
 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, see the Comprehensive Benefits Booklet published 2012 and 2016, as updated, along with amendments/AEMs at [www.emhp.org](http://www.emhp.org) or by calling Employee Benefits Unit (EBU) at 631-853-4866. 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.emhp.org](http://www.emhp.org) or by calling Employee Benefits Unit (EBU) at 631-853-4866 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <u>deductible</u>?</b></p>	<p>Medical/Surgical <u>In-Network</u> Hospital and Medical/Surgical: \$0</p> <p><u>Out-of-Network</u> Hospital: \$0;                      Medical/Surgical: \$1,250 per individual or \$3,750 per family</p>	<p>Medical/Surgical <u>In-Network</u> Hospital and Medical/Surgical and <u>Out-of-Network</u> Hospital: See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.</p> <p>Medical/Surgical <u>Out-of-Network</u> Medical/Surgical: 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 <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the combined family <u>deductible</u>.</p>
<p><b>Are there services covered before you meet your <u>deductible</u>?</b></p>	<p><u>In-Network</u> Medical/Surgical and Hospital and <u>Out-of-Network</u> Hospital: Not applicable.</p> <p>Medical/Surgical <u>Out-of-Network</u> Medical/Surgical: Yes. Chiropractic, acupuncture, ambulance, mammography, mastectomy prostheses, <u>emergency room</u> and <u>prescription drugs</u> expenses are covered before you meet your <u>Out-of-Network</u> Medical/Surgical <u>deductible</u>.</p>	<p><u>In-Network</u> Medical/Surgical and Hospital and <u>Out-of-Network</u> Hospital: This <u>plan</u> does not have a <u>deductible</u>.</p> <p>Medical/Surgical <u>Out-of-Network</u>: This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount; but a separate <u>deductible</u> or a <u>copayment</u> or <u>coinsurance</u> may apply.</p>
<p><b>Are there other <u>deductibles</u> for specific services?</b></p>	<p>Yes.</p> <p><u>Out-of-Network</u> Mental Health and Substance Use Disorder Benefits: Inpatient, Partial <u>Hospitalization</u>, Rehab and Residential: \$2,000 per employee; \$2,000 per spouse/domestic partner; \$2,000 aggregate for all eligible children.</p> <p><u>Out-of-Network</u> Mental Health and Substance Use Disorder Benefits Professional services and office visits, Intensive outpatient and outpatient detox: \$500 per employee; \$500 per spouse/domestic partner; \$500 aggregate for all eligible children.</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.</p>

Important Questions	Answers	Why This Matters:
<p><b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b></p>	<p>There are no other specific <u>deductibles</u>.</p> <p><u>In-Network</u> Medical/Surgical and Hospital: \$3,650 per individual or \$7,300 per family;  <u>In-Network</u> Mental Health and Substance Use Disorder Benefits: \$1,500 per individual or \$3,000 per family;  <u>Prescription drugs</u> obtained at a <u>participating</u> retail and/or mail order pharmacy (combined) for Non-Medicare prime members: \$2,750 per individual or \$5,500 per family;  <u>Out-of-Network</u> Medical/Surgical/Surgical 20% “coinsurance” maximum: \$3,750 per individual or \$11,250 per family;  <u>Out-of-Network Hospital</u>: \$1,500 per employee; \$1,500 per spouse/domestic partner; or \$1,500 aggregate for all eligible children; Medical/Surgical</p> <p><u>Out-of-Network</u> Mental Health/Substance Use Disorder and <u>Prescription Drugs</u>: No limit.</p>	<p>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.</p> <p>This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses for <u>Out-of-Network</u> Mental Health/Substance Use Disorder and Prescription Drugs.</p>
<p><b>What is not included in the <u>out-of-pocket limit</u>?</b></p>	<p><u>Premiums</u>, <u>balance-billing</u> charges, <u>Out-of-Network deductibles</u> and <u>copayments</u>, penalties for failure to obtain <u>preauthorization</u>, and health care this <u>plan</u> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p><b>Will you pay less if you use a <u>network provider</u>?</b></p>	<p>Yes.  Hospital/Medical/Surgical see <a href="http://www.empireblue.com">www.empireblue.com</a> or call 1-800-939-7515 for a list of participating <u>in-network providers</u>.  Mental Health/Substance Use Disorder see <a href="http://www.achievesolutions.net/suffolk">www.achievesolutions.net/suffolk</a> or call 1-866-909-6472.  <u>Prescription Drug</u> see <a href="http://emhp.welldynrx.com">emhp.welldynrx.com</a> or call 1-855-799-6831 or for specialty medications see <a href="http://www.usspecialtycare.com">www.usspecialtycare.com</a> or call 1-800-641-8475.  <u>Prescription Drug</u> for Medicare eligible Retirees see <a href="http://www.express-scripts.com">www.express-scripts.com</a> or call 1-800-987-5242.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plans' 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's</u> 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.</p>
<p><b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b></p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>

