



Bedabox LLC dba ShipMonk : Mid EPO Plan



This 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 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, call 1-800-830-1501. 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 [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-830-1501 to request a copy.

| Important Questions                                                | Answers                                                                                                                                                  | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | In-Network <b>\$1,500</b> person/ <b>\$3,000</b> family.                                                                                                 | Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                                                                  |
| <b>Are there services covered before you meet your deductible?</b> | Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .                                                                | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                    |
| <b>Are there other deductibles for specific services?</b>          | No.                                                                                                                                                      | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>What is the out-of-pocket limit for this plan?</b>              | In-Network <b>\$3,500</b> person/ <b>\$7,000</b> family.                                                                                                 | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges and health care this <u>plan</u> doesn't cover.                                                         | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="http://www.MyHealthToolkitFL.com">www.MyHealthToolkitFL.com</a> or call 1-800-810-BLUE (2583) for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a referral to see a specialist?</b>                 | No.                                                                                                                                                      | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |



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                                                                                                                                                                                                                                                                                                                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                             |                                                  | In-Network Provider<br>(You will pay the least)                                                                                  | Out-of-Network Provider<br>(You will pay the most)                 |                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                               | Primary care visit to treat an injury or illness | \$25 <u>Copay</u> / visit;<br><u>deductible</u> does not apply                                                                   | Not Covered                                                        | Teladoc visits are covered at No Charge. Dialysis, labs/x-rays and second surgical opinions are covered at No Charge.                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                             | <u>Specialist</u> visit                          | \$50 <u>Copay</u> / visit;<br><u>deductible</u> does not apply                                                                   | Not Covered                                                        | Teladoc dermatology visits are covered at No Charge. Dialysis, labs/x-rays and second surgical opinions are covered at No Charge.                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                             | <u>Preventive care/screening/immunization</u>    | No Charge                                                                                                                        | Not Covered                                                        | See <a href="http://www.healthcare.gov">www.healthcare.gov</a> for <u>preventive care</u> guidelines. There may be additional benefits available. See your Employer for details.<br>You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.                                   |
| <b>If you have a test</b>                                                                                                                                                                                                   | <u>Diagnostic test</u> (x-ray, blood work)       | No Charge                                                                                                                        | No Charge                                                          | None                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                             | Imaging (CT/PET scans, MRIs)                     | 20% <u>Coinsurance</u>                                                                                                           | Not Covered                                                        | None                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.MyHealthToolkitFL.com">www.MyHealthToolkitFL.com</a> | Generic drugs (Retail)                           | Retail 30-day supply: \$10 copay, deductible does not apply.<br><br>Retail 90-day supply: \$20 copay, deductible does not apply. | Reimbursed at the SmithRx calculated rate minus copay/coinsurance. | Retail: up to a 90-day supply.<br>Mail Order: up to a 90-day supply.<br><br>You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by SmithRx.<br><br>Certain drugs may have a pre-authorization requirement or may result in a higher cost.<br><br>Certain preventive medications are covered at no charge.<br><br>Dispense as written (DAW) provision applies. |
|                                                                                                                                                                                                                             | Generic drugs (Mail Order)                       | Mail Order: \$20 copay, deductible does not apply.                                                                               |                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                             | Preferred brand drugs (Retail)                   | Retail 30-day supply: \$25 copay, deductible does not apply.<br><br>Retail 90-day supply: \$50 copay, deductible does not apply. |                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                               |

|  |                                        |                                                                                                                                                                       |                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--|----------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | Preferred brand drugs (Mail Order)     | Mail Order: \$50 copay, deductible does not apply.                                                                                                                    | Reimbursed at the SmithRx calculated rate minus copay/coinsurance. | <p>Retail: up to a 90-day supply.<br/>Mail Order: up to a 90-day supply.</p> <p>You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by SmithRx.</p> <p>Certain drugs may have a pre-authorization requirement or may result in a higher cost.</p> <p>Certain preventive medications are covered at no charge.</p> <p>Dispense as written (DAW) provision applies.</p> |
|  | Non-preferred brand drugs (Retail)     | <p>Retail 30-day supply: \$75 copay, deductible does not apply.</p> <p>Retail 90-day supply: \$150 copay, deductible does not apply.</p>                              |                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                       |
|  | Non-preferred brand drugs (Mail Order) | Mail Order: \$150 copay, deductible does not apply.                                                                                                                   |                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                       |
|  | <u>Specialty drugs</u>                 | <p>Tier 4 Preferred specialty drugs: \$150 copay, deductible does not apply.</p> <p>Tier 5 Non-preferred specialty drugs: \$150 copay, deductible does not apply.</p> | Not Covered                                                        | <p>Specialty Medications: up to a 30-day supply.</p> <p>You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by SmithRx.</p> <p>Certain drugs may have a pre-authorization requirement or may result in a higher cost.</p> <p>Certain preventive medications are covered at no charge.</p> <p>Dispense as written (DAW) provision applies.</p>                         |

