



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, visit <http://PacificSource.com/uo>. 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 [Healthcare.gov/SBC-Glossary/](https://www.healthcare.gov/SBC-Glossary/) or call 1-855-274-9814 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	University Health Services (UHS) in-network <a href="#">provider</a> : \$0 individual/ \$0 family   UO Exclusive in-network <a href="#">provider</a> and Navigator in-network <a href="#">provider</a> : \$300 individual/ \$900 family   <a href="#">Out-of-network provider</a> : \$1,000 individual/ \$3,000 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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. All services provided by a UHS <a href="#">provider</a> , if available. <a href="#">Preventive care</a> ; In-network <a href="#">provider emergency room care</a> visits and <a href="#">out-of-network provider emergency room care</a> medical emergency visits. In-network <a href="#">provider</a> : office visits, <a href="#">specialist</a> visits, outpatient <a href="#">rehabilitation services</a> , outpatient <a href="#">habilitation services</a> , <a href="#">urgent care</a> , ambulance. <a href="#">Prescription drug coverage</a> : Tier one drugs, Tier two drugs, Tier three drugs. In-network <a href="#">provider</a> : Vision age 18 and younger - vision exam and hardware. Pediatric dental check-up age 18 and younger.	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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. Pediatric dental <a href="#">deductible</a> : \$150. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	University Health Services (UHS), UO Exclusive in-network <a href="#">provider</a> , Navigator in-network <a href="#">provider</a> : \$5,000 individual/ \$10,000 family   <a href="#">out-of-network provider</a> : \$10,000 individual/ \$12,700 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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://providerdirectory.PacificSource.com/?nPlan=Navigator">http://providerdirectory.PacificSource.com/?nPlan=Navigator</a> or call 1-855-274-9814 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You pay the least if you use a <a href="#">provider</a> in the UHS <a href="#">network</a> . You pay more if you use a <a href="#">provider</a> in the UO Exclusive <a href="#">network</a> . You pay more if you use a <a href="#">provider</a> in the Navigator <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 <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 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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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
		University Health Services (UHS) In-network Provider (You will pay the least)	UO Exclusive In-network Provider (You will pay more)	Navigator In-network Provider (You will pay more)	Out-of-network Providers (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	No charge, <a href="#">deductible</a> does not apply	First 3 visits \$5 <a href="#">co-pay</a> /visit, <a href="#">deductible</a> does not apply. Subsequent visit, \$25 <a href="#">co-pay</a> / visit, <a href="#">deductible</a> does not apply	First 3 visits \$5 <a href="#">co-pay</a> /visit, <a href="#">deductible</a> does not apply. Subsequent visit, \$40 <a href="#">co-pay</a> /visit, <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	First 3 visits/benefit year combined for primary care, mental health, behavioral health, and substance abuse visits.
	<a href="#">Specialist</a> visit	No charge, <a href="#">deductible</a> does not apply	\$35 <a href="#">co-pay</a> /visit, <a href="#">deductible</a> does not apply	\$50 <a href="#">co-pay</a> /visit, <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge, <a href="#">deductible</a> does not apply Well baby/Well child care / Mammogram / Colonoscopy: Not available	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	Not covered	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge, <a href="#">deductible</a> does not apply	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Some UHS In-network <a href="#">provider</a> services are provided by a partner entity. If a student receives a service through these external partners, the student will receive a bill directly from that partner entity and

