

Welcome to the Coverage Examples Cost Sharing Calculator

All insurer data entry fields are highlighted in orange.

The Cost Sharing Calculator operates in two modes.

Click the button that corresponds to the mode you want to use.

The user enters data for an individual plan and views the results.

The user loads data for multiple plans and runs the calculator.
The user can then browse the results for the individual plans, save the results to an external file, or copy and paste the results for the individual plans to a separate worksheet.

Single Plan Mode

Plan Selection:

Enter or modify data for each plan.

Data entry fields are highlighted in orange.

Plan Name	Plan 1
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Benefit category	Type of cost sharing that applies	Cost sharing ¹			Coverage Limits		OOP limit applies?
		Benefit Deductible	Co-payment	Co-insurance	per month	per year	
Inpatient Hospital Care (Facility)	Not Covered						
Other Facility Services	Not Covered						
Emergency Department (Facility)	Not Covered						
Ambulance	Not Covered						
Professional Services: Primary Care	Not Covered						
Professional Services: Emergency Department	Not Covered						
Professional Services: Inpatient	Not Covered						
Professional Services: Specialist	Not Covered						
Professional Services: Obstetric Care (Bundled)	Not Covered						
Professional Services: Procedures & Other	Not Covered						
Professional Services: Physical Therapy	Not Covered						
Diagnostic Services: Radiology	Not Covered						
Diagnostic Services: Laboratory	Not Covered						
Prescription Drugs: Generic	Not Covered						
Prescription Drugs: Branded	Not Covered						
Prescription Drugs: Insulin	Not Covered						
Over-the-counter Drugs	Not Covered						
Preventive Services & Vaccines	Not Covered						
Durable Medical Equipment	Not Covered						
Medical Supplies	Not Covered						
Over-the-counter Medical Supplies	Not Covered						
Other Items & Services	Not Covered						
Plan Deductible							

Rx Deductible		
Deductible C		
Deductible D		
Individual Out-of-Pocket (OOP) Limit		

Additional Options	Applies?	# Visits
Begin Primary Care Cost-Sharing After A Set Number of Visits?	No	
Begin Primary Care Cost-Sharing Deductible or Coinsurance After a Set Number of Copays?	No	

¹ The benefit-specific deductible, copayment amount, or coinsurance rate that determines consumer liability.

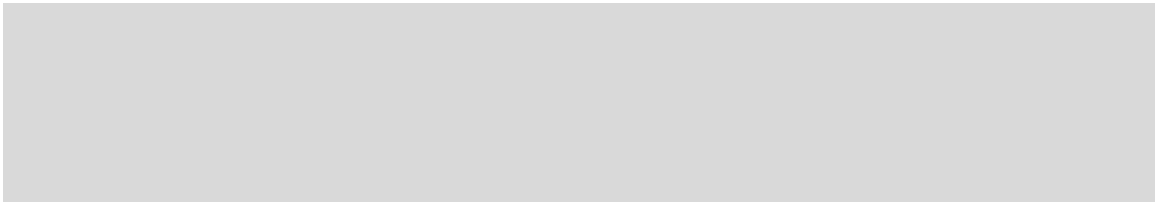
² Outpatient services include non-professional Emergency Department services. Professional services fall under the Professional Services benefit categories.

This worksheet contains the benefit parameters for multiple plans.
You can copy and paste data for individual plans from an external source start

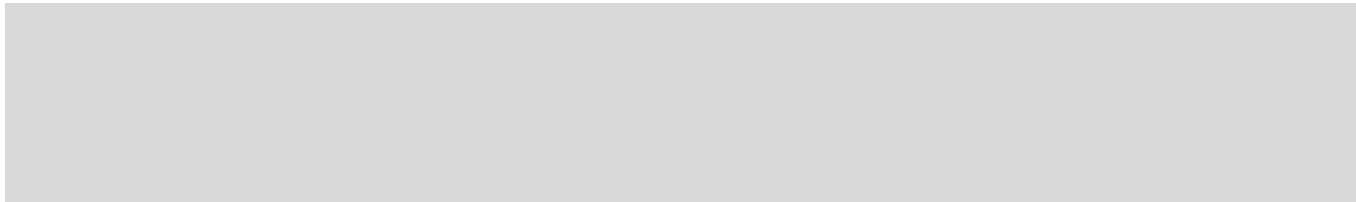
PLAN_ID	Plan deductible	Rx deductible	Deductible C	Deductible D
Plan 1				
Plan 2				
Plan 3				
Plan 4				
Plan 5				
Plan 6				

ing on row 8.

OOP Limit	Inpatient Hospital Care (Facility) Cost sharing Type Not Covered	Benefit Deductible	Co-payment	Co-insurance
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Monthly Limits	Annual Limits	OOP Limit Applies	Other Facility Services Cost sharing Type Not Covered
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Benefit Deductible

Co-payment

Co-insurance

Monthly Limits

Annual Limits

OOP Limit Applies

Emergency Department (Facility)