| Common Medical Event                                                             | Services You May Need                          | What You Will Pay                                           |                                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                    |
|----------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                                | <u>In-Network Provider</u><br>(You will pay the least)      | <u>Out-of-Network Provider</u><br>(You will pay the most) |                                                                                                                                                                                                                                                                                                           |
| <b>If you have outpatient surgery</b>                                            | Facility fee (e.g., ambulatory surgery center) | 20% <u>Coinsurance</u>                                      | Not Covered                                               | <u>Pre-authorization</u> is required for some outpatient surgeries. Penalty for not obtaining <u>pre-authorization</u> is \$250.                                                                                                                                                                          |
|                                                                                  | Physician/surgeon fees                         | 20% <u>Coinsurance</u>                                      | Not Covered                                               | None                                                                                                                                                                                                                                                                                                      |
| <b>If you need immediate medical attention</b>                                   | <u>Emergency room care</u>                     | 20% <u>Coinsurance</u>                                      | 20% <u>Coinsurance</u>                                    | None                                                                                                                                                                                                                                                                                                      |
|                                                                                  | <u>Emergency medical transportation</u>        | 20% <u>Coinsurance</u>                                      | 20% <u>Coinsurance</u>                                    | None                                                                                                                                                                                                                                                                                                      |
|                                                                                  | <u>Urgent care</u>                             | \$75 <u>Copay</u> / visit; <u>deductible</u> does not apply | Not Covered                                               | None                                                                                                                                                                                                                                                                                                      |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)             | 20% <u>Coinsurance</u>                                      | Not Covered                                               | <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is \$250.                                                                                                                                                                                                        |
|                                                                                  | Physician/surgeon fees                         | 20% <u>Coinsurance</u>                                      | Not Covered                                               | None                                                                                                                                                                                                                                                                                                      |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Mental/behavioral health outpatient services   | 20% <u>Coinsurance</u>                                      | Not Covered                                               | Teladoc behavioral health visits are covered at No Charge. <u>Pre-authorization</u> is required for some outpatient services. Penalty for not obtaining <u>pre-authorization</u> is \$250. Office visits are covered with a \$25 <u>Copay</u> .                                                           |
|                                                                                  | Substance use disorder outpatient services     | 20% <u>Coinsurance</u>                                      | Not Covered                                               |                                                                                                                                                                                                                                                                                                           |
|                                                                                  | Mental/behavioral health inpatient services    | 20% <u>Coinsurance</u>                                      | Not Covered                                               | <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is \$250.                                                                                                                                                                                                        |
|                                                                                  | Substance use disorder inpatient services      | 20% <u>Coinsurance</u>                                      | Not Covered                                               |                                                                                                                                                                                                                                                                                                           |
| <b>If you are pregnant</b>                                                       | Office visits                                  | \$25 <u>Copay</u> / visit; <u>deductible</u> does not apply | Not Covered                                               | <u>Pre-authorization</u> for facility services is required. Penalty for not obtaining <u>pre-authorization</u> is \$250. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> . |
|                                                                                  | Childbirth/delivery professional services      | 20% <u>Coinsurance</u>                                      | Not Covered                                               | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)                                                                                                                                                                                                           |