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		University Health Services (UHS) In-network Provider (You will pay the least)	UO Exclusive In-network Provider (You will pay more)	Navigator In-network Provider (You will pay more)	Out-of-network Providers (You will pay the most)	
						normal <a href="#">deductibles</a> , <a href="#">co-pays</a> and/or <a href="#">coinsurance</a> will apply according to the tiered benefits.
	Imaging (CT/PET scans, MRIs)	No charge, <a href="#">deductible</a> does not apply	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If not received, you will be responsible for the expenses.
<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://PacificSource.com/uo">http://PacificSource.com/uo</a> .	Generic drugs - Tier 1	<a href="#">Preventive</a> : No charge, <a href="#">deductible</a> does not apply Retail: \$10 <a href="#">co-pay</a> /prescription, <a href="#">deductible</a> does not apply Mail order: Not available	<a href="#">Preventive</a> : No charge, <a href="#">deductible</a> does not apply \$15 <a href="#">co-pay</a> /prescription, <a href="#">deductible</a> does not apply (retail & mail order)	<a href="#">Preventive</a> : No charge, <a href="#">deductible</a> does not apply \$15 <a href="#">co-pay</a> /prescription, <a href="#">deductible</a> does not apply (retail & mail order)	Not covered	Prescription benefit includes certain outpatient drugs as a <a href="#">preventive</a> benefit at no charge, <a href="#">deductible</a> does not apply.  In-network <a href="#">formulary</a> prescription insulin is not subject to a <a href="#">deductible</a> and may not exceed \$85 per 30 day supply.  Retail limited to 30 day supply. Mail order limited to 30 day supply.
	Preferred drugs - Tier 2	Retail: \$25 <a href="#">co-pay</a> /prescription, <a href="#">deductible</a> does not apply Mail order: Not available	\$50 <a href="#">co-pay</a> /prescription, <a href="#">deductible</a> does not apply (retail and mail order)	\$50 <a href="#">co-pay</a> /prescription, <a href="#">deductible</a> does not apply (retail and mail order)	Not covered	<a href="#">Preauthorization</a> is required for certain drugs. If not received, you will be responsible for the expenses.
	Non-preferred drugs - Tier 3	Retail: \$50 <a href="#">co-pay</a> /prescription, <a href="#">deductible</a> does not apply Mail order: Not available	\$75 <a href="#">co-pay</a> /prescription, <a href="#">deductible</a> does not apply (retail and mail order)	\$75 <a href="#">co-pay</a> /prescription, <a href="#">deductible</a> does not apply (retail and mail order)	Not covered	Select medications from the UHS available for 90 day supply.  <a href="#">Specialty drugs</a> : First fill via in-network retail pharmacy or University Health Services will be covered. All subsequent fills are required to be at an in-network specialty pharmacy <a href="#">provider</a> . Limited to 30 day supply.
	<a href="#">Specialty drugs</a> – Tier 4	Retail: 50% <a href="#">coinsurance</a> Mail order: Not available	50% <a href="#">coinsurance</a> (retail and mail order)	50% <a href="#">coinsurance</a> (retail and mail order)	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Not available	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for some surgeries. If not received, you will be responsible for the expenses.
	Physician/surgeon fees	No charge, <a href="#">deductible</a> does not apply	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		University Health Services (UHS) In-network Provider (You will pay the least)	UO Exclusive In-network Provider (You will pay more)	Navigator In-network Provider (You will pay more)	Out-of-network Providers (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	Not available	Medical Emergency: \$300 <a href="#">co-pay</a> /visit, <a href="#">deductible</a> does not apply Non-Emergency: \$300 <a href="#">co-pay</a> /visit, + 10% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply	Medical Emergency: \$300 <a href="#">co-pay</a> /visit, <a href="#">deductible</a> does not apply Non-Emergency: \$300 <a href="#">co-pay</a> /visit, + 20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply	Medical Emergency: \$300 <a href="#">co-pay</a> /visit, <a href="#">deductible</a> does not apply Non-Emergency: 50% <a href="#">coinsurance</a>	<a href="#">Co-pay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	Ground and Air: Not available	Ground: \$300 <a href="#">co-pay</a> /trip + 10% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply Air: Not available	Ground and Air: \$300 <a href="#">co-pay</a> /trip + 20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply	Ground and Air: 50% <a href="#">coinsurance</a>	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate.
	<a href="#">Urgent care</a>	Not available	\$50 <a href="#">co-pay</a> /visit, <a href="#">deductible</a> does not apply	\$75 <a href="#">co-pay</a> /visit, <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not available	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to semi-private room, except when a private room is determined necessary.. <a href="#">Preauthorization</a> is required for some inpatient services. If not received, you will be responsible for the expenses.
	Physician/surgeon fees	Not available	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge, <a href="#">deductible</a> does not apply	First 3 visits \$5 <a href="#">co-pay</a> /visit, <a href="#">deductible</a> does not apply. Subsequent visit, \$25 <a href="#">co-pay</a> /visit, <a href="#">deductible</a> does not apply	First 3 visits \$5 <a href="#">co-pay</a> /visit, <a href="#">deductible</a> does not apply. Subsequent visit, \$40 <a href="#">co-pay</a> /visit,	50% <a href="#">coinsurance</a>	First 3 visits/benefit year combined for primary care, mental health, behavioral health, and substance abuse visits.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		University Health Services (UHS) In-network Provider (You will pay the least)	UO Exclusive In-network Provider (You will pay more)	Navigator In-network Provider (You will pay more)	Out-of-network Providers (You will pay the most)	
				<a href="#">deductible</a> does not apply		
	Inpatient services	Not available	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for some inpatient services. If not received, you will be responsible for the expenses.
If you are pregnant	Office visits	Not available	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Delivery and hospital visits are covered under prenatal and postnatal care. Facility is covered the same as any other hospital services. Coverage includes termination of pregnancy.
	Childbirth/delivery professional services	Not available	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	Not available	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Not available	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	No coverage for private duty nursing or custodial care.
	<a href="#">Rehabilitation services</a>	Inpatient: Not available Outpatient: No charge, <a href="#">deductible</a> does not apply	Inpatient: 10% <a href="#">coinsurance</a> Outpatient: \$25 <a href="#">co-pay</a> /visit, <a href="#">deductible</a> does not apply	Inpatient: 20% <a href="#">coinsurance</a> Outpatient: \$40 <a href="#">co-pay</a> /visit, <a href="#">deductible</a> does not apply	Inpatient and Outpatient: 50% <a href="#">coinsurance</a>	Inpatient: Limited to 30 days/benefit year. Recreation therapy is covered as part of the inpatient admission. Outpatient: No coverage for recreation therapy. Limited to a combined maximum of 30 visits/benefit year.
	<a href="#">Habilitation services</a>	Inpatient: Not available Outpatient: No charge, <a href="#">deductible</a> does not apply	Inpatient: 10% <a href="#">coinsurance</a> Outpatient: \$25 <a href="#">co-pay</a> /visit, <a href="#">deductible</a> does not apply	Inpatient: 20% <a href="#">coinsurance</a> Outpatient: \$40 <a href="#">co-pay</a> /visit, <a href="#">deductible</a> does not apply	Inpatient and Outpatient: 50% <a href="#">coinsurance</a>	Inpatient: Limited to 30 days/benefit year. Recreation therapy is covered as part of the inpatient admission. Outpatient: No coverage for recreation therapy. Limited to a combined maximum of 30 visits/benefit year.
	<a href="#">Skilled nursing care</a>	Not available	Not available	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to 60 days/benefit year. No coverage for custodial care.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		University Health Services (UHS) In-network Provider (You will pay the least)	UO Exclusive In-network Provider (You will pay more)	Navigator In-network Provider (You will pay more)	Out-of-network Providers (You will pay the most)	
	<a href="#">Durable medical equipment</a>	No charge, <a href="#">deductible</a> does not apply	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to: \$5,000/benefit year overall if not an essential health benefit; one pair/benefit year for glasses or contact lenses; one breast pump/pregnancy; one wig/benefit year for chemotherapy or radiation therapy. Hearing aids are limited to one per hearing impaired ear every 36 months or more frequently if modification to an existing hearing aid will not meet the needs of the member. Some UHS In-network <a href="#">provider</a> services are provided by a partner entity. If a student receives a service through these external partners, the student will receive a bill directly from that partner entity and normal <a href="#">deductibles</a> , <a href="#">co-pays</a> and/or <a href="#">coinsurance</a> will apply according to the tiered benefits. <a href="#">Preauthorization</a> required if equipment is over \$2,500 and for power-assisted wheelchairs. If not received, you will be responsible for the expenses.
	<a href="#">Hospice services</a>	Not available	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	No coverage for private duty nursing. Respite care limited to 30 days/lifetime.
If your child needs dental or eye care	Children's eye exam	Not available	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	25% <a href="#">coinsurance</a>	One routine eye exam/benefit year for age 18 or younger when provided by a licensed provider. For age 18 or younger, one pair of glasses (frames and lenses) or contacts (lenses and fitting) in lieu of glasses per benefit year.
	Children's glasses	Not available	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	25% <a href="#">coinsurance</a>	
	Children's dental check-up	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	Routine and problem focused dental exams are covered for members through age 18.