Cost sharing Type

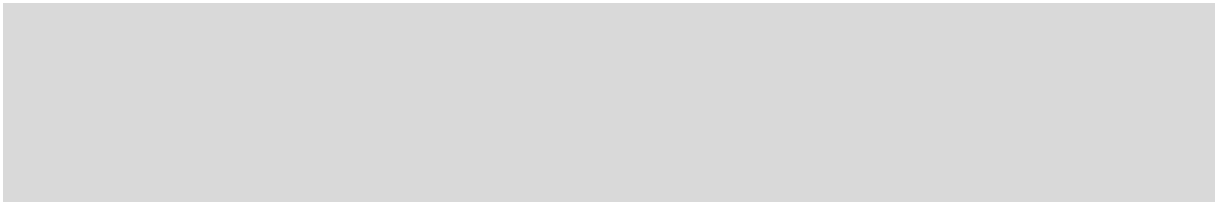
Benefit Deductible

Co-payment

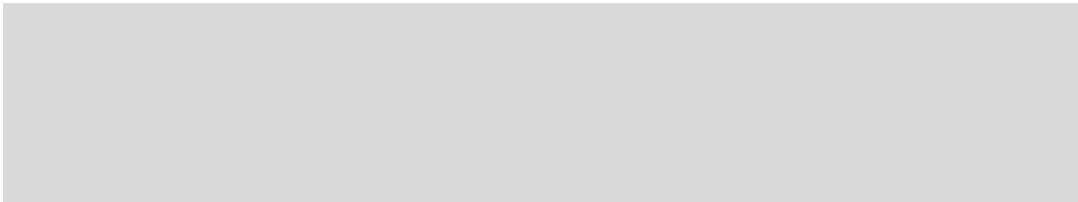
Co-insurance

Monthly Limits

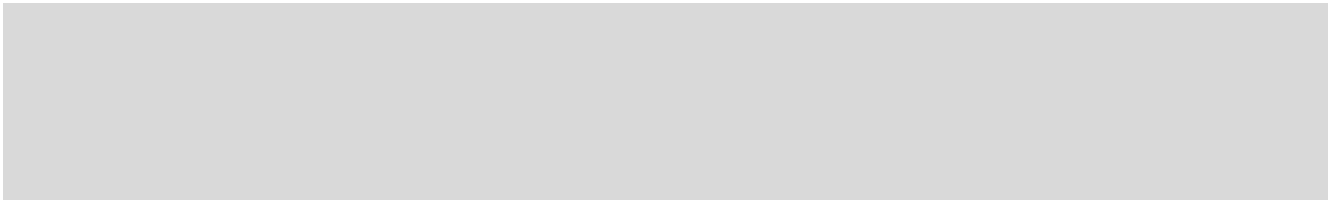
Not Covered



Annual Limits	OOP Limit Applies	Ambulance Cost sharing Type Not Covered	Benefit Deductible
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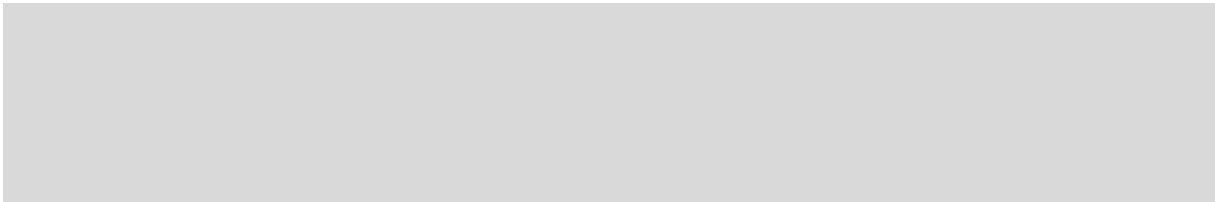


Co-payment Co-insurance Monthly Limits Annual Limits OOP Limit Applies



Professional Services: Primary Care

Cost sharing Type	Benefit Deductible	Co-payment	Co-insurance	Monthly Limits
Not Covered				



Annual Limits	OOP Limit Applies	Professional Services: Emergency Department	Benefit Deductible
		Cost sharing Type	
		Not Covered	



Co-payment Co-insurance Monthly Limits Annual Limits OOP Limit Applies

Professional Services: Inpatient

Cost sharing Type

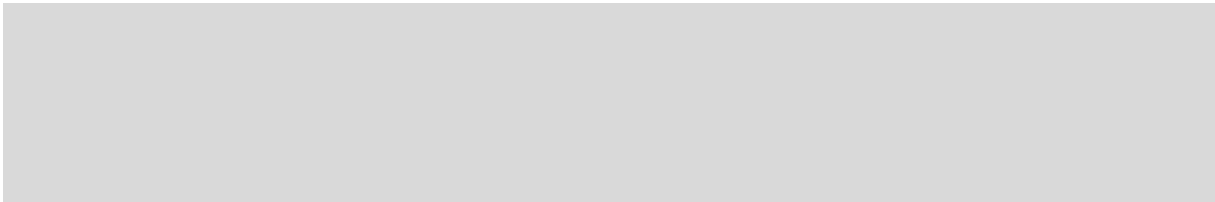
Benefit Deductible

Co-payment

Co-insurance

Monthly Limits

Not Covered



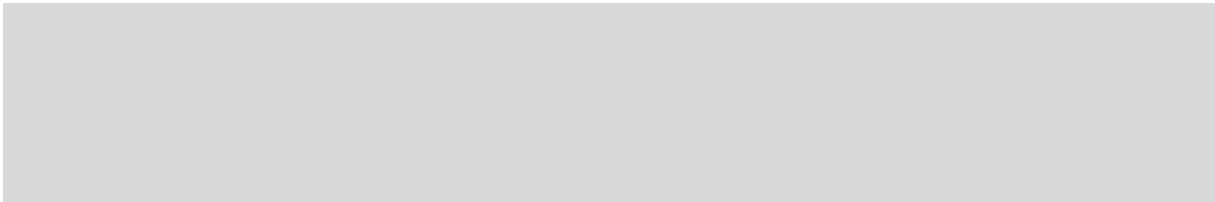
Annual Limits	OOP Limit Applies	Professional Services: Specialist Cost sharing Type Not Covered	Benefit Deductible
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Co-payment Co-insurance Monthly Limits Annual Limits OOP Limit Applies

Professional Services: Obstetric Care (Bundled)

Cost sharing Type	Benefit Deductible	Co-payment	Co-insurance	Monthly Limits
Not Covered				



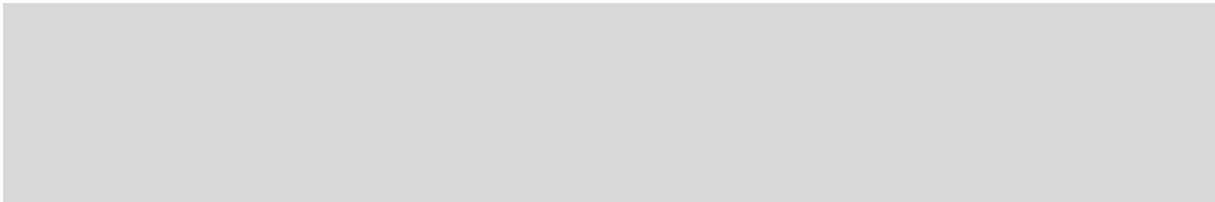
Annual Limits	OOP Limit Applies	Professional Services: Procedures & Other	Benefit Deductible
		Cost sharing Type	
		Not Covered	



Co-payment Co-insurance Monthly Limits Annual Limits OOP Limit Applies

Professional Services: Physical Therapy

Cost sharing Type	Benefit Deductible	Co-payment	Co-insurance	Monthly Limits
Not Covered				



Annual Limits	OOP Limit Applies	Diagnostic Services: Radiology Cost sharing Type Not Covered	Benefit Deductible
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Co-payment Co-insurance Monthly Limits Annual Limits OOP Limit Applies

Diagnostic Services: Laboratory

Cost sharing Type

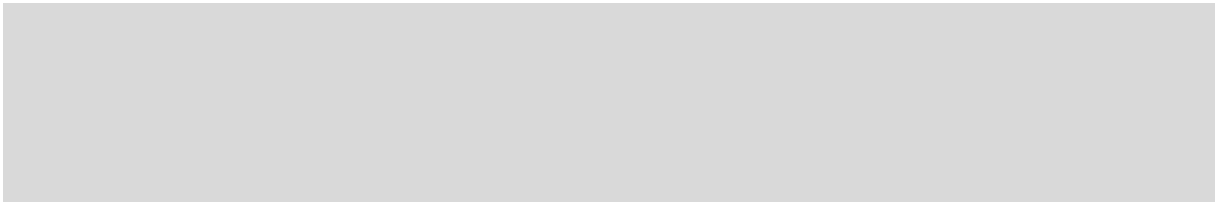
Benefit Deductible

Co-payment

Co-insurance

Monthly Limits

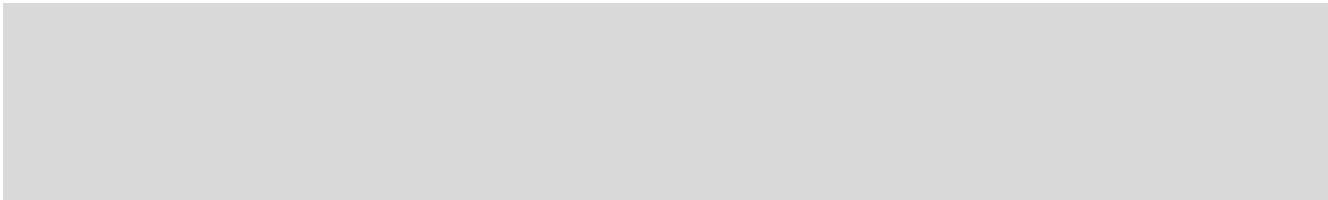
Not Covered



Annual Limits	OOP Limit Applies	Prescription Drugs: Generic Cost sharing Type Not Covered	Benefit Deductible
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Co-payment Co-insurance Monthly Limits Annual Limits OOP Limit Applies



