**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services **Coverage Period: 01/01/2024 – 12/31/2024**

**PA-Prev Copay-02-01: *sponsor not specified*** **Coverage for: Individual & Family | Plan Type: PPO**

|  |
| --- |
| Picture of exclamation point to label important information**The Summary of Benefits and Coverage (SBC) document will help you choose a health** [**plan.**](https://www.healthcare.gov/sbc-glossary/#plan) **The SBC shows you how you and the** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **would share the cost for covered health care services. NOTE: Information about the cost of this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **(called the** [**premium**](https://www.healthcare.gov/sbc-glossary/#premium)**) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call a Benefit Advocate at (888) 920-7526. For general definitions of common terms, such as [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) [balance billing,](https://www.healthcare.gov/sbc-glossary/#balance-billing) [coinsurance,](https://www.healthcare.gov/sbc-glossary/#coinsurance) [copayment,](https://www.healthcare.gov/sbc-glossary/#copayment) [deductible](https://www.healthcare.gov/sbc-glossary/#deductible), [provider,](https://www.healthcare.gov/sbc-glossary/#provider) or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary.com](http://www.healthcare.gov/sbc-glossary.com) or call 888-920-7526 to request a copy. |

| **Important Questions** | **Answers** | **Why This Matters:** |
| --- | --- | --- |
| **What is the overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | $0 | See the Common Medical Events chart below for your costs for services this [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers. |
| **Are there services covered before you meet your** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | Not Applicable | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) does not have a [deductible](https://www.healthcare.gov/sbc-glossary/#deductible), but a [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) may apply. This [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers certain [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care) without [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing). See a list of covered [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care) at [www.healthcare.gov/coverage/preventive-care-benefits/](http://www.healthcare.gov/coverage/preventive-care-benefits/). |
| **Are there other** [**deductibles**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | No | You don’t have to meet [deductible](https://www.healthcare.gov/sbc-glossary/#deductible)s for specific services. |
| **What is the** [**out-of-pocket**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)[**limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) **for this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**?** | Not Applicable | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) does not have an [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) on your expenses. |
| **What is not included in the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)**?** | Not Applicable | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) does not have an [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) on your expenses. |
| **Will you pay less if you use a** [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** | Yes. See the [MultiPlan website](https://www.multiplan.com/webcenter/portal/ProviderSearch?SiteId=84477) or call 866-981-7427 for a list of [network providers](https://www.healthcare.gov/sbc-glossary/#network-provider). | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) uses a [provider](https://www.healthcare.gov/sbc-glossary/#provider) [network](https://www.healthcare.gov/sbc-glossary/#network). You will pay less if you use a [provider](https://www.healthcare.gov/sbc-glossary/#provider) in the [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) [network](https://www.healthcare.gov/sbc-glossary/#network). You will pay the most if you use an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider), and you might receive a bill from a [provider](https://www.healthcare.gov/sbc-glossary/#provider) for the difference between the [provider’s](https://www.healthcare.gov/sbc-glossary/#provider) charge and what your [plan](https://www.healthcare.gov/sbc-glossary/#plan) pays ([balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). Be aware, your [network provider](https://www.healthcare.gov/sbc-glossary/#network-provider) might use an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) for some services (such as lab work). Check with your [provider](https://www.healthcare.gov/sbc-glossary/#provider) before you get services. **This** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **uses *MultiPlan’s PHCS Specific Services* Network.** |
| **Do you need a** [**referral**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)**?** | No | You can see the [specialist](https://www.healthcare.gov/sbc-glossary/#specialist) you choose without a [referral](https://www.healthcare.gov/sbc-glossary/#referral). |

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| --- |
| Picture of exclamation point to label important informationAll [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) and [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) costs shown in this chart are after your [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) has been met, if a [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) applies.  [**Copayment**](https://www.healthcare.gov/sbc-glossary/#copayment)for office visits apply to visits only. In-office procedures may not be covered.  Out-of-Network care is covered at 150% of Medicare reimbursement rates (RBP). In the absence of a Medicare rate the [plan](https://www.healthcare.gov/sbc-glossary/#plan) will pay [UCR](https://www.healthcare.gov/sbc-glossary/#ucr). |

