



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, go to [www.culinaryhealthfund.org](http://www.culinaryhealthfund.org) or call 702-733-9938 or 1-800-457-8512. 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.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or [www.cciio.cms.gov](http://www.cciio.cms.gov) or [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-800-457-8512 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                                                                                                                               | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$0.00                                                                                                                                                                                                                                                                                                                                                                                | See the Common Medical Events chart below for your costs for services this plan covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Not Applicable                                                                                                                                                                                                                                                                                                                                                                        | Not Applicable                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 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> ? | \$6,350 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 plan, they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                                      |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Dental <a href="#">copayments</a> , expenses incurred out of network unless the Plan Administrator allows coverage at PPO rates provided an eligible person obtains prior authorization and the medical procedure is not available in the Las Vegas area, <a href="#">premiums</a> , <a href="#">balance billing</a> charges, and healthcare 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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.culinaryhealthfund.org">www.culinaryhealthfund.org</a> or call 702-733-9938 or 1-800-457-8512.                                                                                                                                                                                                                                                           | This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's PPO <a href="#">network</a> . You will pay the most if you use a Non-PPO <a href="#">provider</a> , and you might receive a bill from a Non-PPO <a href="#">provider</a> for the difference between the Non-PPO <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your PPO network <a href="#">provider</a> might use a Non-PPO provider for some services (such as labwork). 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                                                                                                                                                                                                                                                                                                  |
|------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                        |                                                        | PPO Provider<br>(You will pay the least)                                                                                                                                                                                                                                                                                                                 | Non-PPO Provider<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       | \$0 <a href="#">copay</a> /visit at Culinary Health Center                                                                                                                                                                                                                                                                                               | Not covered                                 | Las Vegas metropolitan area residents: Adult care must be provided at Culinary Health Center.                                                                                                                                                                                                                                                           |
|                                                                        |                                                        | \$25 <a href="#">copay</a> /visit - pediatric or adult care (see Limitations, Exceptions, & Other Information)                                                                                                                                                                                                                                           |                                             | Residents of Tonopah, Pahrump, Mesquite, Laughlin, Logandale only: Adult care can be provided at Culinary Health Center or with a PPO provider.                                                                                                                                                                                                         |
|                                                                        | <a href="#">Specialist</a> visit                       | \$40 <a href="#">copay</a> /visit                                                                                                                                                                                                                                                                                                                        | Not covered                                 | —————none—————                                                                                                                                                                                                                                                                                                                                          |
|                                                                        | <a href="#">Preventive care/screening/immunization</a> | No charge                                                                                                                                                                                                                                                                                                                                                | Not covered                                 | Refer to <a href="http://www.healthcare.gov">www.healthcare.gov</a> for a complete list of covered preventive health services.                                                                                                                                                                                                                          |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)    | <b>XRAY:</b><br>\$20 <a href="#">copay</a> /visit at freestanding facility<br>\$30 <a href="#">copay</a> /visit in dr's office<br>\$45 <a href="#">copay</a> /visit in hospital outpatient<br><b>BLOOD WORK:</b><br>\$0 <a href="#">copay</a> /visit at freestanding facility or in dr's office<br>\$15 <a href="#">copay</a> /visit hospital outpatient | Not covered                                 | Some services require prior authorization and will not be covered without such authorization.<br><br><a href="#">Copay</a> for bloodwork done in an outpatient department of a hospital applies to hospital based pre-operative or diagnostic services only.<br><br>No <a href="#">copay</a> for X-rays or lab work done at the Culinary Health Center. |
|                                                                        | Imaging (CT/PET scans, MRIs)                           | <b>CT/MRI/MRA:</b><br>\$125 <a href="#">copay</a> /visit<br><b>PET/PET CT:</b><br>\$175 <a href="#">copay</a> /visit at free-standing facility<br><b>PET/PET CT:</b><br>\$225 <a href="#">copay</a> /visit in dr's office or hospital outpatient                                                                                                         | Not covered                                 | Some services require prior authorization and will not be covered without such authorization.<br><br>No <a href="#">copay</a> for ultrasounds, bone density tests, and CT scans with contrast done at the Culinary Health Center.                                                                                                                       |