Prescription Drugs: Branded

Cost sharing Type

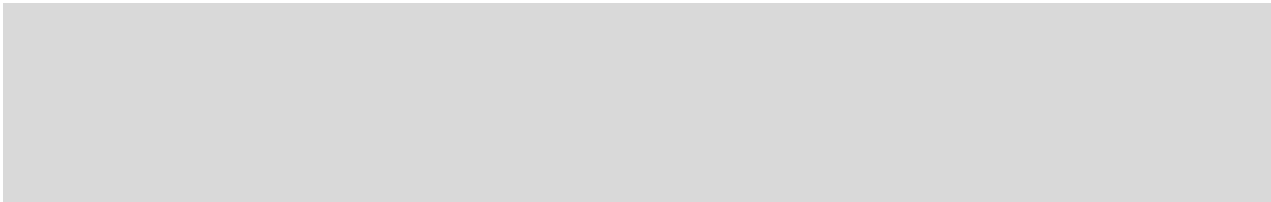
Benefit Deductible

Co-payment

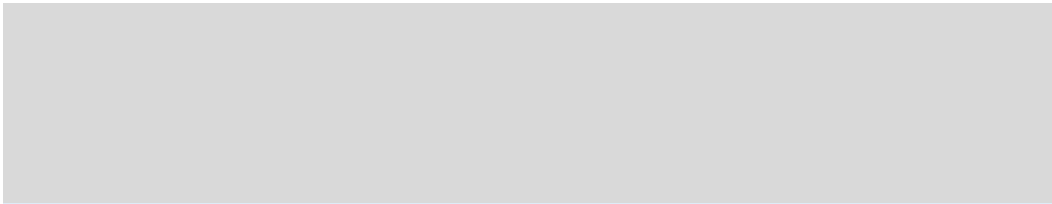
Co-insurance

Monthly Limits

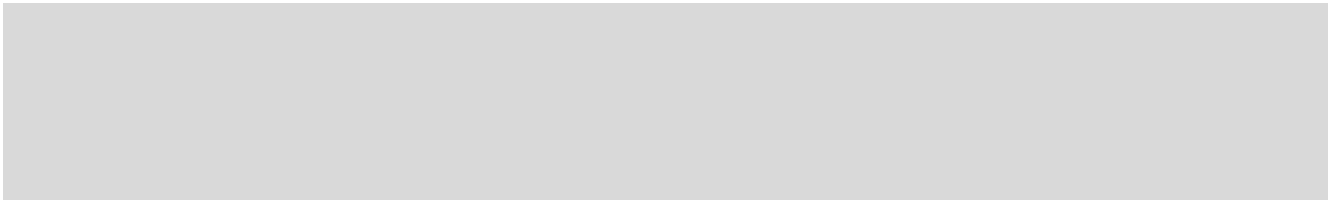
Not Covered



Annual Limits	OOP Limit Applies	Prescription Drugs: Insulin	Cost sharing Type	Benefit Deductible	Co-payment
		Not Covered			



Co-insurance	Monthly Limits	Annual Limits	OOP Limit Applies
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Over-the-counter Drugs

Cost sharing Type

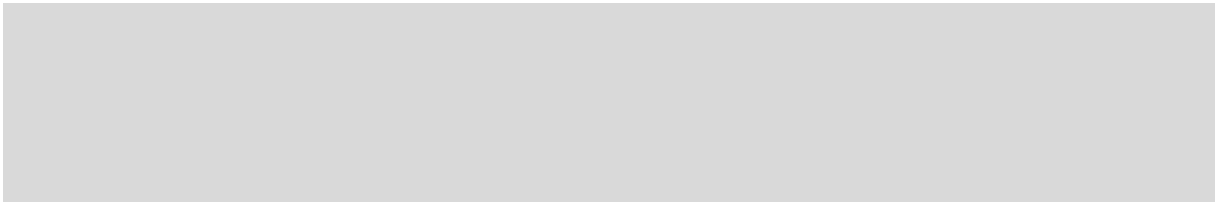
Benefit Deductible

Co-payment

Co-insurance

Monthly Limits

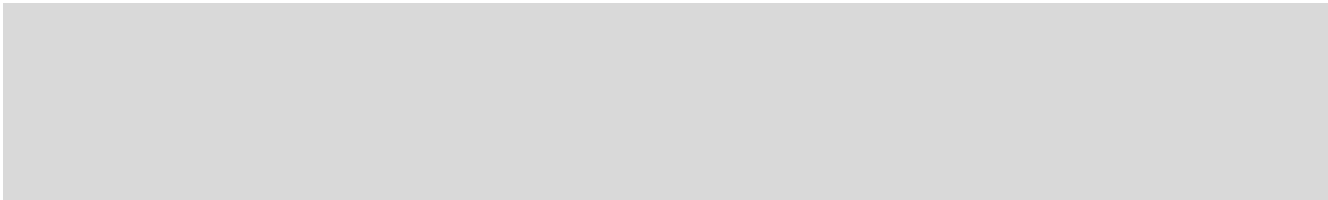
Not Covered



Annual Limits	OOP Limit Applies	Preventive Services & Vaccines Cost sharing Type Not Covered	Benefit Deductible
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Co-payment Co-insurance Monthly Limits Annual Limits OOP Limit Applies



