



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, you can access [www.ssspr.com](http://www.ssspr.com) or call (787) 774-6060.

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 <https://www.healthcare.gov/sbc-glossary> or call 1-800-981-3241 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                                                                     | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$0                                                                                                                                                                                                                                                                                                                         | See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Does not apply                                                                                                                                                                                                                                                                                                              | You don't have to meet <a href="#">deductibles</a> for specific services, but a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | Yes. Major Medical coverage - <b>\$50</b> Individual / <b>\$150</b> Family.<br>There are no other specific <a href="#">deductibles</a> .                                                                                                                                                                                    | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For medical, hospital and prescription drug services provided by <a href="#">in-network providers</a> - <b>\$6,350</b> Individual / <b>\$12,700</b> Family.                                                                                                                                                                 | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance billing charges</a> , health care this <a href="#">plan</a> doesn't cover, payments for non essential benefits, <a href="#">out of network coinsurance</a> / <a href="#">copayments</a> , and penalties for failure to obtain <a href="#">precertification</a> for services. | 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.ssspr.com">www.ssspr.com</a> or call 1-800-981-3241 for a list of <a href="#">network providers</a> .                                                                                                                                                                                          | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.                                                                                                                                                                                                                                                                                                                         | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event                                                   | Services You May Need                                   | What You Will Pay                                                                                                                                                                                                    |                                                                                                                                                         | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                        |
|------------------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                        |                                                         | Network Provider (You will pay the least)                                                                                                                                                                            | Out-of-Network Provider (You will pay the most)                                                                                                         |                                                                                                                                                                                                                                                               |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness        | \$10 <a href="#">copay</a> / visit<br>\$0 <a href="#">copay</a> / visit at SALUS Clinics                                                                                                                             | Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage | Telemedicine services (Teleconsulta MD) through virtual medical consultations, unlimited. \$10.00 <a href="#">copay</a> will apply per consult.                                                                                                               |
|                                                                        | <a href="#">Specialist/</a> subspecialist visit         | \$15 <a href="#">copay</a> / <a href="#">specialist</a> visit<br>\$15 <a href="#">copay</a> / subspecialist visit<br>\$0 <a href="#">copay</a> / visit at SALUS Clinics                                              | Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage | -----none-----                                                                                                                                                                                                                                                |
|                                                                        | <a href="#">Preventive care/screening</a> /immunization | No charge for preventive services according to the Federal Law<br>No charge for other immunizations<br>20% <a href="#">coinsurance</a> for the immunization for respiratory syncytial virus                          | Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage | Immunization for respiratory syncytial virus requires <a href="#">precertification</a> .<br>You may have to pay for non-preventive services. Ask your provider if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)     | 25% <a href="#">coinsurance</a> / laboratories and radiology<br>10% <a href="#">coinsurance</a> / diagnostic tests<br>0% <a href="#">coinsurance</a> / laboratories, radiology and diagnostic tests at SALUS Clinics | Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage | -----none-----                                                                                                                                                                                                                                                |
|                                                                        | Imaging (CT/PET scans, MRIs)                            | 25% <a href="#">coinsurance</a><br>0% <a href="#">coinsurance</a> / at SALUS Clinics                                                                                                                                 | Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage | Pet Scan and PET CT, subject to <a href="#">precertification</a> .                                                                                                                                                                                            |