| Common Medical Event                                                  | Services You May Need                 | What You Will Pay                                           |                                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                             |
|-----------------------------------------------------------------------|---------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                       | <u>In-Network Provider</u><br>(You will pay the least)      | <u>Out-of-Network Provider</u><br>(You will pay the most) |                                                                                                                                                                                                                                                    |
|                                                                       | Childbirth/delivery facility services | 20% <u>Coinsurance</u>                                      | Not Covered                                               |                                                                                                                                                                                                                                                    |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>               | 20% <u>Coinsurance</u>                                      | Not Covered                                               | 60 visits/benefit year. <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of all charges.                                                                                                         |
|                                                                       | <u>Rehabilitation services</u>        | \$50 <u>Copay</u> / visit; <u>deductible</u> does not apply | Not Covered                                               | 20 combined visits/benefit year for Occupational Therapy & Physical Therapy. 20 visits/benefit year for Speech Therapy.                                                                                                                            |
|                                                                       | <u>Habilitation services</u>          | \$50 <u>Copay</u> / visit; <u>deductible</u> does not apply | Not Covered                                               | 20 combined visits/benefit year for Occupational Therapy & Physical Therapy. 20 visits/benefit year for Speech Therapy.                                                                                                                            |
|                                                                       | <u>Skilled nursing care</u>           | 20% <u>Coinsurance</u>                                      | Not Covered                                               | 60 days/benefit year. <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is \$250.                                                                                                                           |
|                                                                       | <u>Durable medical equipment</u>      | 20% <u>Coinsurance</u>                                      | Not Covered                                               | Purchase or rentals of \$1,000 or more require <u>pre-authorization</u> . Penalty for not obtaining <u>pre-authorization</u> is denial of all charges. Wigs are limited to \$500, every 5 years. Hearing aids are limited to \$2,500/benefit year. |
|                                                                       | <u>Hospice services</u>               | 20% <u>Coinsurance</u>                                      | Not Covered                                               | <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is \$250 In-Network for Inpatient services and denial of all charges for In-Network Outpatient and all Out-of-Network services.                           |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                   | Not Covered                                                 | Not Covered                                               | See your Employer for benefit details.                                                                                                                                                                                                             |
|                                                                       | Children's glasses                    | Not Covered                                                 | Not Covered                                               | See your Employer for benefit details.                                                                                                                                                                                                             |
|                                                                       | Children's dental check-up            | Not Covered                                                 | Not Covered                                               | See your Employer for benefit details.                                                                                                                                                                                                             |

## 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.)

- |                                                      |                            |                        |
|------------------------------------------------------|----------------------------|------------------------|
| • Acupuncture                                        | • Dental Care (Child)      | • Routine Foot Care    |
| • Bariatric Surgery                                  | • Long-Term Care           | • Weight Loss Programs |
| • Cosmetic Surgery                                   | • Routine Eye Care (Adult) |                        |
| • Dental Care (Adult)                                | • Routine Eye Care (Child) |                        |
| • Non-emergency care when traveling outside the U.S. |                            |                        |

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

- |                                             |                                                     |                                                                           |
|---------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------------------|
| • Chiropractic Care, 20 visits/benefit year | • Infertility Treatment, diagnosis and testing only | • Private-Duty Nursing, if part of pre-authorized <u>home health care</u> |
| • Hearing Aids                              |                                                     |                                                                           |

**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: The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa>. 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 on how 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: 1-800-830-1501 or visit us at [www.MyHealthToolkitFL.com](http://www.MyHealthToolkitFL.com), the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa>.

**Does this plan provide Minimum Essential Coverage? Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet Minimum Value Standards? 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.

