



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 call 800-966-4086. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 800-966-4086 to request a copy.

| Important Questions                                                                   | Answers                                                                                                                                                                                                                                                                                                                  | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | <p><a href="#">In-network provider</a>: \$100 individual / \$300 family per calendar year.</p> <p><a href="#">Out-of-network provider</a>: \$500 individual / \$1,500 family per calendar year.</p>                                                                                                                      | Generally, you must pay all of the costs from <a href="#">provider</a> , up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                      |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes. Certain <a href="#">Preventive care</a> , <a href="#">prescription drug</a> coverage and those services listed below as " <a href="#">deductible</a> does not apply." "No charge" means \$0 <a href="#">copayment</a> , or 0% <a href="#">coinsurance</a> , regardless of <a href="#">deductible</a> applicability. | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> , or <a href="#">coinsurance</a> , may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive</a> services without cost sharing and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive</a> services at <a href="http://healthcare.gov/coverage/preventive-care-benefits">healthcare.gov/coverage/preventive-care-benefits</a> . |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | No.                                                                                                                                                                                                                                                                                                                      | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | <p><a href="#">In-network provider</a>: \$900 individual / \$1,900 family per calendar year.</p> <p><a href="#">Out-of-network provider</a>: \$2,500 individual / \$5,500 family per calendar year.</p>                                                                                                                  | 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 limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                         |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | <a href="#">Premiums</a> , <a href="#">prescription drug cost sharing</a> , <a href="#">balance billing</a> , charges, and health care this <a href="#">plan</a> doesn't cover.                                                                                                                                          | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

| Important Questions                                                          | Answers                                                                                                                                                                                   | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Will you pay less if you use a <a href="#">network provider</a> ?            | Yes. See <a href="https://kingcountycolliance.orderlyhealth.com/">https://kingcountycolliance.orderlyhealth.com/</a> or call 800-966-4086 for a list of <a href="#">network providers</a> | This plan uses a <a href="#">provider network</a> . You pay the least if you use a <a href="#">provider</a> , in the preferred network. 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 <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your network provider 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                                    | In-Network Provider<br>(You will pay the least)                                                                                                   | Out-of-Network Provider<br>(You will pay the most)   | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                     |
|------------------------------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                        |                                                          |                                                                                                                                                   |                                                      |                                                                                                                                                                                                                                                                                                                            |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness         | \$20 <a href="#">copay</a> / office visit, <a href="#">deductible</a> does not apply;<br><br>10% <a href="#">coinsurance</a> , for other services | 40% <a href="#">coinsurance</a>                      | None.                                                                                                                                                                                                                                                                                                                      |
|                                                                        | <a href="#">Specialist</a> visit                         | \$20 <a href="#">copay</a> / office visit, <a href="#">deductible</a> does not apply;<br><br>10% <a href="#">coinsurance</a> , for other services | 40% <a href="#">coinsurance</a>                      | None.                                                                                                                                                                                                                                                                                                                      |
|                                                                        | <a href="#">Preventive care/screening</a> / immunization | No charge, <a href="#">deductible</a> does not apply                                                                                              | No charge, <a href="#">deductible</a> does not apply | No charge, <a href="#">deductible</a> does not apply for childhood immunizations from <a href="#">out-of-network providers</a> . You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |

| Common Medical Event                                 | Services You May Need                                 | In-Network Provider<br>(You will pay the least)                                                                                                                                                                                                             | Out-of-Network Provider<br>(You will pay the most)                                         | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                            |
|------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                      |                                                       |                                                                                                                                                                                                                                                             |                                                                                            |                                                                                                                                                                                                                                                                                                   |
| If you have a test                                   | <a href="#">Diagnostic test</a> (x-ray, blood work)   | 10% <a href="#">coinsurance</a>                                                                                                                                                                                                                             | 40% <a href="#">coinsurance</a>                                                            | None                                                                                                                                                                                                                                                                                              |
|                                                      | Imaging (CT/PET scans, MRIs)                          | 10% <a href="#">coinsurance</a>                                                                                                                                                                                                                             | 40% <a href="#">coinsurance</a>                                                            | None                                                                                                                                                                                                                                                                                              |
| If you need drugs to treat your illness or condition | Tier 1<br>(Generic drugs)                             | Retail: \$5 <a href="#">copay</a> up to 30-day supply<br>Retail: \$10 <a href="#">copay</a> for 31–91 day supply, except at CVS and Walgreens which are limited to 30-day supply<br><br>Mail order: \$10 <a href="#">copay</a> , up to 91-day supply        | \$5 <a href="#">copay</a> , plus remaining balance after pharmacy is paid at network rate  | Your <a href="#">prescription drug coverage</a> is administered through your pharmacy vendor.<br><br>There is no <a href="#">deductible</a> applied to prescription drug purchases.<br><br><a href="#">Prescription drug out-of-pocket limit</a> :<br>\$1,500 individual/ \$3,000 family per year |
|                                                      | Tier 2<br>(Preferred drugs)                           | Retail: \$25 <a href="#">copay</a> , up to 30-day supply<br>Retail: \$50 <a href="#">copay</a> , for 31-91 day supply, except at CVS and Walgreens which are limited to 30-day supply<br><br>Mail order: \$50 <a href="#">copay</a> , up to 91-day supply   | \$25 <a href="#">copay</a> , plus remaining balance after pharmacy is paid at network rate |                                                                                                                                                                                                                                                                                                   |
|                                                      | Tier 3<br>(Non-preferred drugs)                       | Retail: \$75 <a href="#">copay</a> , up to 30-day supply<br>Retail: \$150 <a href="#">copay</a> , for 31-91 day supply, except at CVS and Walgreens which are limited to 30-day supply<br><br>Mail-order: \$150 <a href="#">copay</a> , up to 91-day supply | \$75 <a href="#">copay</a> , plus remaining balance after pharmacy is paid at network rate |                                                                                                                                                                                                                                                                                                   |
|                                                      | Tier 4<br>(Preferred <a href="#">Specialty</a> drugs) | Specialty mail order: \$25 <a href="#">copay</a> , per 30-day supply                                                                                                                                                                                        | \$25 <a href="#">copay</a> , plus remaining balance after pharmacy is paid at network rate |                                                                                                                                                                                                                                                                                                   |