| Common Medical Event                                                                                                                                                                                                        | Services You May Need                            | What You Will Pay                                                                                                 |                                                                                                  | Limitations, Exceptions, & Other Important Information                                                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                             |                                                  | PPO Provider<br>(You will pay the least)                                                                          | Non-PPO Provider<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.culinaryhealthfund.org">www.culinaryhealthfund.org</a> | Generic drugs (Tier 1)                           | \$10 <a href="#">copay</a> /prescription (retail and mail order)                                                  | Not covered                                                                                      | No <a href="#">copay</a> for prescriptions filled at the Culinary pharmacy.<br><br>Quantity limits, prior authorization requirements, and other cost-containment programs may apply. |
|                                                                                                                                                                                                                             | Formulary drugs (Tier 2)                         | \$20 <a href="#">copay</a> /prescription (retail and mail order)                                                  | Not covered                                                                                      |                                                                                                                                                                                      |
|                                                                                                                                                                                                                             | Non-Formulary drugs (Tier 3)                     | \$35 <a href="#">copay</a> /prescription (retail and mail order)                                                  | Not covered                                                                                      |                                                                                                                                                                                      |
|                                                                                                                                                                                                                             | <a href="#">Specialty drugs</a> (Tier 4)         | 25% <a href="#">coinsurance</a>                                                                                   | Not covered                                                                                      |                                                                                                                                                                                      |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                       | Facility fee (e.g., ambulatory surgery center)   | \$150 <a href="#">copay</a> /surgery (ambulatory surgery center); \$250 <a href="#">copay</a> /surgery (hospital) | Not covered                                                                                      | Benefits may be denied if the prior authorization program is not followed.                                                                                                           |
|                                                                                                                                                                                                                             | Physician/surgeon fees                           | No charge                                                                                                         | Not covered                                                                                      |                                                                                                                                                                                      |
| <b>If you need immediate medical attention</b>                                                                                                                                                                              | <a href="#">Emergency room care</a>              | \$300 <a href="#">copay</a> /visit                                                                                | \$300 <a href="#">copay</a> /visit                                                               | No coverage for non-emergency care in a Non-PPO emergency room in the Las Vegas geographic area.                                                                                     |
|                                                                                                                                                                                                                             | <a href="#">Freestanding Emergency Room care</a> | \$750 <a href="#">copay</a> /visit                                                                                | \$750 <a href="#">copay</a> /visit                                                               |                                                                                                                                                                                      |
|                                                                                                                                                                                                                             | <a href="#">Emergency medical transportation</a> | 25% <a href="#">coinsurance</a> (ground); \$500 <a href="#">copay</a> /person/incident (air)                      | 25% <a href="#">coinsurance</a> (ground); \$500 <a href="#">copay</a> /person/incident (air)     | —————none—————                                                                                                                                                                       |
|                                                                                                                                                                                                                             | <a href="#">Urgent care</a>                      | \$50 <a href="#">copay</a> /visit                                                                                 | \$50 <a href="#">copay</a> /visit                                                                | No coverage for services at Non-PPO Urgent Care in the Las Vegas geographic area. <a href="#">Copay</a> includes all covered services related to the visit.                          |
| <b>If you have a hospital stay</b>                                                                                                                                                                                          | Facility fee (e.g., hospital room)               | \$250 <a href="#">copay</a> /admission                                                                            | \$2,000 <a href="#">copay</a> / admission + 40% <a href="#">coinsurance</a> of Allowable Charges | Benefits may be denied if the prior authorization program is not followed for Non-PPO <a href="#">Providers</a> .                                                                    |
|                                                                                                                                                                                                                             | Physician/surgeon fees                           | No charge                                                                                                         | Not covered                                                                                      |                                                                                                                                                                                      |