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

**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 <u>plan's</u> overall <u>deductible</u> | \$1,500                                                                                                                                                                                                                                          | -                  | The <u>plan's</u> overall <u>deductible</u>                                                                                                                                                                                                 | \$1,500 |
| -                                                                                                                                                                                                                                                                                   | <u>Specialist Copayment</u>                 | \$50                                                                                                                                                                                                                                             | -                  | <u>Specialist Copayment</u>                                                                                                                                                                                                                 | \$50    |
| -                                                                                                                                                                                                                                                                                   | Hospital (facility) <u>Coinsurance</u>      | 20%                                                                                                                                                                                                                                              | -                  | Hospital (facility) <u>Coinsurance</u>                                                                                                                                                                                                      | 20%     |
| -                                                                                                                                                                                                                                                                                   | Other <u>Coinsurance</u>                    | 20%                                                                                                                                                                                                                                              | -                  | Other <u>Coinsurance</u>                                                                                                                                                                                                                    | 20%     |
| This EXAMPLE event includes services like:<br><u>Specialist</u> office visits (prenatal care)<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br><u>Diagnostic tests</u> (ultrasounds and blood work)<br><u>Specialist</u> visit (anesthesia) |                                             | This EXAMPLE event includes services like:<br><u>Primary care physician</u> office visits (including disease education)<br><u>Diagnostic tests</u> (blood work)<br><u>Prescription drugs</u><br><u>Durable medical equipment</u> (glucose meter) |                    | This EXAMPLE event includes services like:<br><u>Emergency room care</u> (including medical supplies)<br><u>Diagnostic test</u> (x-ray)<br><u>Durable medical equipment</u> (crutches)<br><u>Rehabilitation services</u> (physical therapy) |         |
| Total Example Cost                                                                                                                                                                                                                                                                  |                                             | \$12,700                                                                                                                                                                                                                                         | Total Example Cost |                                                                                                                                                                                                                                             | \$5,600 |
| In this example, Peg would pay:                                                                                                                                                                                                                                                     |                                             | In this example, Joe would pay:                                                                                                                                                                                                                  |                    | In this example, Mia would pay:                                                                                                                                                                                                             |         |
| Cost Sharing                                                                                                                                                                                                                                                                        |                                             | Cost Sharing                                                                                                                                                                                                                                     |                    | Cost Sharing                                                                                                                                                                                                                                |         |
| <u>Deductibles</u>                                                                                                                                                                                                                                                                  | \$1,500                                     | <u>Deductibles</u>                                                                                                                                                                                                                               | \$800              | <u>Deductibles</u>                                                                                                                                                                                                                          | \$1,500 |
| <u>Copayments</u>                                                                                                                                                                                                                                                                   | \$0                                         | <u>Copayments</u>                                                                                                                                                                                                                                | \$300              | <u>Copayments</u>                                                                                                                                                                                                                           | \$400   |
| <u>Coinsurance</u>                                                                                                                                                                                                                                                                  | \$1,900                                     | <u>Coinsurance</u>                                                                                                                                                                                                                               | \$0                | <u>Coinsurance</u>                                                                                                                                                                                                                          | \$100   |
| What isn't covered                                                                                                                                                                                                                                                                  |                                             | What isn't covered                                                                                                                                                                                                                               |                    | What isn't covered                                                                                                                                                                                                                          |         |
| Limits or exclusions                                                                                                                                                                                                                                                                | \$70                                        | Limits or exclusions                                                                                                                                                                                                                             | \$3,500            | Limits or exclusions                                                                                                                                                                                                                        | \$100   |
| The total Peg would pay is                                                                                                                                                                                                                                                          | \$3,470                                     | The total Joe would pay is                                                                                                                                                                                                                       | \$4,600            | The total Mia would pay is                                                                                                                                                                                                                  | \$2,010 |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-830-1501.

The plan would be responsible for the other costs of these EXAMPLE covered services.

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-832-9686 (TTY: 711) or speak to your provider.

Espanol: ATENCION: Si habla espafiol, tiene a su disposici6n servicios gratuitos de asistencia lingufstica. Tambien estan disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar informaci6n en formatos accesibles. Llame al 1-844-396-0183 (TTY: 711) o hable con su proveedor. (Spanish)

cpx:: 5.1:i:: frD:lj!:f\$>[cp:X:J,□11'5oJt□f□t:IH:Jt:tkolnf□r:Jl!}]J\$fi□, -llioJtJ:tko□t:IH:Jt□□i"7□Jl:JL□!PJ\$fi□, tJii\illlrMt□t:, 'HM'nfl◊ \$□iR□ 1-844-396-0188 (TTY: 111) W: !Mf□B"1t:, 'H:Jt:t:f\$◊, f\*Jlli◊ (Chinese)

Ti□ng Vi\$!: LL'J'U Y: N□u quy vi n6i ti□ng Vi\$!, chung t6i cung ctip mi□n phi cac dich v,i h6 trq ng6n ngfr. Cac h6 trq va dich v,i b6 sung phu hqp dl! cung ctip thong tin theo cac dinh d9ng d□ ti□p c; \in cOng dll'Q'C cung c.fip mi□n phi. Vui long g9i 1-844-389-4838 (TTY: 711) ho; ,lc trao d6i v&i nha cung c.fip dich v,i cua quy vi. (Vietnamese)