 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 provider's office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit	<u>Deductible</u> , 20% <u>coinsurance</u> , plus <u>balance billing</u>	Surgery performed in physician's office is subject to an additional \$25 <u>copayment</u> .
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit; Surgery performed in physician office: additional \$25 <u>copay</u> /visit.	<u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u> ; Acupuncture services: \$30 <u>copay</u> /visit plus balances over <u>in-network</u> rate (payable up to <u>in-network</u> rate); Chiropractic: \$30 <u>copay</u> /visit plus balances over \$60 (maximum <u>plan</u> payment \$30) Medical/Surgical <u>deductible</u> does not apply to chiropractic or acupuncture visits	Chiropractic - One additional <u>copay</u> for necessary related X-rays done at time of visit; maximum two <u>copays</u> /visit. Coverage during active phase of treatment only. Must be precertified after 10 <sup>th</sup> visit or claims will be denied. Maximum 60 visits per calendar year. Acupuncture - benefits during active phase of treatment only. <u>Out-of-Network</u> Chiropractic and Acupuncture, benefits do not count toward annual Out-of-Network Medical/Surgical <u>out-of-pocket limit</u> .
	<u>Preventive care/screening/immunization</u>	No charge	<u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u>	Age and frequency limits may apply. <u>Cost sharing</u> may apply or you may have to pay for services that are not preventive. Ask your <u>provider</u> if the services needed are preventive. Then check with your <u>plan</u> to determine what the plan will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Blood work: No charge; X-ray: In a doctor's office \$25 <u>copay</u> /visit; In a <u>specialist's</u> office \$30 <u>copay</u> /visit; and Hospital outpatient setting \$25 <u>copay</u> .	Lab or doctor's office: <u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u> ; Hospital Outpatient: Greater of 10% <u>coinsurance</u> of billed charges or \$75/service; Medical/Surgical <u>deductible</u> does not apply	In-Network: Routine lab tests ordered by <u>in-network</u> physician but performed by lab other than LabCorp or Quest will be considered <u>out-of-network</u> . Two <u>copay</u> maximum <u>in-network</u> for multiple x-ray services performed during one office visit.
	Imaging (e.g., CT/PET scans, MRIs)	\$50 <u>copay</u> /exam	Medical/Surgical: <u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u> ; Hospital Outpatient: Greater of 10% <u>coinsurance</u> of billed charges or \$75/service; Medical/Surgical <u>deductible</u> does not apply	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.emhp.org">www.emhp.org</a>	Generic drugs	Retail (1 - 21 days): \$10 <u>copay</u> /prescription; Home Delivery/Mail Order (up to 90 days): \$10 <u>copay</u> /prescription	Retail Only (1 - 21 days): \$10 <u>copay</u> /prescription plus <u>balance billing</u> ; Medical/Surgical <u>deductible</u> does not apply.	Non-Medicare eligible members: <u>Plan</u> requires (1) a mandatory generic substitution; and (2) a mandatory mail order program for maintenance medication. <u>Out of pocket limit</u> applies.
	Preferred brand drugs	Retail (1 - 21 days): \$25 <u>copay</u> /prescription; Home Delivery/Mail Order (up to 90 days): \$50 <u>copay</u> /prescription	Retail Only (1 - 21 days): \$25 <u>copay</u> /prescription plus <u>balance billing</u> ; Medical/Surgical <u>deductible</u> does not apply.	Medicare-eligible Retirees: <u>Prescription drug coverage</u> provided through mandatory Medicare Prescription Drug Plan (PDP), Express Scripts Medicare™ (PDP) for Suffolk County EMHP. <u>Out-of-Pocket limit</u> does not apply.*
	Non-preferred brand drugs	Retail (1 - 21 days): \$45 <u>copay</u> /prescription; Home Delivery/Mail Order (up to 90 days): \$90 <u>copay</u> /prescription	Retail Only (1 - 21 days): \$45 <u>copay</u> /prescription plus <u>balance billing</u> ; Medical/Surgical <u>deductible</u> does not apply.	No charge for FDA-approved generic contraceptives and other ACA preventive drugs (or brand if generic is medically inappropriate). Generic non-sedating antihistamines, including levocetirizine, subject to preferred drug <u>copay</u> . Non-network Retail Pharmacies: After <u>copay</u> , <u>plan</u> pays 100% of “ <u>in-network</u> pharmacy contracted price.” You are responsible for charges above contracted price. Maintenance drug fills limited to 21-days from retail pharmacy. *See the Prescription Drug section of <u>Plan</u> .
	<u>Specialty drugs</u>	Retail (1 - 21 days): \$45 <u>copay</u> /prescription; Home Delivery/Mail Order (up to 90 days): \$90 <u>copay</u> /prescription	Retail Only (1 - 21 days): \$45 <u>copay</u> /prescription plus <u>balance billing</u> . Medical/Surgical <u>deductible</u> does not apply.	<u>Specialty drug</u> prescriptions must be filled through US Specialty Care (USSC) or provided by physician for up to 30-day supply. <u>Specialty drugs</u> received from physician payable under Medical/Surgical benefit: No <u>copay</u> for drugs received from <u>in-network</u> physician; <u>out-of-network plan cost sharing</u> applies for drugs received from <u>out-of-network</u> physician. Prescription drugs within Oral Oncology Program only dispensed by USSC Pharmacy for a 15-day supply for the 1st month of therapy, at ½ the applicable retail <u>copay</u> . “New to market”, non-orphan drugs excluded from coverage for initial six-month period following drug’s market launch. *See <u>Prescription Drug</u> section of <u>Plan</u> document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgery: \$15 <u>copay</u> /visit Hospital Outpatient Surgery: \$95 <u>copay</u> /visit	Ambulatory Surgery: <u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u> . Hospital Outpatient: Greater of 10% <u>coinsurance</u> of billed charges or \$75/service	Ambulatory Surgery: None. Hospital Outpatient Surgery: Failure to preauthorize will result in claim denial. <u>Out-of-network</u> Hospital Outpatient Surgery cost sharing subject to annual limit.