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay                                                                                                                                                                                                                                             |                                                                                                 | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                       |
|----------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                           | PPO Provider<br>(You will pay the least)                                                                                                                                                                                                                      | Non-PPO Provider<br>(You will pay the most)                                                     |                                                                                                                                                                                                                                                              |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | <u>Outpatient Therapy:</u><br>No <a href="#">copay</a> first 5 visits/issue, then \$15 <a href="#">copay</a> /visit<br><u>Partial Hospital Admission:</u><br>\$150 <a href="#">copay</a> /treatment plan<br><u>Intensive Outpatient Program:</u><br>No charge | Not covered                                                                                     | Some services require prior authorization and will not be covered without such authorization.<br><br>No <a href="#">copay</a> for outpatient therapy at the Culinary Health Center.                                                                          |
|                                                                                  | Inpatient services                        | \$250 <a href="#">copay</a> /admission                                                                                                                                                                                                                        | \$2,000 <a href="#">copay</a> /admission + 40% <a href="#">coinsurance</a> of Allowable Charges | Benefits may be denied if the prior authorization program is not followed for Non-PPO <a href="#">providers</a> .                                                                                                                                            |
| <b>If you are pregnant</b>                                                       | Office visits                             | No charge                                                                                                                                                                                                                                                     | Not covered                                                                                     | No coverage is provided for pregnancy of a dependent child, except as required under the Affordable Care Act. Additional <a href="#">copay</a> may apply for additional services. Benefits may be denied if the prior authorization program is not followed. |
|                                                                                  | Childbirth/delivery professional services | No charge                                                                                                                                                                                                                                                     | Not covered                                                                                     |                                                                                                                                                                                                                                                              |
|                                                                                  | Childbirth/delivery facility services     | \$250 <a href="#">copay</a> /admission                                                                                                                                                                                                                        | \$2,000 <a href="#">copay</a> /admission + 40% <a href="#">coinsurance</a> of Allowable Charges |                                                                                                                                                                                                                                                              |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                             | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                         |
|----------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | PPO Provider<br>(You will pay the least)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Non-PPO Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                |
| If you need help recovering or have other special health needs | <a href="#">Home Health Care</a>          | No charge                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Not covered                                 | Coverage limited to 60 days/year. Benefits may be denied if the prior authorization program is not followed.                                                                                                                                                                                                                                                                                                                   |
|                                                                | <a href="#">Rehabilitation services</a>   | \$250 <a href="#">copay</a> /inpatient admission<br><u>At a free-standing facility:</u> <ul style="list-style-type: none"> <li>• \$20 <a href="#">copay</a>/visit occupational/speech therapy, age 18 or older</li> <li>• \$10 <a href="#">copay</a>/visit occupational/ speech therapy, under the age of 18</li> </ul>                                                                                                                                                                                                                        | Not covered                                 | Annual limit of 80 visits per therapy type for individuals under the age of 18.<br>Annual limit of 30 visits per therapy type for individuals age 18 or older.<br>Inpatient coverage limited to 60 days/year.<br>The visit limits do not apply to visits primarily for mental health or substance abuse treatment. Benefits may be denied if the prior authorization program is not followed.                                  |
|                                                                | <a href="#">Habilitation services</a>     | <u>At a free-standing facility:</u> <ul style="list-style-type: none"> <li>• No charge for non-surgical and post-surgical physical therapy</li> <li>• No copay for physical therapy received at the Culinary Health Center</li> <li>• \$30 <a href="#">copay</a>/visit for cardio rehab</li> </ul> <u>Hospital Outpatient after an admission:</u> <ul style="list-style-type: none"> <li>• \$30 <a href="#">copay</a>/visit for physical, occupational, speech therapy</li> <li>• \$40 <a href="#">copay</a>/visit for cardio rehab</li> </ul> | Not covered                                 | Outpatient at a hospital after an admission: Physical, occupational or speech therapy limited to 30 visits per therapy type per year. The visit limits do not apply to visits primarily for mental health or substance abuse treatment.<br><br>Cardio rehab: limited to 30 visits per year at a free-standing facility or outpatient at a hospital. Benefits may be denied if the prior authorization program is not followed. |
|                                                                | <a href="#">Skilled nursing care</a>      | \$250 <a href="#">copay</a> /admission                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Not covered                                 | Limited to 60 days per calendar year. Benefits may be denied if the prior authorization program is not followed.                                                                                                                                                                                                                                                                                                               |
|                                                                | <a href="#">Durable medical equipment</a> | 10% <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Not covered                                 | The Fund pays 100% for formula and medical food for enteral nutrition services. Prior authorization required for items over \$500.                                                                                                                                                                                                                                                                                             |
|                                                                | <a href="#">Hospice services</a>          | No charge                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Not covered                                 | —————none—————                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                |                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                |

| Common Medical Event                   | Services You May Need      | What You Will Pay                        |                                             | Limitations, Exceptions, & Other Important Information                  |
|----------------------------------------|----------------------------|------------------------------------------|---------------------------------------------|-------------------------------------------------------------------------|
|                                        |                            | PPO Provider<br>(You will pay the least) | Non-PPO Provider<br>(You will pay the most) |                                                                         |
| If your child needs dental or eye care | Children's eye exam        | Not covered                              | Not covered                                 | Vision benefits may be provided separately.                             |
|                                        | Children's glasses         |                                          |                                             |                                                                         |
|                                        | Children's dental check-up | No charge                                | Varies depending on the cost                | Coverage limited to \$1,500/year for Non-PPO <a href="#">provider</a> . |

#### Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- Cosmetic surgery
- Infertility treatment
- Dental care (Adult) (may be provided separately)
- Dental care (Child) (may be provided separately)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child) (may be provided separately)
- Private-duty nursing
- Weight loss programs
- Glasses (Adult & Child) (may be provided separately)

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

- Chiropractic care
- Hearing aids
- Acupuncture
- Bariatric surgery
- Routine foot care

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

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

**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 1-800-457-8212.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-457-8212.