PYCKKlIlil: BhlIdMAHlIdE! EC/11-1 Bbl rosopme Ha pyccKOM R3blKe, BaM AOCTynHbl 6ecn/laTHble ycnym R3blKOBOfI noMep>KKl-l. CoomeTCBTYIOW,1-le BenOMOraTe/lbHble cpeACTBa 1-1 ycnym no npeAOCTaB/leHI-IIO1-!Hq>OpMau,1-11-1 B AOCTynHblX q>OpMaTax TaK>Ke npeAOCTaB/RIOTCR 6ecn/laTHO. no3BOHI-!Te no Te/eq>OHy 1-844-389-4840 (TTY: 711) 1-1/11-1 o6pamTeCb K CBOeMy noCTaBW,I-KY ycnyr. (Russian)

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, available ang mga libreng serbisyo ng tulong sa wika para sa iyo. Available rin nang walang bayad ang mga naaangkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-844-389-4839 (TTY: 711) o makipag-usap sa iyong provider. (Tagalog)

Portugues do Brasil: ATEN<:::A.O: Se voce fala portugues, ha servi9os gratuitos de assistencia linguistica disponiveis para voce. Assistencia e servi9os auxiliares pr6prios para fornecer informa96es em formatos acessiveis tambem estao disponiveis gratuitamente. Ligue para 1-844-396-0182 (TIY: 711) ou fale com seu provedor. (Portuguese)

Fran9ais : NOTE : Si vous parlez fran9ais, des services gratuits d'assistance linguistique sont it votre disposition. Des aides et des services auxiliaires appropries pouvant fournir des informations dans des formats accessibles sont egalement disponibles gratuitement. Appelez le 1-844-396-0190 (TTY: 711) ou adressez-vous it votre prestataire. (French)

.JJ"lf□tclt l:4lat □'l-11, "lf1 ctil .JJ"lf□tclt1 v.lf□-tclt e1 ct1 l-□ct (>tl□£i1□ Hel□ct l : aqt□1 ctl-ll□ l-lI2 C31.1c-tW:j\_ □- □1.)□ □'l□.ncH1 Hel□ □□ □.Es:afuv.lc-t □'lilmi l-ltctt11.J.,□11.1tsQl l-lI2at1 : aqt□11.1□t tcMl l-J..C□ C31.1c-tW:j\_ □-t- 844-641-2898 (TTY: 711) 1.1□ £s1Ci *£sit* □'1'!Ql ct-l□□ \.lf.lctI Hlel Qlct *£sit*. (Gujarati)

**Deutsch:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen Dienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie unter 1-844-396-0191 (TTY: 711) an oder sprechen Sie mit Iluem Anbieter. (German)

E)-□O: -?-9.l: [E]-□O, ]□ ,A\_ f\_g c'□-fAl'c □ -'l'- -'Fl i '2: ! 0, ;,;l□ Ait tl.'.'':□ Ol\_g c'□-f□ "?" □ .g.1...l cf. Ol.g. 7 f□El- gJ'°l'.c.c.£ □ ./l'.□ Ail□c'□-f'c -?;□□ El- 'il...f'c. 7l-'t'- □ Ait tl.'.'':5.. -'f-li£ Ail□□1...l cf. 1-844-396-0187(TTY: 711)!:!.cc.£ □ .£f c',f7iq Ait tl.'.'': Ail□□xii Oji □9.l c'□-f;□j Al.2.. (Korean)

(Arabic) :.....;Ji r-"') □ J-i (711 :□\ w4Ji :.....;) 1-844-396-0189l")l e)c- J\_□: \ .t4-- 4-;) J\_.....\_ill i:fi-; w□ wl\_□\_k J l\_; ,lyl□U.Owl\_□\_li\_□ J□c l\_....o J;t...J )fa w;□\_l□l□\_y ll □c i\_....Jl wl\_□\_li\_ cll \_j□ □\_□\_y ll **WIG** □□ y) :"%w □\_□\_y ll

YKpa°IHCbKa MOBa: YBA.A! FIKW.O BI-I p03MOB/IReTe yKpa°IHCbKOIO MOBOIO, BaM AOCTynHi 6e3KOWTOBH MOBH nocyM. BiAnOBiAH AOHOmi>KH 3aco61-1 □ nocnym *Afr* HaAaHHR iHq>OpMau,ff B AOCTynHI-IX q>OpMaTax TaKO>K AOCTynHi 6e3KOWTOBHO. 3aTeneq>oHy□Te 3a HOMepoM 1- 844-641-2897 (TTY: 711) a6o 3BepHiTbCR AD csoro nonaYa/lbHI-!Ka. (Ukrainian)

