




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 1-800-843-4876. 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 1-800-843-4876 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	In-Network: \$400/Individual or \$800/Family  Out-of-Network: \$800/Individual or \$1,600/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. Emergency Services and other services as noted 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 <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	In-Network: \$2,000/Individual or \$4,000/Family  Out-of-Network: \$3,000/Individual or \$6,000/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-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even through 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.bcbsm.com">www.bcbsm.com</a> or 1-800- 843-4876 for a list of <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
		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	\$20 <a href="#">copay</a> <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. Out-of-network services limited to colonoscopy, diabetes self-management, mammography, and childhood immunizations.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	The test must be deemed <a href="#">medically necessary</a> . Experimental, investigational or services for your convenience or the convenience of your <a href="#">provider</a> are not covered under the <a href="#">plan</a> .
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	The test must be deemed <a href="#">medically necessary</a> . Experimental, investigational or services for your convenience or the convenience of your <a href="#">provider</a> are not covered under the <a href="#">plan</a> .
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com/som">www.optumrx.com/som</a>	Generic drugs	\$10 <a href="#">copay</a> (retail) \$20 <a href="#">copay</a> (mail order) <a href="#">Deductible</a> does not apply	Not covered	You can find information regarding specific limitations and exceptions by utilizing the <a href="#">formulary</a> link on the Optum Rx State of Michigan <a href="#">website</a> or by contacting Optum Rx Customer Service at 866-633-6433.
	Preferred brand drugs	\$30 <a href="#">copay</a> (retail) \$60 <a href="#">copay</a> (mail order) <a href="#">Deductible</a> does not apply	Not covered	
	Non-preferred brand drugs	\$60 <a href="#">copay</a> (retail) \$120 <a href="#">copay</a> (mail order) <a href="#">Deductible</a> does not apply	Not covered	

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

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$200 <a href="#">copay</a> <a href="#">Deductible</a> does not apply	\$200 <a href="#">copay</a> <a href="#">Deductible</a> does not apply	The <a href="#">copay</a> is waived if admitted as inpatient.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	You are covered for ambulance transport to the nearest medical facility capable of treating your condition.
	<a href="#">Urgent care</a>	\$20 <a href="#">copay</a> <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Unlimited for general medical care days.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <a href="#">copay</a> <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a>	None
	Inpatient services	No charge	20% <a href="#">coinsurance</a>	None
If you are pregnant	Office visits	No charge <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	

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

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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	Not covered	Unlimited visits. Your <a href="#">plan</a> does not cover custodial care, non-skilled care rest therapy and care in a nursing or rest home facility. Must be rendered by a participating home health care agency.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Your <a href="#">plan</a> covers 90 combined visits for physical (PT), occupational (OT), speech (ST), and massage therapies per calendar year. PT, OT, and ST services related to autism treatment are not subject to the combined benefit maximum of 90 visits. Chiropractors may perform massage therapy when provided as part of a formal course of physical therapy and if performed by a massage therapist, supervised by a chiropractor.
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	Not covered	Up to 120 days per confinement. Must be in a Blue Cross approved skilled nursing facility.
	<a href="#">Durable medical equipment</a>	No charge	20% <a href="#">coinsurance</a>	You will pay 20% <a href="#">coinsurance</a> plus the difference between the non-participating <a href="#">provider's</a> charge and the Blue Cross approved amount.
	<a href="#">Hospice services</a>	No charge	Not covered	Limited to the lifetime dollar maximum that is adjusted by the State. Must be a Blue Cross or Medicare-certified hospice program.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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

## 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
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Private-duty nursing
- Routine eye care (Adult)
- Weight Loss

**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 [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services 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: Blue Cross Blue Shield of Michigan, Conference Coordination Unit, P.O. Box 2456, Detroit, MI 48231-2459. For state of Michigan assistance contact the Civil Service Commission, Employee Benefits Division, P.O. Box 30002, Lansing, MI, 48909 or the Department of Insurance and Financial Services, Office of General Counsel-Appeals Section, 530 W. Allegan Street, 7th Floor, P. O. Box 30220, Lansing, MI 48909-7720, <http://www.michigan.gov/difs>; call 1-877-999-6442 or fax: 517-284-8838.

### 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](#).

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-469-2583.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawagsa 1-877-469-2583.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-469-2583.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-469-2583

**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.

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



## ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

### We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فليك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711. إذا لم تكن مشتركاً بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話：如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

بہم کہیں، آپ یا آپ کی مدد کرنے والے شخص کو کسی زبان کی مدد کی ضرورت ہو، تو آپ کو اپنی زبان میں سہولت کی ضرورت ہے۔ کسی زبان میں مدد کے لیے، اپنے کارڈ کے پیچھے دیے گئے گاہک سروس نمبر پر یا 877-469-2583 پر (اگر آپ ابھی تک رکن نہیں ہیں) سے رابطہ کریں۔

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy w własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の方の身回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号（メンバーでない方は 877-469-2583, TTY: 711）までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

### Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: [CivilRights@bcbsm.com](mailto:CivilRights@bcbsm.com). If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & 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, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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>	\$400
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

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>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$400
<a href="#">Copayments</a>	\$33
<a href="#">Coinsurance</a>	\$980
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,473</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>	\$400
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

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>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$134
<a href="#">Copayments</a>	\$699
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$255
<b>The total Joe would pay is</b>	<b>\$1,088</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>	\$400
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

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>
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$400
<a href="#">Copayments</a>	\$20
<a href="#">Coinsurance</a>	\$98
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$518</b>

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