YEARLY LIMIT - this limit gives you financial protection

This limit tells the most you will have to pay in “out-of-pocket” costs, copays, and coinsurance for medical and hospital services covered by the plan.

This yearly limit is called your “out-of-pocket maximum.” It puts a limit on how much you have to pay, but it does not put a limit on how much care you can get.

Your out-of-pocket spending for non-Medicare covered expenses such as routine hearing, hearing aids, routine dental, home medical monitoring, meals programs and other non-covered services will not count toward your yearly out-of-pocket maximum. This means:

- Once you have reached your limit in out-of-pocket costs, you stop paying out of pocket for all services except non-covered services.

- You keep getting your covered medical and hospital services as usual, and the plan will pay the full cost for the rest of the year. Your out-of-pocket spending for services that are not covered by Medicare does not count toward your out-of-pocket maximum.

As of February 28, 2022, (for the plan year 2022), you have had $135.52 in out-of-pocket costs that count toward your $4,900.00 out-of-pocket maximum for covered services.

Combined (in-network + out-of-network) limit

In 2022, $4,900.00 is the most you will have to pay for covered services you get from all providers (in-network providers + out of network providers combined).

As of February 28, 2022, (for plan year 2022), you have had $135.52 in out-of-pocket costs that count toward your $4,900.00 combined out-of-pocket maximum for covered services.
## Details for claims processed in February 2022

<table>
<thead>
<tr>
<th>Provider: EXAMPLE PROVIDER</th>
<th>Claim Number: 20001E00001</th>
<th>Date of Service</th>
<th>Amount the provider billed the plan</th>
<th>Total cost (amount the plan approved)</th>
<th>Plan’s share</th>
<th>Your share</th>
</tr>
</thead>
<tbody>
<tr>
<td>OFFICE/OUTPATIENT VISIT EST 99213</td>
<td></td>
<td>01/17/2022</td>
<td>$212.00</td>
<td>$72.05</td>
<td>$65.81</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**You pay a $0.00 copayment for services from an in-network provider.**

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1. The total amount providers billed the plan for services received during the month
2. The total amount the plan approved to pay for the services received during the month
3. The total amount the plan paid your provider (your savings) for the month
4. The amount you owe for services received for the month
5. The year the service was received
6. The total amount providers have billed for the plan year indicated
7. The total amount the plan approved to pay for services received so far this year
8. The total amount the plan paid your provider (your savings) so far this year
9. The total amount you’ve paid for services received this year
10. The amount you have spent toward your maximum out-of-pocket costs
11. Your maximum out-of-pocket costs for the plan year
12. Indicates the month when claims were processed for the services listed (Network Health receives claims from your provider)
13. Names the provider submitting the claim for services received
14. A number generated to identify the claim
15. Describes if this provider is in-network or out-of-network
16. A brief description of the service received
17. The date the service was provided
18. The total amount the provider billed for the service
19. The total amount the plan approved
20. The amount the plan paid your provider (your savings)
21. The amount you’ll pay for this service
22. A code the provider uses to indicate the reason for service
23. Explains why you owe this amount

*The plan’s share and your share may not always equal the total cost. You are not responsible for the difference.*