	Physician/ surgeon fees	No copayment	<u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u>	None.
If you need immediate medical attention	<u>Emergency room care</u> (physicians)	\$100 <u>copay</u> /visit (if not admitted to the hospital)	\$100 plus <u>balance billing</u> (if not admitted to the hospital)	No charge for ER physician, radiology and pathology charges and anesthesiology charges only. Coverage of all other medical service providers, e.g, specialists (cardiologist, plastic surgeon, orthopedist, etc.) depends on provider's <u>network</u> status. Professional / physician charges may be billed separately.
	<u>Emergency medical transportation</u>	Local professional: \$70 <u>copay</u> /trip; Organized Volunteer Service: balances over \$50/trips under 50 miles, balances over \$75/trips over 50 miles; Air ambulance: No charge	Local professional: \$70/ <u>copay</u> per trip; Organized Volunteer service: balances over \$50/trips under 50 miles, balances over \$75/trips over 50 miles; Air ambulance: No charge	Air Ambulance. Covered in full if land transport would pose threat to health or cannot be provided due to distance. <u>Preauthorization</u> required within 48 hours of services if for transfer from facility to facility. Failure to preauthorize will result in \$200 penalty. <u>In-network copayment</u> and <u>out-of-network deductible</u> and <u>coinsurance</u> do not apply.
	<u>Urgent care</u>	\$50 <u>copay</u> /visit	<u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Greater of 10% of billed charges or \$75/stay; Medical/Surgical <u>Deductible</u> does not apply	<u>Preauthorization</u> required. Failure to preauthorize will result in \$200 penalty.
	Physician/surgeon fees	No charge	<u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u>	None.
If you need mental health, behavioral health, or substance use disorder	Outpatient services	Mental/Behavioral health: \$25 <u>copay</u> /visit; Substance Use: \$15/ <u>copay</u>	Separate mental health/substance use disorder <u>Deductible</u> plus 50% <u>coinsurance</u> of <u>allowed amount</u> or <u>provider's charge</u> , whichever is less; Medical/Surgical <u>deductible</u> does not apply.	<u>Out-of-network provider</u> maximum 30 visits per calendar year. <u>Preauthorization</u> required. Failure to preauthorize will result in reduced benefits. *For more information about <u>preauthorization</u> process, see the Mental Health and Substance Use Disorder section of the <u>plan</u> document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<b>services</b>	Inpatient services	No charge	Separate mental health/ substance use disorder <u>Deductible</u> , 50% <u>coinsurance</u> of lesser of <u>allowed amount</u> or <u>provider's charge</u> ; Medical/Surgical <u>deductible</u> does not apply.	Failure to preauthorize will result in reduced benefits. *See the Mental Health and Substance Use Disorder <u>Preauthorization</u> section of the <u>plan</u> document. <u>Out-of-</u> <u>network provider</u> : Mental/Behavioral: maximum 30 days per calendar year; Substance Use Disorder: maximum of 1 stay per year/3 stays per lifetime.
<b>If you are pregnant</b>	Office visits	\$25 <u>copay</u> for first visit only	<u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u>	In-network doctor's charges for delivery are part of prenatal and postnatal care. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests/services described somewhere else in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	No charge	<u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u>	
	Childbirth/delivery facility services	No charge	Greater of 10% of billed charges or \$75/visit; Medical/Surgical <u>deductible</u> does not apply	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	<u>Deductible</u> , 50% <u>coinsurance</u> plus <u>balance billing</u>	<u>Preauthorization</u> required; failure to preauthorize will result in denial of <u>claim</u> . Subject to <u>deductible</u> and payment of charges above Maximum Allowable Amounts.
	<u>Rehabilitation services</u>	Inpatient (physical therapy/rehabilitation and cardiac rehab only): No charge; Outpatient: \$30 <u>copay</u> /visit; Stand-alone facility or <u>provider</u> : Physical Therapy: \$30 <u>copay</u> /visit Occupational Therapy: \$30 <u>copay</u> /visit	Inpatient (PT & rehab only) and Outpatient Hospital facility: Greater of 10% of billed charges or \$75/visit; Freestanding facility/ <u>provider</u> for speech & vision: <u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u> : PT: \$30 <u>copay</u> /visit plus balances over \$70 (maximum plan payment \$40); OT: \$30 <u>copay</u> /visit plus balances over \$80 (maximum plan payment \$50)	Physical (PT), occupational (OT), speech and vision therapies & <u>rehabilitation services</u> covered during the active phase of treatment only. Failure to preauthorize after 20th visit will result in claim denial. Outpatient hospital based facility only covered for physical therapy (PT) and if in connection with <u>hospitalization</u> or surgery within 6 months of discharge/surgery. Hospital Inpatient only physical therapy/rehabilitation and cardiac rehab covered at an <u>in-network</u> hospital. Failure to preauthorize will result in \$200 penalty. *See Rehabilitation section of Plan Document.
	<u>Habilitation services</u>			
	<u>Skilled nursing care</u>	No charge	Greater of 10% of billed charges or \$75/visit	No coverage for skilled nursing facilities if Medicare is primary. Custodial care not covered. Failure to preauthorize will result in \$200 penalty. Must be referred by a doctor for continuing treatment; admission to skilled