| Common Medical Event                                                                                                                                                                                    | Services You May Need                            | What You Will Pay                                                                                                           |                                                                                                                                                                                                                                            | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.ssspr.com">www.ssspr.com</a> . | Generic drugs                                    | \$2 <a href="#">copay</a> / \$6 <a href="#">copay</a> mail order                                                            | Prescription drug coverage - covered in United States or its territories by reimbursement to the members up to 75% of Triple-S Salud established fees, less the applicable drug <a href="#">copayment</a> or <a href="#">coinsurance</a> . | The following rules apply: <ul style="list-style-type: none"> <li>• Generic drugs as first option.</li> <li>• Up to 30-day (retail) supply and 90-day supply or mail order for some maintenance drugs.</li> <li>• Mail order is not available for <a href="#">specialty drugs</a> or drugs for chemotherapy.</li> <li>• Some medications require <a href="#">precertification</a> from the <a href="#">plan</a>.</li> </ul> |
|                                                                                                                                                                                                         | Brand drugs                                      | 20% minimum \$4 <a href="#">copay</a> / \$12 <a href="#">copay</a> mail order                                               |                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                         | <a href="#">Specialty drugs</a>                  | 20% minimum \$50 maximum \$100 <a href="#">copay</a>                                                                        |                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                         | Drugs for chemotherapy                           | No charge                                                                                                                   |                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>If you have outpatient surgery</b>                                                                                                                                                                   | Facility fee (e.g., ambulatory surgery center)   | No Charge / visit                                                                                                           | Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage                                                                                    | -----none-----                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                         | Physician / surgeon fees                         | No Charge                                                                                                                   | Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage                                                                                    | -----none-----                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>If you need immediate medical attention</b>                                                                                                                                                          | <a href="#">Emergency room care</a>              | \$50 <a href="#">copay</a> / illness visit<br>No charge / accident visit                                                    | \$50 <a href="#">copay</a> / illness visit<br>No charge / accident visit                                                                                                                                                                   | No charge if recommended by <i>Teleconsulta</i> . <a href="#">Coinsurance</a> may apply for non-routine <a href="#">diagnostic tests</a> other than x-rays.                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                         | <a href="#">Emergency medical transportation</a> | Up to \$80 / occurrence                                                                                                     | Up to \$80 / occurrence                                                                                                                                                                                                                    | You pay for the services and the <a href="#">plan</a> will reimburse the submitted charges.                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                         | <a href="#">Urgent care</a>                      | \$25 <a href="#">copay</a> / illness visit<br>No charge / accident visit                                                    | \$25 <a href="#">copay</a> / illness visit<br>No charge / accident visit                                                                                                                                                                   | <a href="#">Coinsurance</a> may apply for non-routine <a href="#">diagnostic tests</a> other than x-rays.                                                                                                                                                                                                                                                                                                                   |
| <b>If you have a hospital stay</b>                                                                                                                                                                      | Facility fee (e.g., hospital room)               | \$75 <a href="#">copay</a> / admission preferred hospital<br>\$150 <a href="#">copay</a> / admission non-preferred hospital | Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage                                                                                    | -----none-----                                                                                                                                                                                                                                                                                                                                                                                                              |

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay                                                                                                                                                                                                                                                         |                                                                                                                                                         | Limitations, Exceptions, & Other Important Information                                                                                               |
|----------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  | Physician/surgeon fees                    | No charge                                                                                                                                                                                                                                                                 | Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage | Lithotripsy requires <a href="#">precertification</a> .                                                                                              |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$15 <a href="#">copay</a> / group therapy<br>\$15 <a href="#">copay</a> / visit (includes collaterals)<br>\$0 <a href="#">copay</a> / visit at SALUS Clinics                                                                                                             | Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage | -----none-----                                                                                                                                       |
|                                                                                  | Inpatient services                        | \$75 <a href="#">copay</a> / admission preferred hospital<br>\$150 <a href="#">copay</a> / admission non-preferred hospital<br>\$35 <a href="#">copay</a> / partial admission preferred hospital<br>\$75 <a href="#">copay</a> / partial admission non-preferred hospital | Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage | -----none-----                                                                                                                                       |
| <b>If you are pregnant</b>                                                       | Office visits                             | \$15 <a href="#">copay</a><br>\$0 <a href="#">copay</a> / visit at SALUS Clinics                                                                                                                                                                                          | Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
|                                                                                  | Childbirth/delivery professional services | No charge                                                                                                                                                                                                                                                                 | Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage |                                                                                                                                                      |
|                                                                                  | Childbirth/delivery facility services     | \$75 <a href="#">copay</a> / admission preferred hospital<br>\$150 <a href="#">copay</a> / admission non-preferred hospital                                                                                                                                               | Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage |                                                                                                                                                      |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | 25% <a href="#">coinsurance</a>                                                                                                                                                                                                                                           | Covered by reimbursement or assignment of benefits, subject to a 25% <a href="#">coinsurance</a>                                                        | Up to 40 visits per contract year for physical, occupational and speech therapies. Requires <a href="#">precertification</a> .                       |