Durable Medical Equipment

Cost sharing Type

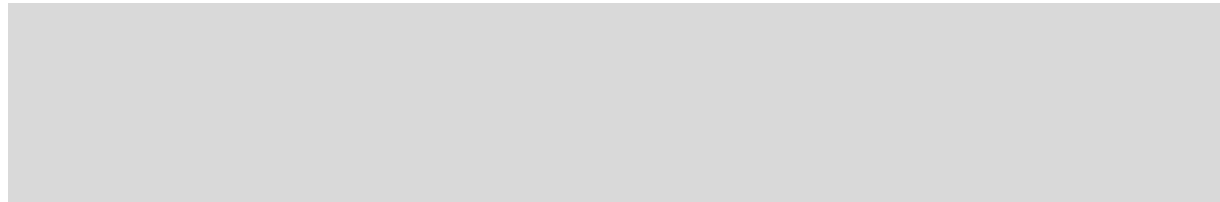
Benefit Deductible

Co-payment

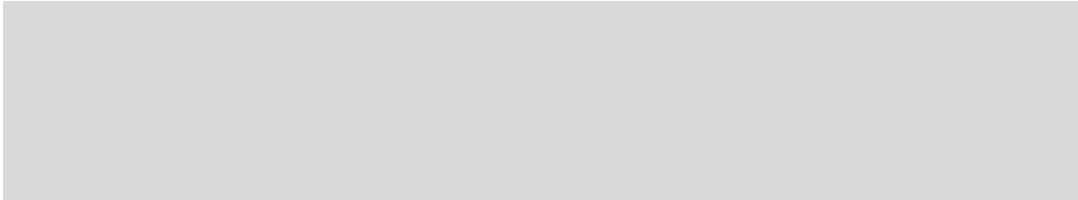
Co-insurance

Monthly Limits

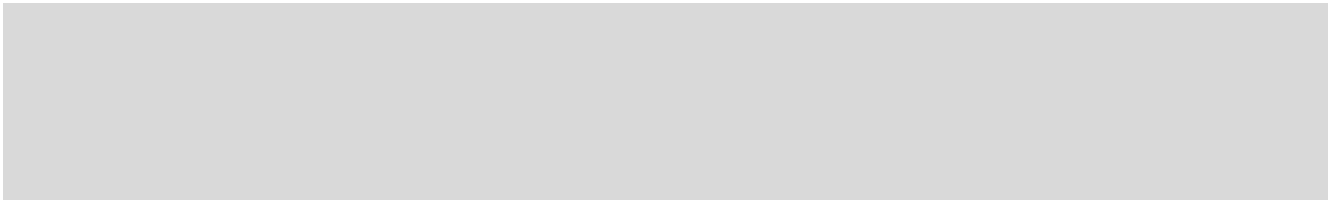
Not Covered



Annual Limits	OOP Limit Applies	Medical Supplies Cost sharing Type Not Covered	Benefit Deductible
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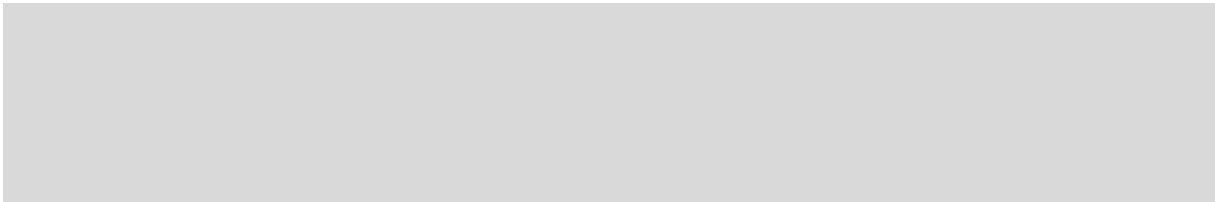


Co-payment Co-insurance Monthly Limits Annual Limits OOP Limit Applies

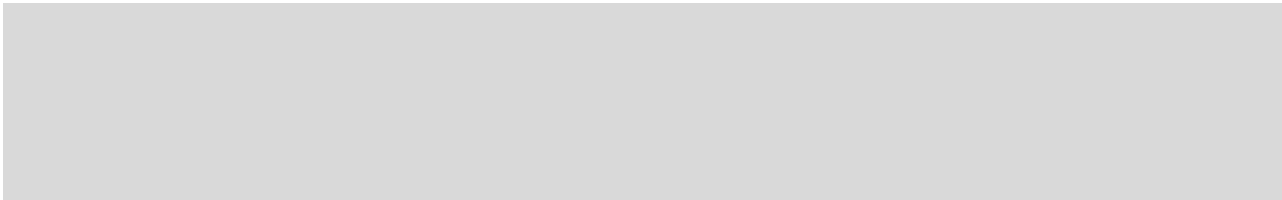


Over-the-counter Medical Supplies

Cost sharing Type	Benefit Deductible	Co-payment	Co-insurance	Monthly Limits
Not Covered				



Annual Limits	OOP Limit Applies	Other Items & Services Cost sharing Type Not Covered	Benefit Deductible
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Co-payment	Co-insurance	Monthly Limits	Annual Limits	OOP Limit Applies	Begin Primary Ca Applies? Applies?
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re Cost-Sharing ABegin Primary Care Cost-Sharing Deductible or Coinsurance After a Set Number of Copays?

Visits Applies? # Visits

Visits No

Summary of Subscriber & Plan Payments

Select Plan:

Summary for Plan 2

Maternity Example

Plan Pays:	\$10,626
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Patient Pays*:	\$2,061
Deductibles	\$1,000
Copayments	\$0
Coinsurance	\$1,000
Exclusions & Limits	\$61

Diabetes Type 2 Example

Plan Pays:	\$3,579
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Patient Pays*:	\$2,022
Deductibles	\$1,950
Copayments	\$50
Coinsurance	\$0
Exclusions & Limits	\$22

Foot Fracture Example

Plan Pays:	\$1,167
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Patient Pays*:	\$1,633
Deductibles	\$1,005
Copayments	\$0
Coinsurance	\$628
Exclusions & Limits	\$0

*Note: Patient Pays Amount is capped at the individual out of pocket limit. Total Amounts may not add up due to rounding.

Claim number	Date	Calendar Month	Item or Service Code	Description
1	01/03/2016	1	14	BD Ultrafine Insulin Syringes /
2	01/03/2016	1	5	OneTouch Delica Lancets (100 p
3	01/03/2016	1	3	OneTouch Delica Lancing Device
4	01/03/2016	1	7	OneTouch Ultra 2 Blood Glucose
5	01/03/2016	1	4	OneTouch Ultra Blue Test Strips
6	01/03/2016	1	6	OneTouch Ultra Control Solution
7	01/03/2016	1	26	Aspirin 81mg (OTC - bottle 100)
8	01/03/2016	1	1	Glucagon Emergency Kit
9	01/03/2016	1	17	Insulin glargine 100 unit/ml inje
10	01/03/2016	1	32	Metformin Hydrochloride 500 M
11	01/03/2016	1	19	Lisinopril 20mg (Rx) [1 QD; #30
12	01/03/2016	1	33	Atorvastatin 40 MG tablet 90 CT
13	01/03/2016	1	13	Assay of Urine Creatinine
14	01/03/2016	1	8	Comprehen Metabolic Panel
15	01/03/2016	1	16	Glycosylated Hemoglobin Test
16	01/03/2016	1	9	Lipid panel
17	01/03/2016	1	12	Microalbumin Quantitative
18	01/03/2016	1	2	Routine Venipuncture
19	01/03/2016	1	24	Office/Outpatient Visit Est
20	01/04/2016	1	21	Diabetes outpatient self-manag
21	01/04/2016	1	20	Med Nutrition Indiv Subseq
22	01/06/2016	1	23	Office/Outpatient Visit New
23	01/07/2016	1	22	Ophthalmological services: med
24	01/31/2016	1	17	Insulin glargine 100 unit/ml inje
25	02/02/2016	2	14	BD Ultrafine Insulin Syringes /
26	02/02/2016	2	32	Metformin Hydrochloride 500 M
27	02/02/2016	2	19	Lisinopril 20mg (Rx) [1 QD; #30
28	02/28/2016	2	17	Insulin glargine 100 unit/ml inje
29	03/04/2016	3	14	BD Ultrafine Insulin Syringes /
30	03/04/2016	3	32	Metformin Hydrochloride 500 M
31	03/04/2016	3	19	Lisinopril 20mg (Rx) [1 QD; #30
32	03/28/2016	3	26	Aspirin 81mg (OTC - bottle 100)
33	03/28/2016	3	17	Insulin glargine 100 unit/ml inje
34	03/28/2016	3	24	Office/Outpatient Visit Est
35	04/03/2016	4	14	BD Ultrafine Insulin Syringes /
36	04/03/2016	4	32	Metformin Hydrochloride 500 M
37	04/03/2016	4	19	Lisinopril 20mg (Rx) [1 QD; #30