B \*□i: ii: B \*□/□□□9□□-g-' □,¥40)□□i:Rti-lf-l::'A□.=flljfflL ,t=f.3.lt°\*9. 7?-ll'/:::'Jt.(ti'tflljffl'□□J::'?lllGft□nt.=) fJJftitt"tlU!x□m1:tt:9M.=d.>O)jjli;J]tJ1ifi.lJJJ:Rtif-'-lf-l::'At□,¥4t'.=flljfflL ,f=-t:3\_W\*9.1 844-396-0185 (TTY: 711) act'S□tl<t:3.□L◊ *act*.=/t, '=f1Jffio)\$□□1::;t;,"9L,-g-t,-tt(t:3.□L◊ (Japanese)

"lvm: lu,,ivi>lu: 1117flf!T°M1:~!&1ml,n LVliJ 1,l□u□m,m1□<d1ml1lii.i'l'wlunml,nv-J□u.i;ri;ilriii J□faF1□u□□i1ln□u□m,<d1tJmii.ilvfo't□'ll'm,Jn'tu.'j,lJ1luuvi-l-ihii□'l.f1&1dUJ1liDfi1L'D'lltJ lu,,ilvi,m.im.ivi 1-844-641-2896 (TTY: J111□.i,J□m,mJ't□u□m>'llil□f!™ (Thai)

□10: ci;iu;:ilu: Tf1uhuc61w1□1 □10, 'iil'iiu5mutjoe.ici1uw1□1ccuu6c□e.i.h'luihu. iicteJtjoe.i cc□• rnuu5rnuccuu6c□e.i.h11icim1◊:BJ.JctJe'luiJ;□u'lu□uccuudi□w1oet1cii'JLci. tunmcu 1-844-641-2895 (TTY: 711) qi ;5rn'5uc,i'Zuiiu5rnui2e'Juiw. (Lao)

f!c!t: UIR i: '1ft ,3fJq f!c!t□ l m ,3fJLj\$ □ f.'t, □ '4MIT □ □ mc!t il wPl-/ mFm *if*□ □ □ \$□ □ □ □ -m□ ,3fR □ ilt f.'t, □ □ i l 1-844-641-2894 (TTY: 711)□ ffl cR ◀ 3f8 □ □ of@ cR l (Hindi)

Dine SHOOH: Dine bee yanilti'gogo, saad bee ana'awo' bee aka'anida'awo'it'aajiik'eh na h61Q. Bee ahil hane'go bee nida'anishi t'aa akodaat'ehigii d66 bee aka'anida'wo'i ako bee baa hane'i bee hadadilyaa bich'i' ahoot'i'igii *ei* t'aa jiik'eh h61Q. Kohji' 1-844-516-6328 (TTY: 711) hodiilnih doodago nika'analwo'i bich'i' hanidziih. (Navajo)

Kiswahili MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo iii kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-844-465-1726 (TTY: 711) au zungumza na mtoa huduma wako. (Swahili)

i'.atJC<' atJr'u!rtf'- i'.atJC<' l'OLL'iy74- hl!7= l'!l;>,lI> f:~f/- i'.7C1"7\~t m, .e<>CfICl'iP;rCI: /Jll.(□", n+.et-n 'P(ilt i\atq,({l +In\_ W'r +r,T;atJ<'!, '1'7tiPf l,'i'.7C1"71'l-H l,,".11\_1.} m, .e,7<'}\~: nMh 9?'1'( 1-844-465-1592 (TTY: 711) £,£(!).i\~ CDE,9" i'.7C1"7\~t i'.<|>+l\_ 'iP", l'i"J4-: (Amharic)

Soomaali FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 1-844-465-1724 (TTY: 711) ama la hadal bixiyahaaga. (Somali)

ILOCANO PANANGIKASO: No agsaasaoka iti Ilocano, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao. Libre met laeng a magun-odan dagiti maitutop a katulongan ken serbisio a mangipaay iti impormasion kadagiti ma-aksas a pormat. Awagan ti 1-800-832-9686 (TTY: 711) wenna makisarita iti mangipapaay kenka. (Ilocano)