| **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** [**provider’s**](https://www.healthcare.gov/sbc-glossary/#provider) **office or clinic** | Primary care visit to treat an injury or illness | $20 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit | $20 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit | [Plan](https://www.healthcare.gov/sbc-glossary/#plan) will pay up to $150/visit. |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit | $50 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit | $50 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit | [Plan](https://www.healthcare.gov/sbc-glossary/#plan) will pay up to $300/visit. |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)/[screening](https://www.healthcare.gov/sbc-glossary/#screening)/  immunization | No Charge | No Charge | You may have to pay for services that aren’t [preventive](https://www.healthcare.gov/sbc-glossary/#preventive-care). Ask your [provider](https://www.healthcare.gov/sbc-glossary/#provider) if the services needed are [preventive](https://www.healthcare.gov/sbc-glossary/#preventive-care), then check what your [plan](https://www.healthcare.gov/sbc-glossary/#plan) will pay for. **If you receive a bill for preventive services, call a Benefit Advocate at (888) 920-7526**. |
| **If you have a test** | [Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (x-ray, blood work) | $50 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/x-ray  $10 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/lab test | $50 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/x-ray  $10 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/lab test | [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) apply to lab work on a per-test basis, not per draw or per sample. X-Ray limit 5/plan year and $250/x-ray limit. Lab test limit 15/plan year and $100/lab test limit. |
| Imaging (CT/PET scans, MRIs) | $200 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/test | $200 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/test | Covered services include CAT scans, MRI, and Ultrasound. Imaging limit 2/plan year. [Plan](https://www.healthcare.gov/sbc-glossary/#plan) will pay up to $1,000/test. |
| **If you need drugs to treat your illness or condition**  More information about [**prescription drug** **coverage**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) is available at OptumRx.com | Generic drugs | $10 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/prescription | Not Covered | Plan pays up to a maximum of $150/prescription per month. No Coverage for [Specialty Drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug). May be excluded from coverage or subject to prior authorization. |
| Preferred brand drugs | $25 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/prescription | Not Covered |
| Non-preferred brand drugs | $50 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/prescription | Not Covered |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) | Not Covered | Not Covered |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Not Covered | Not Covered | No coverage for Surgical care. |
| Physician/surgeon fees | Not Covered | Not Covered | No coverage for Surgical care. |
| **If you need immediate medical attention** | [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) | Not Covered | Not Covered | No Coverage for [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services). |
| [Emergency medical transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) | Not Covered | Not Covered | No Coverage for [Emergency medical transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation). |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) | $50 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit | $50 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit | [Plan](https://www.healthcare.gov/sbc-glossary/#plan) will pay up to $300/visit. |
| **If you have a hospital stay** | Facility fee (e.g. hospital room) | Not Covered | Not Covered | No Coverage for Inpatient care. |
| Physician/surgeon fees | Not Covered | Not Covered | No Coverage for Inpatient care. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Not Covered | Not Covered | No Coverage for Outpatient care. |
| Inpatient services | Not Covered | Not Covered | No Coverage for Inpatient care. |
| **If you are pregnant** | Office visits | $50 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit | $50 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit | [Cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) does not apply for [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care). Depending on the type of services, a [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) may apply. Out-of-Network visits are covered at 150% of Medicare reimbursement rates. |
| Childbirth/delivery professional services | Not Covered | Not Covered | No Coverage for Childbirth and delivery services. |
| Childbirth/delivery facility services | Not Covered | Not Covered | No Coverage for Childbirth and delivery services at any facility. |
| **If you need help recovering or have other special health needs** | [Home health care](https://www.healthcare.gov/sbc-glossary/#home-health-care) | Not Covered | Not Covered | No Coverage for private-duty nursing, home health aides, respite, custodial, supportive, or rest care. |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | Not Covered | Not Covered | No Coverage for Rehabilitation services. |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) | Not Covered | Not Covered | No Coverage for Habilitation services. |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | Not Covered | Not Covered | No Coverage for Skilled nursing care. |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) | Not Covered | Not Covered | No Coverage for Medical equipment. |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) | Not Covered | Not Covered | No Coverage for Hospice services. |
| **If your child needs dental or eye care** | Children’s eye exam | No Charge \* | No Charge \* | No Coverage for vision care, except as otherwise covered in Section VI of the Summary Plan Description. |
| Children’s glasses | Not Covered | Not Covered | No Coverage for contacts, lenses, and frames. |
| Children’s dental check-up | No Charge \* | No charge \* | No Coverage for dental care, except as otherwise covered in Section VI of the Summary Plan Description. |