| Common Medical Event                   | Services You May Need                     | What You Will Pay                                                                                            |                                                                                                                                                                                                                                                                                                            | Limitations, Exceptions, & Other Important Information                                                                                       |
|----------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|
|                                        | <a href="#">Rehabilitation services</a>   | \$5 <a href="#">copay</a> / physical therapies<br>\$7 <a href="#">copay</a> / chiropractor and manipulations | Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage                                                                                                                                                    | Up to 15 physical therapies per policy year, per member.<br>Up to 15 manipulations per policy year, per member.                              |
|                                        | <a href="#">Habilitation services</a>     | See Rehabilitation services.                                                                                 | See Rehabilitation services.                                                                                                                                                                                                                                                                               | See Rehabilitation services.                                                                                                                 |
|                                        | <a href="#">Skilled nursing care</a>      | No charge                                                                                                    | Covered by reimbursement or assignment of benefits.                                                                                                                                                                                                                                                        | Up to 120 days per year, per member. Requires <a href="#">precertification</a> .                                                             |
|                                        | <a href="#">Durable medical equipment</a> | 25% <a href="#">coinsurance</a>                                                                              | Covered by reimbursement or assignment of benefits, subject to a 25% <a href="#">coinsurance</a>                                                                                                                                                                                                           | Requires <a href="#">precertification</a> .                                                                                                  |
|                                        | <a href="#">Hospice service</a>           | Covered through Case Management, subject to be a <a href="#">precertification</a> .                          | Not covered                                                                                                                                                                                                                                                                                                | -----none-----                                                                                                                               |
| If your child needs dental or eye care | Children's eye exam                       | 10% <a href="#">coinsurance</a>                                                                              | Covered by reimbursement at 100% of the Triple-S Salud established fees less <a href="#">copayment</a> or <a href="#">coinsurance</a> of basic coverage                                                                                                                                                    | Up to one (1) refraction exam per year, per member.                                                                                          |
|                                        | Children's glasses                        | Covered by reimbursement or assignment of benefits                                                           | Covered by reimbursement or assignment of benefits                                                                                                                                                                                                                                                         | Covered up to \$100 every two years for glasses and contact lenses. This benefit does not apply to the <a href="#">out-of-pocket limit</a> . |
|                                        | Children's dental check-up                | No charge                                                                                                    | Triple-S Salud will reimburse the member the lesser amount between the cost incurred and the fee that would have been paid to a participating provider in Puerto Rico for the same service, based on the fees established by Triple-S Salud, after deducting the applicable <a href="#">coinsurances</a> . | Covered through Dental coverage. Up to one (1) dental check-up every six (6) months.                                                         |

## 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
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

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

- Acupuncture (covered through Major Medical coverage)
- Bariatric surgery subject to pre-certification
- Chiropractic care
- Dental care
- Hearing aids (covered through Major Medical coverage)
- Routine eye care
- 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage. For more information about the individual insurance coverage, visit [www.ssspr.com](http://www.ssspr.com) or call 787-774-6060 or toll free 1-800-981-3241.

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or visit [www.ssspr.com](http://www.ssspr.com) or call 787-774-6060 or toll free 1-800-981-3241.

### 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 **787-774-6060** or toll free **1-800-981-3241**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **787-774-6060** or toll free **1-800-981-3241**.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **787-774-6060** or toll free **1-800-981-3241**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' **787-774-6060** or toll free **1-800-981-3241**.