Chinese [(中文): 如果需要中文的帮助, 请拨打这个号码 1-800-457-8212.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-457-8212.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 1-800-457-8212 uff.

Samoa (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-457-8212.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-457-8212.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang 1-800-457-8212.

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

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

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<br>(9 months of in-network pre-natal care and a hospital delivery)                                                                                                                                                                                                                        |          | Managing Joe's type 2 Diabetes<br>(a year of routine in-network care of a well-controlled condition)                                                                                                                                                                                 |         | Mia's Simple Fracture<br>(in-network emergency room visit and follow up care)                                                                                                                                                                                                   |         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a>                                                                                                                                                                                                                                                | \$0      | ■ The <a href="#">plan's</a> overall <a href="#">deductible</a>                                                                                                                                                                                                                      | \$0     | ■ The <a href="#">plan's</a> overall <a href="#">deductible</a>                                                                                                                                                                                                                 | \$0     |
| ■ <a href="#">Specialist</a> <a href="#">copayment</a>                                                                                                                                                                                                                                                         | \$0      | ■ <a href="#">Specialist</a> <a href="#">copayment</a>                                                                                                                                                                                                                               | \$80    | ■ <a href="#">Specialist</a> <a href="#">copayment</a>                                                                                                                                                                                                                          | \$40    |
| ■ Hospital (facility) <a href="#">copayment</a>                                                                                                                                                                                                                                                                | \$250    | ■ Hospital (facility) <a href="#">copayment</a>                                                                                                                                                                                                                                      | \$0     | ■ Emergency Room <a href="#">copayment</a>                                                                                                                                                                                                                                      | \$300   |
| ■ Other <a href="#">copayment</a>                                                                                                                                                                                                                                                                              | \$10     | ■ Other <a href="#">copayment</a>                                                                                                                                                                                                                                                    | \$0     | ■ Other <a href="#">coinsurance</a>                                                                                                                                                                                                                                             | \$330   |
| This EXAMPLE event includes services like:<br><a href="#">Specialist</a> office visits (prenatal care)<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br><a href="#">Diagnostic tests</a> (ultrasounds and blood work)<br><a href="#">Specialist</a> visit (anesthesia) |          | This EXAMPLE event includes services like:<br><a href="#">Primary care physician</a> office visits (including disease education)<br><a href="#">Diagnostic tests</a> (blood work)<br><a href="#">Prescription drugs</a><br><a href="#">Durable medical equipment</a> (glucose meter) |         | This EXAMPLE event includes services like:<br><a href="#">Emergency room care</a> (including medical supplies)<br><a href="#">Diagnostic test</a> (x-ray)<br><a href="#">Durable medical equipment</a> (crutches)<br><a href="#">Rehabilitation services</a> (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                                                                                                                                                                                                                                                                    |         |
| <a href="#">Deductibles</a>                                                                                                                                                                                                                                                                                    | \$0      | <a href="#">Deductibles</a>                                                                                                                                                                                                                                                          | \$0     | <a href="#">Deductibles</a>                                                                                                                                                                                                                                                     | \$0     |
| <a href="#">Copayments</a>                                                                                                                                                                                                                                                                                     | \$260    | <a href="#">Copayments</a>                                                                                                                                                                                                                                                           | \$80    | <a href="#">Copayments</a>                                                                                                                                                                                                                                                      | \$385   |
| <a href="#">Coinsurance</a>                                                                                                                                                                                                                                                                                    | \$0      | <a href="#">Coinsurance</a>                                                                                                                                                                                                                                                          | \$0     | <a href="#">Coinsurance</a>                                                                                                                                                                                                                                                     | \$330   |
| What isn't covered                                                                                                                                                                                                                                                                                             |          | What isn't covered                                                                                                                                                                                                                                                                   |         | What isn't covered                                                                                                                                                                                                                                                              |         |
| Limits or exclusions                                                                                                                                                                                                                                                                                           | \$60     | Limits or exclusions                                                                                                                                                                                                                                                                 | \$0     | Limits or exclusions                                                                                                                                                                                                                                                            | \$0     |
| The total Peg would pay is                                                                                                                                                                                                                                                                                     | \$320    | The total Joe would pay is                                                                                                                                                                                                                                                           | \$80    | The total Mia would pay is                                                                                                                                                                                                                                                      | \$715   |