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
				nursing facility must immediately follow a hospital stay of at least 3 consecutive days.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u> Hospital Inpatient: No charge; Hospital Outpatient: \$25 <u>copay</u>	<u>Deductible</u> , 50% <u>coinsurance</u> plus <u>balance billing</u> ; Hospital: Greater of 10% of billed charges or \$75/visit	<u>Coinsurance</u> , where applicable, applies to the cost of purchasing or renting.
	<u>Hospice services</u>	No charge	Not covered	<u>Preauthorization</u> required. Failure to preauthorize will result in \$200 penalty. Covered when provided by a hospice organization certified under New York State law, or comparable certification if outside of NYS.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	You must pay 100% of this service, even <u>in-network</u> .
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

**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 eye care (Adult and child)                         |
| • Dental care (Adult and child) | • Private-duty nursing | • Weight loss programs, except as required, with limitations |

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

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|---|---|--|
| • Acupuncture (if prescribed for rehabilitation purposes)   | • Hearing aids                                    | • Non-emergency coverage when traveling outside the United States. (See <a href="http://www.empireblue.com">www.empireblue.com</a> ) |
| • Bariatric surgery   | • Infertility treatment ( <u>In-network</u> only) | • Routine foot care  |
| • Chiropractic care (during the active phase only; limited to 60 visits/year and maximum reimbursement of \$30/visit) |   |  |

**Your Rights to Continue Coverage:** For more information on your rights to continue coverage, contact your Employee Benefits Unit at 631-853-4866. There are also agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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 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: EMHP Labor/Management Committee, Attention: EMHP Administrator, c/o the Department of Civil Service/Administration, Building 158, William J. Lindsay County Complex, 725 Veterans Memorial Highway, P.O. Box 6100, Hauppauge, New York 11788-0099; Phone: 1-800-939-7515.

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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-939-7515.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-939-7515.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-939-7515.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-939-7515.

————— *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 \$0
- Specialist copayment \$30
- Hospital (facility) cost sharing None
- Other copayment \$30

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>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$85
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$150</b>

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

- The plan's overall deductible \$0
- Specialist copayment \$30
- Hospital (facility) cost sharing None
- Other copayment \$30

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>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,170
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,200</b>

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

- The plan's overall deductible \$0
- Specialist copayment \$30
- Hospital (facility) cost sharing None
- Other copayment \$30

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>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$260
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$260</b>