*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 **0.02** 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 plan's overall <a href="#">deductible</a>                                                                                                                                                                                                                                                                                                  | \$0             | ■ The plan's overall <a href="#">deductible</a>                                                                                                                                                                                                                                                                        | \$0            | ■ The plan's overall <a href="#">deductible</a>                                                                                                                                                                                                                                                                            | \$0            |
| ■ <a href="#">Specialist copayment</a>                                                                                                                                                                                                                                                                                                           | \$15            | ■ <a href="#">Specialist copayment</a>                                                                                                                                                                                                                                                                                 | \$15           | ■ <a href="#">Specialist copayment</a>                                                                                                                                                                                                                                                                                     | \$15           |
| ■ Hospital (facility) <a href="#">copayment</a>                                                                                                                                                                                                                                                                                                  | \$75            | ■ Hospital (facility) <a href="#">copayment</a>                                                                                                                                                                                                                                                                        | \$75           | ■ Hospital (facility) <a href="#">copayment</a>                                                                                                                                                                                                                                                                            | \$75           |
| ■ Other <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                                                              | 25%             | ■ Other <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                                    | 25%            | ■ Other <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                                        | 25%            |
| <b>This EXAMPLE event includes services like:</b><br><a href="#">Specialist</a> office visits ( <i>prenatal care</i> )<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br><a href="#">Diagnostic tests</a> ( <i>ultrasounds and blood work</i> )<br><a href="#">Specialist</a> visit ( <i>anesthesia</i> ) |                 | <b>This EXAMPLE event includes services like:</b><br><a href="#">Primary care physician</a> office visits ( <i>including disease education</i> )<br><a href="#">Diagnostic tests</a> ( <i>blood work</i> )<br><a href="#">Prescription drugs</a><br><a href="#">Durable medical equipment</a> ( <i>glucose meter</i> ) |                | <b>This EXAMPLE event includes services like:</b><br><a href="#">Emergency room care</a> ( <i>including medical supplies</i> )<br><a href="#">Diagnostic test</a> ( <i>x-ray</i> )<br><a href="#">Durable medical equipment</a> ( <i>crutches</i> )<br><a href="#">Rehabilitation services</a> ( <i>physical therapy</i> ) |                |
| <b>Total Example Cost</b>                                                                                                                                                                                                                                                                                                                        | <b>\$12,700</b> | <b>Total Example Cost</b>                                                                                                                                                                                                                                                                                              | <b>\$5,600</b> | <b>Total Example Cost</b>                                                                                                                                                                                                                                                                                                  | <b>\$2,800</b> |
| <b>In this example, Peg would pay:</b>                                                                                                                                                                                                                                                                                                           |                 | <b>In this example, Joe would pay:</b>                                                                                                                                                                                                                                                                                 |                | <b>In this example, Mia would pay:</b>                                                                                                                                                                                                                                                                                     |                |
| <i>Cost Sharing</i>                                                                                                                                                                                                                                                                                                                              |                 | <i>Cost Sharing</i>                                                                                                                                                                                                                                                                                                    |                | <i>Cost Sharing</i>                                                                                                                                                                                                                                                                                                        |                |
| <a href="#">Deductibles</a>                                                                                                                                                                                                                                                                                                                      | \$0             | <a href="#">Deductibles</a>                                                                                                                                                                                                                                                                                            | \$50           | <a href="#">Deductibles</a>                                                                                                                                                                                                                                                                                                | \$50           |
| <a href="#">Copayments</a>                                                                                                                                                                                                                                                                                                                       | \$80            | <a href="#">Copayments</a>                                                                                                                                                                                                                                                                                             | \$200          | <a href="#">Copayments</a>                                                                                                                                                                                                                                                                                                 | \$300          |
| <a href="#">Coinsurance</a>                                                                                                                                                                                                                                                                                                                      | \$400           | <a href="#">Coinsurance</a>                                                                                                                                                                                                                                                                                            | \$800          | <a href="#">Coinsurance</a>                                                                                                                                                                                                                                                                                                | \$80           |
| <i>What isn't covered</i>                                                                                                                                                                                                                                                                                                                        |                 | <i>What isn't covered</i>                                                                                                                                                                                                                                                                                              |                | <i>What isn't covered</i>                                                                                                                                                                                                                                                                                                  |                |
| Limits or exclusions                                                                                                                                                                                                                                                                                                                             | \$0             | Limits or exclusions                                                                                                                                                                                                                                                                                                   | \$0            | Limits or exclusions                                                                                                                                                                                                                                                                                                       | \$0            |
| <b>The total Peg would pay is</b>                                                                                                                                                                                                                                                                                                                | <b>\$480</b>    | <b>The total Joe would pay is</b>                                                                                                                                                                                                                                                                                      | <b>\$1,050</b> | <b>The total Mia would pay is</b>                                                                                                                                                                                                                                                                                          | <b>\$430</b>   |

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