



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 1-888-802-8776, refer to group number 7SPW00 when calling or visit us at [www.bcbsil.com/boeing](http://www.bcbsil.com/boeing). 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 1-866-473-2016 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | <a href="#">Network</a> : \$600 per individual, \$1,800 per family; Nonnetwork: \$1,200 per individual, \$3,600 per family. Nonnetwork charges apply toward the <a href="#">network deductible</a> .                                                                                                                                                                                                                                                                                    | 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="#">Deductible</a> does not apply to <a href="#">copayments</a> , <a href="#">prescription drugs</a> , <a href="#">preventive care</a> or vision.                                                                                                                                                                                                                                                                                                                          | 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> ? | <a href="#">Network</a> : \$2,300 per individual, \$6,900 per family for medical expenses; Nonnetwork: \$4,600 per individual, \$13,800 per family for medical expenses; Nonnetwork applies toward <a href="#">network</a> medical out-of-pocket maximum, <a href="#">plan</a> year medical <a href="#">deductible</a> is included in medical out-of-pocket maximum amount; Separate \$5,150 per individual, \$8,100 per family for <a href="#">network</a> prescription drug expenses. | 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.                                                                                                                                                                                                                                                                                       |

| Important Questions                                                          | Answers                                                                                                                                                                            | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is not included in the <a href="#">out-of-pocket limit</a> ?            | <a href="#">Premiums</a> , balance-billed charges, health care this <a href="#">plan</a> doesn't cover, penalties for failing to obtain <a href="#">preauthorization</a> , vision. | 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.bcbsil.com/boeing">www.bcbsil.com/boeing</a> or call 1-888-802-8776 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 <a href="#">plan's network</a> . You will pay the most if you use a <a href="#">nonnetwork provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use a <a href="#">nonnetwork 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<br>(You will pay the least)                  | Nonnetwork<br>(You will pay the most) |                                                                                                                                                                                                                               |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness        | 10% after <a href="#">deductible</a>                 | 40% after <a href="#">deductible</a>  | _____none_____                                                                                                                                                                                                                |
|                                                                        | <a href="#">Specialist</a> visit                        | 10% after <a href="#">deductible</a>                 | 40% after <a href="#">deductible</a>  | _____none_____                                                                                                                                                                                                                |
|                                                                        | <a href="#">Preventive care/screening</a> /immunization | No charge, <a href="#">deductible</a> does not apply | Not covered                           | According to prescribed guidelines. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)     | 10% after <a href="#">deductible</a>                 | 40% after <a href="#">deductible</a>  | _____none_____                                                                                                                                                                                                                |
|                                                                        | Imaging (CT/PET scans, MRIs)                            | 10% after <a href="#">deductible</a>                 | 40% after <a href="#">deductible</a>  | _____none_____                                                                                                                                                                                                                |

