**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services **Coverage Period: 01/01/2022 – 12/31/2022**

# Picture of exclamation point to label important information. Insurance Company 1: Plan Option 1 Coverage for: Family | Plan Type: PPO

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| **The Summary of Benefits and Coverage (SBC) document will help you choose a health** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**. The SBC shows you how you and the** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **would share the cost for covered health care services. NOTE: Information about the cost of this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **(called the** [**premium**](https://www.healthcare.gov/sbc-glossary/#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, [insert contact information]. For definitions of common terms, such as [allowed amount](https://www.healthcare.gov/sbc-glossary/#allowed-amount), [balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing), [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance), [copayment](https://www.healthcare.gov/sbc-glossary/#copayment), [deductible](https://www.healthcare.gov/sbc-glossary/#deductible)[, provider](https://www.healthcare.gov/sbc-glossary/#provider), or other underlined terms see the Glossary. You can view the Glossary at [www.](http://www/)[insert].com or call 1-800-[insert] to request a copy. |
| **Important Questions** | **Answers** | **Why This Matters** |
| **What is the overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | $500/Individual or $1,000/family | Generally, you must pay all of the costs from providers up to the [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount before this [plan](https://www.healthcare.gov/sbc-glossary/#plan) begins to pay. If you have other family members on the [plan,](https://www.healthcare.gov/sbc-glossary/#plan) each family member must meet their own individual [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) until the total amount of [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) expenses paid by all family members meets the overall family [deductible](https://www.healthcare.gov/sbc-glossary/#deductible). |
| **Are there services covered before you meet your** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | Yes. [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care) and primary care services are covered before you meet your [deductible.](https://www.healthcare.gov/sbc-glossary/#deductible) | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers some items and services even if you haven’t yet met the [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount. But a [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) or [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) may apply. For example, this [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers certain [preventive](https://www.healthcare.gov/sbc-glossary/#preventive-care) [services](https://www.healthcare.gov/sbc-glossary/#preventive-care) without [cost-sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) and before you meet your [deductible.](https://www.healthcare.gov/sbc-glossary/#deductible) See a list of covered [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care) at [https://www.healthcare.gov/coverage/preventive-care-benefits/.](https://www.healthcare.gov/coverage/preventive-care-benefits/) |
| **Are there other** [**deductibles**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | Yes. $300 for [prescription drug](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) [coverage](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) and $300 for occupational therapy services. | You must pay all of the costs for these services up to the specific [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount before this [plan](https://www.healthcare.gov/sbc-glossary/#plan) begins to pay for these services. |
| **What is the** [**out-of-pocket**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)[**limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) **for this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**?** | For [network providers](https://www.healthcare.gov/sbc-glossary/#network-provider) $2,500 individual / $5,000 family; for [out-](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) [of-network providers](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) $4,000 individual / $8,000 family | The [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) is the most you could pay in a year for covered services. If you have other family members in this [plan,](https://www.healthcare.gov/sbc-glossary/#plan) they have to meet their own [out-of-pocket limits](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) until the overall family [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) has been met. |
| **What is not included in the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)**?** | [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) for certain services, [premiums,](https://www.healthcare.gov/sbc-glossary/#premium) [balance-billing](https://www.healthcare.gov/sbc-glossary/#balance-billing) charges, and health care this [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn’t cover. | Even though you pay these expenses, they don’t count toward the [out–of–pocket limit.](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) |
| **Will you pay less if you use a** [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** | Yes. See [www.](http://www/)[insert].com or call 1-800-[insert] for a list of [network](https://www.healthcare.gov/sbc-glossary/#network-provider) [providers.](https://www.healthcare.gov/sbc-glossary/#network-provider) | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) uses a provider [network.](https://www.healthcare.gov/sbc-glossary/#network) You will pay less if you use a [provider](https://www.healthcare.gov/sbc-glossary/#provider) in the plan’s [network.](https://www.healthcare.gov/sbc-glossary/#network) You will pay the most if you use an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider), and you might receive a bill from a [provider](https://www.healthcare.gov/sbc-glossary/#provider) for the difference between the provider’s charge and what your [plan](https://www.healthcare.gov/sbc-glossary/#plan) pays [(balance](https://www.healthcare.gov/sbc-glossary/#balance-billing) [billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). Be aware, your [network provider](https://www.healthcare.gov/sbc-glossary/#network-provider) might use an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) for some services (such as lab work). Check with your [provider](https://www.healthcare.gov/sbc-glossary/#provider) before you get services. |
| **Do you need a** [**referral**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)**?** | Yes. | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) will pay some or all of the costs to see a [specialist](https://www.healthcare.gov/sbc-glossary/#specialist) for covered services but only if you have a [referral](https://www.healthcare.gov/sbc-glossary/#referral) before you see the [specialist.](https://www.healthcare.gov/sbc-glossary/#specialist) |