38	04/03/2016	4	33	Atorvastatin 40 MG tablet 90 CT
39	04/12/2016	4	5	OneTouch Delica Lancets (100 p
40	04/12/2016	4	4	OneTouch Ultra Blue Test Strips
41	04/25/2016	4	17	Insulin glargine 100 unit/ml inje
42	05/03/2016	5	14	BD Ultrafine Insulin Syringes /
43	05/03/2016	5	32	Metformin Hydrochloride 500 M
44	05/03/2016	5	19	Lisinopril 20mg (Rx) [1 QD; #30
45	05/23/2016	5	17	Insulin glargine 100 unit/ml inje
46	06/02/2016	6	14	BD Ultrafine Insulin Syringes /
47	06/02/2016	6	32	Metformin Hydrochloride 500 M
48	06/02/2016	6	19	Lisinopril 20mg (Rx) [1 QD; #30
49	06/20/2016	6	26	Aspirin 81mg (OTC - bottle 100)
50	06/20/2016	6	17	Insulin glargine 100 unit/ml inje
51	06/27/2016	6	16	Glycosylated Hemoglobin Test
52	06/27/2016	6	2	Routine Venipuncture
53	06/27/2016	6	24	Office/Outpatient Visit Est
54	06/28/2016	6	21	Diabetes outpatient self-manag
55	06/28/2016	6	20	Med Nutrition Indiv Subseq
56	07/02/2016	7	14	BD Ultrafine Insulin Syringes /
57	07/02/2016	7	6	OneTouch Ultra Control Solutio
58	07/02/2016	7	32	Metformin Hydrochloride 500 M
59	07/02/2016	7	19	Lisinopril 20mg (Rx) [1 QD; #30
60	07/02/2016	7	33	Atorvastatin 40 MG tablet 90 CT
61	07/18/2016	7	17	Insulin glargine 100 unit/ml inje
62	07/21/2016	7	5	OneTouch Delica Lancets (100 p
63	07/21/2016	7	4	OneTouch Ultra Blue Test Strips
64	08/01/2016	8	14	BD Ultrafine Insulin Syringes /
65	08/01/2016	8	32	Metformin Hydrochloride 500 M
66	08/01/2016	8	19	Lisinopril 20mg (Rx) [1 QD; #30
67	08/15/2016	8	17	Insulin glargine 100 unit/ml inje
68	08/31/2016	8	14	BD Ultrafine Insulin Syringes /
69	08/31/2016	8	32	Metformin Hydrochloride 500 M
70	08/31/2016	8	19	Lisinopril 20mg (Rx) [1 QD; #30
71	09/12/2016	9	26	Aspirin 81mg (OTC - bottle 100)
72	09/12/2016	9	17	Insulin glargine 100 unit/ml inje
73	09/26/2016	9	24	Office/Outpatient Visit Est
74	09/30/2016	9	14	BD Ultrafine Insulin Syringes /
75	09/30/2016	9	32	Metformin Hydrochloride 500 M
76	09/30/2016	9	19	Lisinopril 20mg (Rx) [1 QD; #30
77	10/03/2016	10	28	Immunization admin each add
78	10/03/2016	10	27	Immunization Admin ADMIN
79	10/03/2016	10	29	Vaccine for pneumococcal polys
80	10/03/2016	10	30	Flu Vaccine No Preserv 3 & >
81	10/03/2016	10	33	Atorvastatin 40 MG tablet 90 CT
82	10/10/2016	10	17	Insulin glargine 100 unit/ml inje

83	10/29/2016	10	5	OneTouch Delica Lancets (100 p
84	10/29/2016	10	4	OneTouch Ultra Blue Test Strips
85	10/30/2016	10	14	BD Ultrafine Insulin Syringes /
86	10/30/2016	10	32	Metformin Hydrochloride 500 N
87	10/30/2016	10	19	Lisinopril 20mg (Rx) [1 QD; #30
88	11/07/2016	11	17	Insulin glargine 100 unit/ml inje
89	11/29/2016	11	14	BD Ultrafine Insulin Syringes /
90	11/29/2016	11	32	Metformin Hydrochloride 500 N
91	11/29/2016	11	19	Lisinopril 20mg (Rx) [1 QD; #30
92	12/05/2016	12	26	Aspirin 81mg (OTC - bottle 100)
93	12/05/2016	12	17	Insulin glargine 100 unit/ml inje
94	12/29/2016	12	14	BD Ultrafine Insulin Syringes /
95	12/29/2016	12	6	OneTouch Ultra Control Solutio
96	12/29/2016	12	32	Metformin Hydrochloride 500 N
97	12/29/2016	12	19	Lisinopril 20mg (Rx) [1 QD; #30

Phase 1

Benefit Category	Cost-sharing type	Allowed amount
Medical Supplies	Not Covered	\$20.62
Medical Supplies	Not Covered	\$8.73
Medical Supplies	Not Covered	\$14.33
Medical Supplies	Not Covered	\$14.70
Medical Supplies	Not Covered	\$109.61
Medical Supplies	Not Covered	\$6.63
Over-the-counter Drugs	Not Covered	\$4.47
Prescription Drugs: Generic	Not Covered	\$241.05
Prescription Drugs: Insulin	Not Covered	\$240.37
Prescription Drugs: Generic	Not Covered	\$3.21
Prescription Drugs: Generic	Not Covered	\$3.38
Prescription Drugs: Generic	Not Covered	\$9.66
Diagnostic Services: Laboratory	Not Covered	\$9.53
Diagnostic Services: Laboratory	Not Covered	\$29.63
Diagnostic Services: Laboratory	Not Covered	\$16.98
Diagnostic Services: Laboratory	Not Covered	\$23.40
Diagnostic Services: Laboratory	Not Covered	\$13.10
Diagnostic Services: Laboratory	Not Covered	\$6.43
Professional Services: Primary Care	Not Covered	\$121.70
Professional Services: Primary Care	Not Covered	\$77.82
Professional Services: Primary Care	Not Covered	\$36.83
Professional Services: Specialist	Not Covered	\$182.19
Professional Services: Specialist	Not Covered	\$118.55
Prescription Drugs: Insulin	Not Covered	\$240.37
Medical Supplies	Not Covered	\$20.62
Prescription Drugs: Generic	Not Covered	\$3.21
Prescription Drugs: Generic	Not Covered	\$3.38
Prescription Drugs: Insulin	Not Covered	\$240.37
Medical Supplies	Not Covered	\$20.62
Prescription Drugs: Generic	Not Covered	\$3.21
Prescription Drugs: Generic	Not Covered	\$3.38
Over-the-counter Drugs	Not Covered	\$4.47
Prescription Drugs: Insulin	Not Covered	\$240.37
Professional Services: Primary Care	Not Covered	\$121.70
Medical Supplies	Not Covered	\$20.62
Prescription Drugs: Generic	Not Covered	\$3.21
Prescription Drugs: Generic	Not Covered	\$3.38