## 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](#).)

- Bariatric surgery
- Cosmetic surgery (except in certain situations)
- Custodial care
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Massage therapy
- Non-emergency care when traveling outside the U.S. (If received in country of citizenship)
- Outpatient recreational therapy
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care, other than with diabetes mellitus

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

- Abortion
- Acupuncture (Acupuncture is limited to 12 visits per benefit year.)
- Chiropractic care (Chiropractic care is limited to 20 visits per benefit year.)
- Hearing aids (Hearing aids are limited to one per hearing impaired ear every 36 months or more frequently if modification to an existing hearing aid will not meet the needs of the member.)
- Weight loss programs

**Your Rights to Continue Coverage:** Federal and State laws may provide protections that allow you to keep this [health insurance](#) as long as you pay your [premium](#).

There are exceptions however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

**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: The PacificSource Customer Service team at 1-855-274-9814.

**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 [Minimum Value Standards](#)? Not Applicable.**

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 1-855-274-9814.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-281-1464.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-281-1464.

*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>	\$300
■ <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>
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In this example, Peg would pay:

<i>Cost sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,470</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>	\$300
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">copayment</a>	\$25

This EXAMPLE event includes services like:

- [Primary care physician](#) office visits (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Prescription drugs](#)
- [Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$520</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>	\$300
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">copayment</a>	\$300

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic tests](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost sharing</i>	
<a href="#">Deductibles</a>	\$40
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$840</b>

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