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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| important iconAll [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) and [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) costs shown in this chart are after your [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) has been met, if a [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) applies. |

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| Blank cell | **What You Will Pay:** | Blank cell |
| **Common Medical Event** | **Services You May Need** | **Network Provider****(You will pay the least)** | **Out-of-Network Provider****(You will pay the most)** | **Limitations, Exceptions, & Other****Important Information** |

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| **If you visit a health care** [**provider’s**](https://www.healthcare.gov/sbc-glossary/#provider) **office or clinic** | Primary care visit to treat an injury or illness | $35 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/office visit and 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) for other outpatient services; [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | None |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit | $50 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment)visit | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required. If you don't get [preauthorization,](https://www.healthcare.gov/sbc-glossary/#preauthorization) benefits could be reduced by 50% of the total cost of the service. |
| [Preventive](https://www.healthcare.gov/sbc-glossary/#preventive-care) [care](https://www.healthcare.gov/sbc-glossary/#preventive-care)[/screening/](https://www.healthcare.gov/sbc-glossary/#screening)immunization | No charge | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | You may have to pay for services that aren’t [preventive](https://www.healthcare.gov/sbc-glossary/#preventive-care). Ask your [provider](https://www.healthcare.gov/sbc-glossary/#provider) if the services you need are preventive. Then check what your [plan](https://www.healthcare.gov/sbc-glossary/#plan) will pay for. |
| **If you have a test** | [Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (x-ray, blood work) | $10 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/test | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | None |
| Imaging (CT/PET scans, MRIs) | $50 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/test | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| **If you need drugs to treat your illness or condition More information about** [**prescription drug coverage**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) **is available at** [**www.[i**](http://www/)**nsert].com** | Generic drugs (Tier 1) | $10 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment)prescription (retail & mail order) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). |
| Preferred brand drugs (Tier 2) | $30 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment)prescription (retail & mail order) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| Non-preferred brand drugs (Tier 3) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 60% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) (Tier 4) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 70% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $100/day [copay](https://www.healthcare.gov/sbc-glossary/#copayment) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required. If you don't get [preauthorization,](https://www.healthcare.gov/sbc-glossary/#preauthorization) benefits could be reduced by 50% of the total cost of the service. |
| Physician/surgeon fees | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) for anesthesia. |
| **If you need immediate medical attention** | [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | None |
| [Emergency medical transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) | $30 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| **If you have a hospital stay** | Facility Fee (e.g., hospital room) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required. If you don't get [preauthorization,](https://www.healthcare.gov/sbc-glossary/#preauthorization) benefits could be reduced by 50% of the total cost of the service. |

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| Blank cell | **What You Will Pay:** | Blank cell |
| **Common Medical Event** | **Services You May Need** | **Network Provider****(You will pay the least)** | **Out-of-Network Provider****(You will pay the most)** | **Limitations, Exceptions, & Other****Important Information** |

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| **If you have a hospital stay** | Physician/surgeon fees | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) for anesthesia |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $35 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/office visit and 20% [coinsuranc](https://www.healthcare.gov/sbc-glossary/#coinsurance)e for other outpatient services | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | None |
| Inpatient services | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| **If you are pregnant** | Office visits | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) does not apply to certain [preventive services.](https://www.healthcare.gov/sbc-glossary/#preventive-care) Depending on the type of services, [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| Childbirth/delivery professional services | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| Childbirth/delivery facility services | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| **If you need help recovering or have other special needs** | [Home health care](https://www.healthcare.gov/sbc-glossary/#home-health-care) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 60 visits/year |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 60 visits/year. Includes physical therapy, speech therapy, and occupational therapy. |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 60 visits/calendar year |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required. If you don't get [preauthorization,](https://www.healthcare.gov/sbc-glossary/#preauthorization) benefits could be reduced by 50% of the total cost of the service. |
| **If your child needs dental or eye care** | Children’s eye exam | $35 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment)visit | Not covered | Coverage limited to one exam/year. |
| Children’s glasses | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Not covered | Coverage limited to one pair of glasses/year. |
| Children’s dental checkups | No charge | Not covered | None |