Prescription Drugs: Generic	Not Covered	\$9.66
Medical Supplies	Not Covered	\$8.73
Medical Supplies	Not Covered	\$109.61
Prescription Drugs: Insulin	Not Covered	\$240.37
Medical Supplies	Not Covered	\$20.62
Prescription Drugs: Generic	Not Covered	\$3.21
Prescription Drugs: Generic	Not Covered	\$3.38
Prescription Drugs: Insulin	Not Covered	\$240.37
Medical Supplies	Not Covered	\$20.62
Prescription Drugs: Generic	Not Covered	\$3.21
Prescription Drugs: Generic	Not Covered	\$3.38
Over-the-counter Drugs	Not Covered	\$4.47
Prescription Drugs: Insulin	Not Covered	\$240.37
Diagnostic Services: Laboratory	Not Covered	\$16.98
Diagnostic Services: Laboratory	Not Covered	\$6.43
Professional Services: Primary Care	Not Covered	\$121.70
Professional Services: Primary Care	Not Covered	\$77.82
Professional Services: Primary Care	Not Covered	\$36.83
Medical Supplies	Not Covered	\$20.62
Medical Supplies	Not Covered	\$6.63
Prescription Drugs: Generic	Not Covered	\$3.21
Prescription Drugs: Generic	Not Covered	\$3.38
Prescription Drugs: Generic	Not Covered	\$9.66
Prescription Drugs: Insulin	Not Covered	\$240.37
Medical Supplies	Not Covered	\$8.73
Medical Supplies	Not Covered	\$109.61
Medical Supplies	Not Covered	\$20.62
Prescription Drugs: Generic	Not Covered	\$3.21
Prescription Drugs: Generic	Not Covered	\$3.38
Prescription Drugs: Insulin	Not Covered	\$240.37
Medical Supplies	Not Covered	\$20.62
Prescription Drugs: Generic	Not Covered	\$3.21
Prescription Drugs: Generic	Not Covered	\$3.38
Over-the-counter Drugs	Not Covered	\$4.47
Prescription Drugs: Insulin	Not Covered	\$240.37
Professional Services: Primary Care	Not Covered	\$121.70
Medical Supplies	Not Covered	\$20.62
Prescription Drugs: Generic	Not Covered	\$3.21
Prescription Drugs: Generic	Not Covered	\$3.38
Preventive Services & Vaccines	Not Covered	\$15.88
Preventive Services & Vaccines	Not Covered	\$28.31
Preventive Services & Vaccines	Not Covered	\$93.74
Preventive Services & Vaccines	Not Covered	\$21.02
Prescription Drugs: Generic	Not Covered	\$9.66
Prescription Drugs: Insulin	Not Covered	\$240.37

Medical Supplies	Not Covered	\$8.73
Medical Supplies	Not Covered	\$109.61
Medical Supplies	Not Covered	\$20.62
Prescription Drugs: Generic	Not Covered	\$3.21
Prescription Drugs: Generic	Not Covered	\$3.38
Prescription Drugs: Insulin	Not Covered	\$240.37
Medical Supplies	Not Covered	\$20.62
Prescription Drugs: Generic	Not Covered	\$3.21
Prescription Drugs: Generic	Not Covered	\$3.38
Over-the-counter Drugs	Not Covered	\$4.47
Prescription Drugs: Insulin	Not Covered	\$240.37
Medical Supplies	Not Covered	\$20.62
Medical Supplies	Not Covered	\$6.63
Prescription Drugs: Generic	Not Covered	\$3.21
Prescription Drugs: Generic	Not Covered	\$3.38

: Determine Covered Amount		Phase 2: Apply OOP Limit			
Service Not covered	Remaining Covered Amount	OPL Valid?	OPL applies	OPL	Remaining OPL after previous subscriber payments
\$20.62	-	-	No.		N/A
\$8.73	-	-	No.		N/A
\$14.33	-	-	No.		N/A
\$14.70	-	-	No.		N/A
\$109.61	-	-	No.		N/A
\$6.63	-	-	No.		N/A
\$4.47	-	-	No.		N/A
\$241.05	-	-	No.		N/A
\$240.37	-	-	No.		N/A
\$3.21	-	-	No.		N/A
\$3.38	-	-	No.		N/A
\$9.66	-	-	No.		N/A
\$9.53	-	-	No.		N/A
\$29.63	-	-	No.		N/A
\$16.98	-	-	No.		N/A
\$23.40	-	-	No.		N/A
\$13.10	-	-	No.		N/A
\$6.43	-	-	No.		N/A
\$121.70	-	-	No.		N/A
\$77.82	-	-	No.		N/A
\$36.83	-	-	No.		N/A
\$182.19	-	-	No.		N/A
\$118.55	-	-	No.		N/A
\$240.37	-	-	No.		N/A
\$20.62	-	-	No.		N/A
\$3.21	-	-	No.		N/A
\$3.38	-	-	No.		N/A
\$240.37	-	-	No.		N/A
\$20.62	-	-	No.		N/A
\$3.21	-	-	No.		N/A
\$3.38	-	-	No.		N/A
\$4.47	-	-	No.		N/A
\$240.37	-	-	No.		N/A
\$121.70	-	-	No.		N/A
\$20.62	-	-	No.		N/A
\$3.21	-	-	No.		N/A
\$3.38	-	-	No.		N/A

\$9.66	-	-	No.	N/A
\$8.73	-	-	No.	N/A
\$109.61	-	-	No.	N/A
\$240.37	-	-	No.	N/A
\$20.62	-	-	No.	N/A
\$3.21	-	-	No.	N/A
\$3.38	-	-	No.	N/A
\$240.37	-	-	No.	N/A
\$20.62	-	-	No.	N/A
\$3.21	-	-	No.	N/A
\$3.38	-	-	No.	N/A
\$4.47	-	-	No.	N/A
\$240.37	-	-	No.	N/A
\$16.98	-	-	No.	N/A
\$6.43	-	-	No.	N/A
\$121.70	-	-	No.	N/A
\$77.82	-	-	No.	N/A
\$36.83	-	-	No.	N/A
\$20.62	-	-	No.	N/A
\$6.63	-	-	No.	N/A
\$3.21	-	-	No.	N/A
\$3.38	-	-	No.	N/A
\$9.66	-	-	No.	N/A
\$240.37	-	-	No.	N/A
\$8.73	-	-	No.	N/A
\$109.61	-	-	No.	N/A
\$20.62	-	-	No.	N/A
\$3.21	-	-	No.	N/A
\$3.38	-	-	No.	N/A
\$240.37	-	-	No.	N/A
\$20.62	-	-	No.	N/A
\$3.21	-	-	No.	N/A
\$3.38	-	-	No.	N/A
\$4.47	-	-	No.	N/A
\$240.37	-	-	No.	N/A
\$121.70	-	-	No.	N/A
\$20.62	-	-	No.	N/A
\$3.21	-	-	No.	N/A
\$3.38	-	-	No.	N/A
\$15.88	-	-	No.	N/A
\$28.31	-	-	No.	N/A
\$93.74	-	-	No.	N/A
\$21.02	-	-	No.	N/A
\$9.66	-	-	No.	N/A
\$240.37	-	-	No.	N/A