| Common Medical Event                                                                                                                                                                                                  | Services You May Need     | What You Will Pay                                                                                                                                                                                                                        |                                                                                                                                             | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                       |                           | Network<br>(You will pay the least)                                                                                                                                                                                                      | Nonnetwork<br>(You will pay the most)                                                                                                       |                                                                                                                                                                                                                                             |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.myprime.com/boeing">www.myprime.com/boeing</a> . | Generic drugs             | Retail: 10%, <a href="#">deductible</a> does not apply, member pays minimum \$10, maximum \$50 per prescription<br>Mail Order: 10%, <a href="#">deductible</a> does not apply, member pays minimum \$25, maximum \$130 per prescription  | Retail: 10%, <a href="#">deductible</a> does not apply, member pays minimum \$10, maximum \$50 per prescription<br>Mail Order: Not covered  | Retail: 30 day supply, up to 90 days available at many retail pharmacies<br>Mail Order: 90 day supply                                                                                                                                       |
|                                                                                                                                                                                                                       | Preferred brand drugs     | Retail: 25%, <a href="#">deductible</a> does not apply, member pays minimum \$35, maximum \$125 per prescription<br>Mail Order: 25%, <a href="#">deductible</a> does not apply, member pays minimum \$85, maximum \$310 per prescription | Retail: 25%, <a href="#">deductible</a> does not apply, member pays minimum \$35, maximum \$125 per prescription<br>Mail Order: Not covered | Retail: 30 day supply, up to 90 days available at many retail pharmacies, Member Pays the Difference for brand drugs when generic available<br>Mail Order: 90 day supply, Member Pays the Difference for brand drugs when generic available |
|                                                                                                                                                                                                                       | Non-preferred brand drugs | Retail: 35%, <a href="#">deductible</a> does not apply, member pays minimum \$50 (no maximum) per prescription<br>Mail Order: 35%, <a href="#">deductible</a> does not apply, member pays minimum \$125 (no maximum) per prescription    | Retail: 35%, <a href="#">deductible</a> does not apply, member pays minimum \$50 (no maximum) per prescription<br>Mail Order: Not covered   | Retail: 30 day supply, up to 90 days available at many retail pharmacies, Member Pays the Difference for brand drugs when generic available<br>Mail Order: 90 day supply, Member Pays the Difference for brand drugs when generic available |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                                                                                                                 |                                                                                                                                                                                   | Limitations, Exceptions, & Other Important Information                                                                                                                                                               |
|---------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Network<br>(You will pay the least)                                                                                                                                               | Nonnetwork<br>(You will pay the most)                                                                                                                                             |                                                                                                                                                                                                                      |
|                                                                           | <a href="#">Specialty drugs</a>                  | Specialty medicines are covered to treat chronic, complex or rare conditions                                                                                                      | Not covered                                                                                                                                                                       | Must be obtained from Specialty Pharmacy, prior authorization or other supply and quantity limits may apply, failure to follow <a href="#">plan</a> procedures may result in non-payment by the <a href="#">plan</a> |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | 10% after <a href="#">deductible</a>                                                                                                                                              | 40% after <a href="#">deductible</a>                                                                                                                                              | —————none—————                                                                                                                                                                                                       |
|                                                                           | Physician/surgeon fees                           | 10% after <a href="#">deductible</a>                                                                                                                                              | 40% after <a href="#">deductible</a>                                                                                                                                              | When surgery performed in an outpatient facility                                                                                                                                                                     |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$150 <a href="#">copayment</a> per visit, then no charge after <a href="#">deductible</a> , non-emergent care 40% after <a href="#">deductible</a> and <a href="#">copayment</a> | \$150 <a href="#">copayment</a> per visit, then no charge after <a href="#">deductible</a> , non-emergent care 40% after <a href="#">deductible</a> and <a href="#">copayment</a> | <a href="#">Copayment</a> waived if admitted                                                                                                                                                                         |
|                                                                           | <a href="#">Emergency medical transportation</a> | 10% after <a href="#">deductible</a> , non-emergent care 40% after <a href="#">deductible</a>                                                                                     | 10% after <a href="#">deductible</a> , non-emergent care 40% after <a href="#">deductible</a>                                                                                     | —————none—————                                                                                                                                                                                                       |
|                                                                           | <a href="#">Urgent care</a>                      | 10% after <a href="#">deductible</a>                                                                                                                                              | 40% after <a href="#">deductible</a>                                                                                                                                              | —————none—————                                                                                                                                                                                                       |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 10% after <a href="#">deductible</a>                                                                                                                                              | 40% after <a href="#">deductible</a>                                                                                                                                              | Preadmission review or preapproval required or penalty is 50% of first \$2,000 of eligible charges                                                                                                                   |
|                                                                           | Physician/surgeon fee                            | 10% after <a href="#">deductible</a>                                                                                                                                              | 40% after <a href="#">deductible</a>                                                                                                                                              | —————none—————                                                                                                                                                                                                       |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | 10% after <a href="#">deductible</a>                                                                                                                                              | 40% after <a href="#">deductible</a>                                                                                                                                              | Failure to obtain preapproval for certain intensive level outpatient services may result in non-payment by the <a href="#">plan</a>                                                                                  |
|                                                                           | Inpatient services                               | 10% after <a href="#">deductible</a>                                                                                                                                              | 40% after <a href="#">deductible</a>                                                                                                                                              | Preadmission review or preapproval required or penalty is 50% of first \$2,000 of eligible charges                                                                                                                   |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                    |                                       | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                           |
|----------------------------------------------------------------|-------------------------------------------|--------------------------------------|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | Network<br>(You will pay the least)  | Nonnetwork<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                  |
| If you are pregnant                                            | Office visits                             | 10% after <a href="#">deductible</a> | 40% after <a href="#">deductible</a>  | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> , maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.), depending on the type of services, a <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. |
|                                                                | Childbirth/delivery professional services | 10% after <a href="#">deductible</a> | 40% after <a href="#">deductible</a>  | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> , maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.), depending on the type of services, a <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. |
|                                                                | Childbirth/delivery facility services     | 10% after <a href="#">deductible</a> | 40% after <a href="#">deductible</a>  | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> , maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.), depending on the type of services, a <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 10% after <a href="#">deductible</a> | 40% after <a href="#">deductible</a>  | Preadmission review or preapproval required or penalty is 50% of first \$2,000 of eligible charges                                                                                                                                                                                               |
|                                                                | <a href="#">Rehabilitation services</a>   | 10% after <a href="#">deductible</a> | 40% after <a href="#">deductible</a>  | After 30 visits per therapy per year, continued therapy must be approved by the service representative                                                                                                                                                                                           |
|                                                                | <a href="#">Habilitation services</a>     | 10% after <a href="#">deductible</a> | 40% after <a href="#">deductible</a>  | Habilitative services not meeting medical necessity/policy are excluded under the <a href="#">plan</a>                                                                                                                                                                                           |
|                                                                | <a href="#">Skilled nursing care</a>      | 10% after <a href="#">deductible</a> | 40% after <a href="#">deductible</a>  | Preadmission review or preapproval required or penalty is 50% of first \$2,000 of eligible charges                                                                                                                                                                                               |