**Excluded Services & Other Covered Services:**

| **Services Your** [**Plan**](https://www.healthcare.gov/sbc-glossary/#plan) **Generally Does NOT Cover (Check your policy or** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services)**.)** | | |
| --- | --- | --- |
| * Acupuncture * Allergy Services * Asthma Treatment, therapeutic * Bariatric Surgery * Cancer-related therapies * Chiropractic care | * Cosmetic Surgery * Dental Care (Adult) * Hearing Aids * Infertility Treatment * Long-term Care * Non-emergency care when traveling outside the U.S. | * Private-duty Nursing * Psychiatric Services * Routine Eye Care (Adult) * Routine Foot Care * Weight Loss Programs |

| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document.)** | | |
| --- | --- | --- |
| Both in- and out-of-network cost-sharing amounts will  charges or charges for services not covered under | be applied to the deductible and out-of-pocket max,  this health plan will not be applied to the deductible or | limited to RBP/UCR rates only. Any balance billing  out-of-pocket maximums. |

**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, Employee Benefits Security Administration, 1-866-444-EBSA (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 through the [Health Insurance](https://www.healthcare.gov/sbc-glossary/#health-insurance) [Marketplace.](https://www.healthcare.gov/sbc-glossary/#marketplace) For more information about the [Marketplace,](https://www.healthcare.gov/sbc-glossary/#marketplace) visit [www.HealthCare.gov](http://www.healthcare.gov/) or call 1-800-318- 2596.

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

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

[Minimum Essential Coverage](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) generally includes [plans](https://www.healthcare.gov/sbc-glossary/#plan), [health insurance](https://www.healthcare.gov/sbc-glossary/#health-insurance) available through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage,](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) you may not be eligible for the [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits).

**Does this plan meet the Minimum Value Standards?** **No**

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

**Language Access Services:**

[Spanish (Español): Para obtener asistencia en Español, llame al (888) 920-7526.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (888) 920-7526.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (888) 920-7526.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (888) 920-7526.

***To see examples of how this*** [***plan***](https://www.healthcare.gov/sbc-glossary/#plan) ***might cover costs for a sample medical situation, see the next section.***

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

**About these Coverage Examples:**

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

**Peg is Having a Baby**

(9 months of in-network pre-natal care and a hospital delivery)

* The [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) overall [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) $0

◼ [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) $50

◼ Hospital (facility) [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) none

◼ Other [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) none

**This EXAMPLE event includes services like:**

Specialist Office Visits (prenatal care)

Childbirth/Delivery Professional Services

Childbirth/Delivery Facility Services

Diagnostic Tests (ultrasounds and blood work)

Specialist Visit (anesthesia)

| **Total Example Cost** | **$12,800** |
| --- | --- |
| **In this example, Peg would pay:** |  |
| *Cost Sharing* | |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $0 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $300 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $12,500 |
| **The total Peg would pay is** | **$12,800** |

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

* The [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) overall [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) $0

◼ [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) $50

◼ Hospital (facility) [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) none

◼ Other [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) none

**This EXAMPLE event includes services like:**

Primary Care Physician Office Visits (including disease education)

Diagnostic Tests (blood work)

Prescription Drugs

Durable Medical Equipment (glucose meter)

| **Total Example Cost** | **$7,400** |
| --- | --- |
| **In this example, Joe would pay:** |  |
| *Cost Sharing* | |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $0 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $1,200 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $6,200 |
| **The total Joe would pay is** | **$7,400** |

**Mia’s Simple Fracture**

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

* The [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) overall [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) $0

◼ [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) $50

◼ Hospital (facility) [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) none

◼ Other [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) none

**This EXAMPLE event includes services like:**

Emergency Room Care (including medical supplies)

Diagnostic Test (x-ray)

Durable Medical Equipment (crutches)

Rehabilitation Services (physical therapy)

| **Total Example Cost** | **$2,500** |
| --- | --- |
| **In this example, Mia would pay:** |  |
| *Cost Sharing* | |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $0 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $200 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $2,300 |
| **The total Mia would pay is** | **$2,500** |

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