\$8.73	-	-	No.	N/A
\$109.61	-	-	No.	N/A
\$20.62	-	-	No.	N/A
\$3.21	-	-	No.	N/A
\$3.38	-	-	No.	N/A
\$240.37	-	-	No.	N/A
\$20.62	-	-	No.	N/A
\$3.21	-	-	No.	N/A
\$3.38	-	-	No.	N/A
\$4.47	-	-	No.	N/A
\$240.37	-	-	No.	N/A
\$20.62	-	-	No.	N/A
\$6.63	-	-	No.	N/A
\$3.21	-	-	No.	N/A
\$3.38	-	-	No.	N/A

Phase 3a: Apply Special cost sharing - Begin Primary Care cost-sharing after a set number of visits

Primary Care Visit?	Begin Primary Care Cost-Sharing After A Set Number of Visits?	# Visits	Primary Care Prior Use	Visit Covered at 100% by plan
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
\$1.00	.	N/A		0
\$1.00	.	N/A		1
\$1.00	.	N/A		2
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
\$1.00	.	N/A		3
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-
-	N/A	N/A	N/A	-

Phase 4: Apply monthly/annual limit

Monthly Limit Valid?	Monthly limit	Prior use (month)	Not Covered because monthly limit exceeded	Annual Limit Valid?	Annual limit	Prior use (annual)
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	1	N/A	-	.	1
-	.	-	N/A	-	.	1
-	.	-	N/A	-	.	1
-	.	-	N/A	-	.	1
-	.	-	N/A	-	.	2
-	.	-	N/A	-	.	2
-	.	-	N/A	-	.	2
-	.	-	N/A	-	.	2
-	.	-	N/A	-	.	1
-	.	-	N/A	-	.	3
-	.	-	N/A	-	.	1
-	.	-	N/A	-	.	3
-	.	-	N/A	-	.	3
-	.	-	N/A	-	.	3

-.	-	N/A	-.	1
-.	-	N/A	-.	1
-.	-	N/A	-.	1
-.	-	N/A	-.	4
-.	-	N/A	-.	4
-.	-	N/A	-.	4
-.	-	N/A	-.	4
-.	-	N/A	-.	5
-.	-	N/A	-.	5
-.	-	N/A	-.	5
-.	-	N/A	-.	5
-.	-	N/A	-.	2
-.	-	N/A	-.	6
-.	-	N/A	-.	1
-.	-	N/A	-.	1
-.	-	N/A	-.	2
-.	-	N/A	-.	1
-.	-	N/A	-.	1
-.	-	N/A	-.	6
-.	-	N/A	-.	1
-.	-	N/A	-.	6
-.	-	N/A	-.	6
-.	-	N/A	-.	2
-.	-	N/A	-.	7
-.	-	N/A	-.	2
-.	-	N/A	-.	2
-.	-	N/A	-.	7
-.	-	N/A	-.	7
-.	-	N/A	-.	7
-.	-	N/A	-.	8
-.	1	N/A	-.	8
-.	1	N/A	-.	8
-.	1	N/A	-.	8
-.	-	N/A	-.	3
-.	-	N/A	-.	9
-.	-	N/A	-.	3
-.	-	N/A	-.	9
-.	-	N/A	-.	9
-.	-	N/A	-.	9
-.	-	N/A	-.	-
-.	-	N/A	-.	-
-.	-	N/A	-.	-
-.	-	N/A	-.	3
-.	-	N/A	-.	10

-.	-	N/A	-.	3
-.	-	N/A	-.	3
-.	-	N/A	-.	10
-.	-	N/A	-.	10
-.	-	N/A	-.	10
-.	-	N/A	-.	11
-.	-	N/A	-.	11
-.	-	N/A	-.	11
-.	-	N/A	-.	11
-.	-	N/A	-.	11
-.	-	N/A	-.	4
-.	-	N/A	-.	12
-.	-	N/A	-.	12
-.	-	N/A	-.	2
-.	-	N/A	-.	12
-.	-	N/A	-.	12

Phase 8: Summarize payments by payer and phase category					
Service Not covered	Exclusions	Subscriber-paid deductible	Subscriber-paid copayment	Subscriber-paid coinsurance	Allowable Charge ChkSum
\$20.62	-	-	-	-	1
\$8.73	-	-	-	-	1
\$14.33	-	-	-	-	1
\$14.70	-	-	-	-	1
\$109.61	-	-	-	-	1
\$6.63	-	-	-	-	1
\$4.47	-	-	-	-	1
\$241.05	-	-	-	-	1
\$240.37	-	-	-	-	1
\$3.21	-	-	-	-	1
\$3.38	-	-	-	-	1
\$9.66	-	-	-	-	1
\$9.53	-	-	-	-	1
\$29.63	-	-	-	-	1
\$16.98	-	-	-	-	1
\$23.40	-	-	-	-	1
\$13.10	-	-	-	-	1
\$6.43	-	-	-	-	1
\$121.70	-	-	-	-	1
\$77.82	-	-	-	-	1
\$36.83	-	-	-	-	1
\$182.19	-	-	-	-	1
\$118.55	-	-	-	-	1
\$240.37	-	-	-	-	1
\$20.62	-	-	-	-	1
\$3.21	-	-	-	-	1
\$3.38	-	-	-	-	1
\$240.37	-	-	-	-	1
\$20.62	-	-	-	-	1
\$3.21	-	-	-	-	1
\$3.38	-	-	-	-	1
\$4.47	-	-	-	-	1
\$240.37	-	-	-	-	1
\$121.70	-	-	-	-	1
\$20.62	-	-	-	-	1
\$3.21	-	-	-	-	1
\$3.38	-	-	-	-	1

