Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
	Limit: 100 visits/benefit period Aggregate with Visiting Nurse	
Hospice	100% after deductible	80% after deductible
Private Duty Nursing	100% after deductible	80% after deductible
	Limit: Inpatient only - 240 hours per benefit period	
Skilled Nursing Facility Care(7)	100% after deductible	80% after deductible
	Limit: 120 days per confinement - benefits renew after 180 days without care	
Transplant Services	100% after deductible	80% after deductible
Onduo Diabetic Management Program	100%	Not Covered
Prescription Drugs		
Prescription Drug Program(10) Mandatory Generic *Defined by the National Plus Pharmacy Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the HCR Comprehensive Formulary with an Incentive Benefit Design.*	**34-Day Supply/Up to a 90-Day Supply** $3 low cost generic copay -- $15 standard generic copay (Up to 90 day supply) $65 / $130 formulary brand copay $100 / $200 non-formulary copay Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a month supply	

1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
2) When calculating the deductible expenses, only the allowable charges are considered.
3) Services must be performed by a Highmark approved telemedicine provider.
4) Services are limited to those listed on the Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
5) Pediatric vision and dental benefits are only available to dependent children or health plan members under age 19.
6) A Medically Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat a severe dentofacial abnormality. Prior approval is required. See your benefit booklet for more details.
7) Precertification or preauthorization requirements may apply to certain inpatient admissions, outpatient procedures, or covered services (including covered medications).
8) Members must use a Davis provider who participates in the Health Care Reform Vision Network
9) Refers to outpatient surgical procedure provided in a hospital or ambulatory facility setting.
10) You have a soft mandatory generic provision, where you are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.
11) Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits.

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield Delaware which is an independent licensee of the Blue Cross Blue Shield Association. Health care plans are subject to terms of the benefit agreement. To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/QualityAssurance; or for a paper copy, call 1-855-873-4109.

All percentages are based on Highmark Blue Cross Blue Shield Delaware's allowable charge. Plan limitations and exclusions apply.

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters

    Information written in other languages

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

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。
ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

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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 www.highmarkbcbsde.com or call 1-800-633-2563. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1-800-633-2563 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,000 individual/$2,000 family network, $2,000 individual/$4,000 family out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Network deductible does not apply to office visits, preventive care services, diagnostic tests, imaging tests, emergency room care, urgent care, outpatient mental health, outpatient substance abuse, rehabilitation services, habilitation services, pediatric vision, pediatric dental, and prescription drug benefits. Copayments and coinsurance amounts don't count toward the network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$8,550 individual/$17,100 family network. $17,100 individual/$34,200 family out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, prescription drug expenses, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. For a list of network providers, see https://www.highmarkbcbsde.com/find-a-doctor/ or call 1-800-633-2563.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your overall **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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit Deductible does not apply.	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please refer to your preventive schedule for additional information.
	Specialist visit	$50 copay/visit Deductible does not apply.	20% coinsurance	
	Preventive care/screening/immunization	No charge Deductible does not apply.	20% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay/visit (lab, blood work) $35 copay/visit (x-ray) Deductible does not apply.	20% coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	$250 copay/visit Deductible does not apply.	20% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.highmarkbcbsde.com/find-a-doctor/#/drug	Low Cost Generic drugs	$3/$3 copay/prescription (retail) $3/$3 copay/prescription (mail order) Deductible does not apply.	Not covered	Up to a 34/90 - day supply retail pharmacy. Up to a 34/90 - day supply maintenance prescription drugs through mail order. This plan has an HCR Comprehensive Formulary. Cost-sharing for Prescription Insulin Drugs will not exceed $100 per month.
	Generic drugs	$15/$15 copay/prescription (retail) $15/$15 copay/prescription (mail order) Deductible does not apply.	Not covered	
	Formulary Brand drugs	$65/$130 copay/ prescription (retail) $65/$130 copay/ prescription (mail order) Deductible does not apply.	Not covered	
	Non-Formulary Brand drugs	$100/$200 copay/ prescription (retail) $100/$200 copay/ prescription (mail order) Deductible does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$130 copay/visit	20% coinsurance	Precertification may be required.
	Physician/surgeon fees	No charge	20% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$300 copay/visit Deductible does not apply.	$300 copay/visit Deductible does not apply.	Copay waived if admitted as an inpatient.
	Emergency medical transportation	No charge	No charge	Out-of-network: Subject to network deductible.
	Urgent care	$60 copay/visit Deductible does not apply.	20% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Precertification may be required.
	Physician/surgeon fees	No charge	20% coinsurance	Precertification may be required.
If you have mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit Deductible does not apply.	20% coinsurance	Precertification may be required.
	Inpatient services	No charge	20% coinsurance	Precertification may be required.
If you are pregnant	Office visits	No charge	20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	Home health care	No charge	20% coinsurance	Combined network and out-of-network: 100 visits per benefit period aggregate with visiting nurse. Precertification may be required.
	Rehabilitation services	$15 copay/visit (physical and occupational therapy) $50 copay/visit (speech therapy) Deductible does not apply.	20% coinsurance	Combined network and out-of-network: 30 combined physical medicine and occupational therapy visits per benefit period; limitation does not apply for the diagnosis of back pain. 30 speech therapy visits per benefit period. Precertification may be required.
	Habilitation services	$15 copay/visit (physical and occupational therapy) $50 copay/visit (speech therapy) Deductible does not apply.	20% coinsurance	Combined network and out-of-network: 30 combined physical medicine and occupational therapy visits per benefit period; limitation does not apply for the diagnosis of mental health, substance abuse, or back pain. 30 speech therapy visits per benefit period. Precertification may be required.
	Skilled nursing care	No charge	20% coinsurance	Combined network and out-of-network: 120 days per confinement. Benefits renew after 180 days without care. Precertification may be required.
	Durable medical equipment	No charge	20% coinsurance	Precertification may be required.
	Hospice services	No charge	20% coinsurance	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	No charge Deductible does not apply.	Not covered	Network: One eye exam per 12 month period up to age 19.
	Children's glasses	No charge Deductible does not apply.	Not covered	Network: One pair frames/lenses every 12 months.
	Children's dental check-up	No charge Deductible does not apply.	Not covered	Network: One exam every 6 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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See http://www.bcbsa.com
- Private-duty nursing

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 1-866-444-3272 or at www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit 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 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:

- Highmark Delaware at 1-800-633-2563.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Department of Consumer Services at 1-877-881-6388.

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.

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 plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	0%
Other coinsurance	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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,460**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	0%
Other coinsurance	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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,220**

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

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	0%
Other coinsurance	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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

The plan would be responsible for the other costs of these EXAMPLE covered services.