**Excluded Services & Other Covered Services**

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| **Services Your** [**Plan**](https://www.healthcare.gov/sbc-glossary/#plan) **Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services)**.)** |
| * Cosmetic Surgery
* Dental Care
* Infertility Treatment
 | * Long Term Care
* Non-emergency care when traveling outside the U.S.
* Private Duty Nursing
 | * Routine eye care (Adult)
* Routine Foot Care
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| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document.)** |
| * Acupuncture (if prescribed for rehabilitation purposes)
* Bariatric Surgery
 | * Chiropractic Care
* Hearing Aids
 | * Weight Loss Programs
 |

**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: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace). For more information about the [Marketplace,](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#plan) for a denial of a [claim.](https://www.healthcare.gov/sbc-glossary/#claim) This complaint is called a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) or [appeal.](https://www.healthcare.gov/sbc-glossary/#appeal) For more information about your rights, look at the explanation of benefits you will receive for that medical [claim.](https://www.healthcare.gov/sbc-glossary/#claim) Your [plan](https://www.healthcare.gov/sbc-glossary/#plan) documents also provide complete information on how to submit a [claim,](https://www.healthcare.gov/sbc-glossary/#claim) [appeal,](https://www.healthcare.gov/sbc-glossary/#appeal) or a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) for any reason to your [plan.](https://www.healthcare.gov/sbc-glossary/#plan) For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

# Does this plan provide Minimum Essential Coverage? [Yes/No]

[Minimum Essential Coverage](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage), you may not be eligible for the premium tax credit.

# Does this plan meet the Minimum Value Standards? [Yes/No/Not Applicable]

If your [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn’t meet the [Minimum Value Standards](https://www.healthcare.gov/sbc-glossary/#minimum-value-standard), you may be eligible for a [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits) to help you pay for a [plan](https://www.healthcare.gov/sbc-glossary/#plan) through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace).

# Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].] [Chinese (中文): 如果需要中文的帮助，请拨打这个号码[insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

***To see examples of how this plan might cover costs for a sample medical situation, see the next section.***

**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number.  The valid OMB control number for this information collection is **0938-1146**.  The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection.  If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports ClearanceOfficer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

# About these Coverage Examples

**This is not a cost estimator.** Treatments shown are just examples of how this [plan](https://www.healthcare.gov/sbc-glossary/#plan) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](https://www.healthcare.gov/sbc-glossary/#provider) charge, and many other factors. Focus on the [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) amounts ([deductibles,](https://www.healthcare.gov/sbc-glossary/#deductible) [copayments](https://www.healthcare.gov/sbc-glossary/#copayment) and [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance)) and [excluded services](https://www.healthcare.gov/sbc-glossary/#excluded-services) under the [plan.](https://www.healthcare.gov/sbc-glossary/#plan) Use this information to compare the portion of costs you might pay under different health [plans](https://www.healthcare.gov/sbc-glossary/#plan). 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)

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

**Mia’s Simple Fracture**

(in-network emergency room visit and follow up care)

* The [plan's](https://www.healthcare.gov/sbc-glossary/#plan) overall [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) $500
* [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) $50
* Hospital (facility) [cost sharing] 20%
* Other [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) 20%

**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*)

* The [plan's](https://www.healthcare.gov/sbc-glossary/#plan) overall [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) $500
* [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) $50
* Hospital (facility) [cost sharing] 20%
* Other [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) 20%

**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*)

* The [plan's](https://www.healthcare.gov/sbc-glossary/#plan) overall [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) $500
* [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) $50
* Hospital (facility) [cost sharing] 20%
* Other [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) 20%

**This EXAMPLE event includes services like:** Emergency room care (*including medical supplies*)

Diagnostic test (*x-ray*)

Durable medical equipment (*crutches*) Rehabilitation services (*physical therapy*)

**Total Example Cost $12,700**

**Total Example Cost $5,600**

**Total Example Cost $2,800**

# In this example, Peg would pay:

**In this example, Joe would pay:**

**In this example, Mia would pay:**

*Cost Sharing*

*Cost Sharing*

*Cost Sharing*

Deductibles $500

Copayments $300

Coinsurance $2,300

Deductibles $800

Copayments $1,200

Coinsurance $300

Deductibles $700

Copayments $50

Coinsurance $300

*What isn’t covered*

*What isn’t covered*

*What isn’t covered*

Limits or exclusions $60

Limits or exclusions $60

Limits or exclusions $0

**The total Peg would pay is $3,160**

**The total Joe would pay is $2,360**

**The total Mia would pay is $1,050**

Note: These numbers assume the patient does not participate in the [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) wellness program. If you participate in the [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert].

\*Note: This plan has other [deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) for specific services included in this coverage example. See "Are there other deductibles for specific services?” row above.

[The [plan](https://www.healthcare.gov/sbc-glossary/#urgent-care) would be responsible for the other costs of these EXAMPLE covered services.]