\$9.66	-	-	-	-	1
\$8.73	-	-	-	-	1
\$109.61	-	-	-	-	1
\$240.37	-	-	-	-	1
\$20.62	-	-	-	-	1
\$3.21	-	-	-	-	1
\$3.38	-	-	-	-	1
\$240.37	-	-	-	-	1
\$20.62	-	-	-	-	1
\$3.21	-	-	-	-	1
\$3.38	-	-	-	-	1
\$4.47	-	-	-	-	1
\$240.37	-	-	-	-	1
\$16.98	-	-	-	-	1
\$6.43	-	-	-	-	1
\$121.70	-	-	-	-	1
\$77.82	-	-	-	-	1
\$36.83	-	-	-	-	1
\$20.62	-	-	-	-	1
\$6.63	-	-	-	-	1
\$3.21	-	-	-	-	1
\$3.38	-	-	-	-	1
\$9.66	-	-	-	-	1
\$240.37	-	-	-	-	1
\$8.73	-	-	-	-	1
\$109.61	-	-	-	-	1
\$20.62	-	-	-	-	1
\$3.21	-	-	-	-	1
\$3.38	-	-	-	-	1
\$240.37	-	-	-	-	1
\$20.62	-	-	-	-	1
\$3.21	-	-	-	-	1
\$3.38	-	-	-	-	1
\$4.47	-	-	-	-	1
\$240.37	-	-	-	-	1
\$121.70	-	-	-	-	1
\$20.62	-	-	-	-	1
\$3.21	-	-	-	-	1
\$3.38	-	-	-	-	1
\$15.88	-	-	-	-	1
\$28.31	-	-	-	-	1
\$93.74	-	-	-	-	1
\$21.02	-	-	-	-	1
\$9.66	-	-	-	-	1
\$240.37	-	-	-	-	1

\$8.73	-	-	-	-	1
\$109.61	-	-	-	-	1
\$20.62	-	-	-	-	1
\$3.21	-	-	-	-	1
\$3.38	-	-	-	-	1
\$240.37	-	-	-	-	1
\$20.62	-	-	-	-	1
\$3.21	-	-	-	-	1
\$3.38	-	-	-	-	1
\$4.47	-	-	-	-	1
\$240.37	-	-	-	-	1
\$20.62	-	-	-	-	1
\$6.63	-	-	-	-	1
\$3.21	-	-	-	-	1
\$3.38	-	-	-	-	1

Claim number	Date	Calendar Month	Item or Service Code	Description
1	06/02/2016	6	2	Ground mileage, per statute mi
2	06/02/2016	6	18	Ambulance service, basic life s
3	06/02/2016	6	4	Emergency department visit for
4	06/02/2016	6	5	Radiologic examination, foot; c
5	06/02/2016	6	6	Closed treatment of metatarsal
6	06/02/2016	6	19	Walking boot, pneumatic and/o
7	06/02/2016	6	9	Crutches, underarm, other than
8	06/02/2016	6	8	Week supply of Acetaminophen
9	06/09/2016	6	11	Office or other outpatient visit
10	06/09/2016	6	7	Radiologic examination, foot; c
11	06/09/2016	6	12	Application of short leg cast (be
12	06/09/2016	6	13	Cast supplies, short leg cast, adu
13	07/14/2016	7	14	X-ray of ankle, minimum of 3 vi
14	07/14/2016	7	15	Office or other outpatient visit
15	08/04/2016	8	16	Physical therapy evaluation
16	08/11/2016	8	17	Therapeutic procedure, 1 or mo
17	08/11/2016	8	17	Therapeutic procedure, 1 or mo
18	08/18/2016	8	17	Therapeutic procedure, 1 or mo

Phase 1

Benefit Category	Cost-sharing type	Allowed amount
Ambulance	Not Covered	\$161.71
Ambulance	Not Covered	\$782.16
Emergency Department (Facility)	Not Covered	\$357.31
Professional Services: Emergency Department	Not Covered	\$49.72
Professional Services: Emergency Department	Not Covered	\$335.16
Durable Medical Equipment	Not Covered	\$211.56
Durable Medical Equipment	Not Covered	\$35.97
Prescription Drugs: Generic	Not Covered	\$5.24
Professional Services: Specialist	Not Covered	\$127.51
Diagnostic Services: Radiology	Not Covered	\$49.72
Professional Services: Specialist	Not Covered	\$132.03
Other Facility Services	Not Covered	\$43.22
Diagnostic Services: Radiology	Not Covered	\$63.18
Professional Services: Specialist	Not Covered	\$81.66
Professional Services: Physical Therapy	Not Covered	\$116.43
Professional Services: Physical Therapy	Not Covered	\$82.53
Professional Services: Physical Therapy	Not Covered	\$82.53
Professional Services: Physical Therapy	Not Covered	\$82.53

: Determine Covered Amount		Phase 2: Apply OOP Limit			
Service Not covered	Remaining Covered Amount	OPL Valid?	OPL applies	OPL	Remaining OPL after previous subscriber payments
\$161.71	-	-	No.		N/A
\$782.16	-	-	No.		N/A
\$357.31	-	-	No.		N/A
\$49.72	-	-	No.		N/A
\$335.16	-	-	No.		N/A
\$211.56	-	-	No.		N/A
\$35.97	-	-	No.		N/A
\$5.24	-	-	No.		N/A
\$127.51	-	-	No.		N/A
\$49.72	-	-	No.		N/A
\$132.03	-	-	No.		N/A
\$43.22	-	-	No.		N/A
\$63.18	-	-	No.		N/A
\$81.66	-	-	No.		N/A
\$116.43	-	-	No.		N/A
\$82.53	-	-	No.		N/A
\$82.53	-	-	No.		N/A
\$82.53	-	-	No.		N/A

sits?	Phase 3b: Apply special cost sharing: Begin primary care c			
Remaining Covered Amount	Primary Care Visit?	Begin Primary Care Cost-Sharing Deductible or Coinsurance After a Set Number of Copays?	# Visits	Primary Care Prior Copay Paid
\$0.00		- N/A	N/A	N/A
-		- N/A	N/A	N/A
-		- N/A	N/A	N/A
-		- N/A	N/A	N/A
-		- N/A	N/A	N/A
-		- N/A	N/A	N/A
-		- N/A	N/A	N/A
-		- N/A	N/A	N/A
-		- N/A	N/A	N/A
-		- N/A	N/A	N/A
-		- N/A	N/A	N/A
-		- N/A	N/A	N/A
-		- N/A	N/A	N/A
-		- N/A	N/A	N/A
-		- N/A	N/A	N/A
-		- N/A	N/A	N/A
-		- N/A	N/A	N/A

Phase 4: Apply monthly/annual limit

Monthly Limit Valid?	Monthly limit	Prior use (month)	Not Covered because monthly limit exceeded	Annual Limit Valid?	Annual limit	Prior use (annual)
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	-	N/A	-	.	-
-	.	1	N/A	-	.	1
-	.	2	N/A	-	.	2

Phase 8: Summarize payments by payer and phase category					
Service Not covered	Exclusions	Subscriber-paid deductible	Subscriber-paid copayment	Subscriber-paid coinsurance	Allowable Charge ChkSum
\$161.71	-	-	-	-	1
\$782.16	-	-	-	-	1
\$357.31	-	-	-	-	1
\$49.72	-	-	-	-	1
\$335.16	-	-	-	-	1
\$211.56	-	-	-	-	1
\$35.97	-	-	-	-	1
\$5.24	-	-	-	-	1
\$127.51	-	-	-	-	1
\$49.72	-	-	-	-	1
\$132.03	-	-	-	-	1
\$43.22	-	-	-	-	1
\$63.18	-	-	-	-	1
\$81.66	-	-	-	-	1
\$116.43	-	-	-	-	1
\$82.53	-	-	-	-	1
\$82.53	-	-	-	-	1
\$82.53	-	-	-	-	1