| Common Medical Event                          | Services You May Need                     | What You Will Pay                                |                                                  | Limitations, Exceptions, & Other Important Information                                                                        |
|-----------------------------------------------|-------------------------------------------|--------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
|                                               |                                           | Network<br>(You will pay the least)              | Nonnetwork<br>(You will pay the most)            |                                                                                                                               |
|                                               | <a href="#">Durable medical equipment</a> | 10% after <a href="#">deductible</a>             | 40% after <a href="#">deductible</a>             | —none—                                                                                                                        |
|                                               | <a href="#">Hospice services</a>          | 10% after <a href="#">deductible</a>             | 10% after <a href="#">deductible</a>             | Subject to 6 month review, preadmission review or preapproval required or penalty is 50% of first \$2,000 of eligible charges |
| <b>If your child needs dental or eye care</b> | Children's eye exam                       | Coverage offered through separate vision benefit | Coverage offered through separate vision benefit | Not covered under the medical <a href="#">plan</a> , coverage offered through separate vision benefit                         |
|                                               | Children's glasses                        | Coverage offered through separate vision benefit | Coverage offered through separate vision benefit | Not covered under the medical <a href="#">plan</a> , coverage offered through separate vision benefit                         |
|                                               | Children's dental check-up                | Coverage offered through separate dental benefit | Coverage offered through separate dental benefit | Not covered under the medical <a href="#">plan</a> , coverage offered through separate dental benefit                         |

## 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](#).)

- Children's dental check-up
- Children's eye exam
- Children's glasses
- Cosmetic surgery (unless reconstructive)
- Dental care (Adult)
- Long-term care
- Private-duty nursing (limited coverage may apply)
- Routine eye care (Adult)
- Routine foot care (limited coverage may apply)
- Weight loss programs

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

- Acupuncture
- Bariatric surgery (limited coverage may apply)
- Chiropractic care
- Hearing aids
- Infertility treatment (limited coverage may apply)
- Non-emergency care when traveling outside the U.S.; <https://www.bcbsil.com/boeing/find-a-doctor-or-hospital/international-travel.html>

**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: 1-866-444-EBSA (3272) or [www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act](http://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: 1-888-802-8776. You can also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act>

### 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 1-866-473-2016.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-473-2016.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-473-2016.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-866-473-2016.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-473-2016.

*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> | \$600 |
| ■ <a href="#">Specialist coinsurance</a>                        | 10%   |
| ■ 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:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$600          |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$1,200        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$1,860</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> | \$600 |
| ■ <a href="#">Specialist coinsurance</a>                        | 10%   |
| ■ 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:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$600          |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$1,000        |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,620</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> | \$600 |
| ■ <a href="#">Specialist coinsurance</a>                        | 10%   |
| ■ 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:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$600          |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$200          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,000</b> |

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