| Common Medical Event                    | Services You May Need                                         | In-Network Provider<br>(You will pay the least)                                                                                              | Out-of-Network Provider<br>(You will pay the most)                                         | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                            |
|-----------------------------------------|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                         |                                                               |                                                                                                                                              |                                                                                            |                                                                                                                                                                                                                                                                                                                   |
|                                         | Tier 5<br>(Non-Preferred<br><a href="#">Specialty drugs</a> ) | Specialty mail order: \$75<br><a href="#">copay</a> , per 30-day supply                                                                      | \$75 <a href="#">copay</a> , plus remaining balance after pharmacy is paid at network rate |                                                                                                                                                                                                                                                                                                                   |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center)                | 10% <a href="#">coinsurance</a>                                                                                                              | 40% <a href="#">coinsurance</a>                                                            | <a href="#">Preauthorization</a> may be required for certain surgeries as found on the <a href="#">Preauthorization</a> list.                                                                                                                                                                                     |
|                                         | Physician/surgeon fees                                        | 10% <a href="#">coinsurance</a>                                                                                                              | 40% <a href="#">coinsurance</a>                                                            |                                                                                                                                                                                                                                                                                                                   |
| If you need immediate medical attention | <a href="#">Emergency room care</a>                           | 10% <a href="#">coinsurance</a> after \$200 <a href="#">copay</a> /visit                                                                     | 10% <a href="#">coinsurance</a> after \$200 <a href="#">copay</a> /visit                   | <a href="#">Copayment</a> applies to facility charge for each visit (waived if admitted), whether or not the <a href="#">deductible</a> has been met.<br><a href="#">Out-of-network provider</a> services apply to the <a href="#">in-network deductible</a> and <a href="#">in-network out-of-pocket limit</a> . |
|                                         | <a href="#">Emergency medical transportation</a>              | 10% <a href="#">coinsurance</a>                                                                                                              | 10% <a href="#">coinsurance</a>                                                            | <a href="#">Out-of-network provider</a> services apply to the <a href="#">in-network deductible</a> and <a href="#">in-network out-of-pocket limit</a> .                                                                                                                                                          |
|                                         | <a href="#">Urgent care</a>                                   | \$20 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply;<br><br>10% <a href="#">coinsurance</a> for all other services | 40% <a href="#">coinsurance</a>                                                            | None.                                                                                                                                                                                                                                                                                                             |
| If you have a hospital stay             | Facility fee (e.g., hospital room)                            | 10% <a href="#">coinsurance</a>                                                                                                              | 40% <a href="#">coinsurance</a>                                                            | <a href="#">Preauthorization</a> may be required for inpatient stays as found on the <a href="#">Preauthorization</a> list.                                                                                                                                                                                       |
|                                         | Physician/surgeon fees                                        | 10% <a href="#">coinsurance</a>                                                                                                              | 40% <a href="#">coinsurance</a>                                                            |                                                                                                                                                                                                                                                                                                                   |

| Common Medical Event                                                      | Services You May Need                     | In-Network Provider<br>(You will pay the least)                                                                                                                      | Out-of-Network Provider<br>(You will pay the most) | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           |                                                                                                                                                                      |                                                    |                                                                                                                                                                                                                                                                                                                                |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$20 <a href="#">copay</a> / office or psychotherapy visit, <a href="#">deductible</a> does not apply;<br><br>10% <a href="#">coinsurance</a> for all other services | 40% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> may be required for inpatient stays as found on the <a href="#">Preauthorization</a> list.                                                                                                                                                                                                    |
|                                                                           | Inpatient services                        | 10% <a href="#">coinsurance</a>                                                                                                                                      | 40% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                                                |
| If you are pregnant                                                       | Office visits                             | 10% <a href="#">coinsurance</a>                                                                                                                                      | 40% <a href="#">coinsurance</a>                    | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply.<br>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                           | Childbirth/delivery professional services | 10% <a href="#">coinsurance</a>                                                                                                                                      | 40% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                                                |
|                                                                           | Childbirth/delivery facility services     | 10% <a href="#">coinsurance</a>                                                                                                                                      | 40% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                                                |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | No charge                                                                                                                                                            | No charge                                          | 130 visits / year combined with private duty nursing visit limit.                                                                                                                                                                                                                                                              |
|                                                                           | <a href="#">Rehabilitation services</a>   | 10% <a href="#">coinsurance</a>                                                                                                                                      | 40% <a href="#">coinsurance</a>                    | 60 inpatient days / year<br>60 outpatient days / year<br>Includes physical therapy, occupational therapy<br>speech therapies.                                                                                                                                                                                                  |
|                                                                           | <a href="#">Habilitation services</a>     | 10% <a href="#">coinsurance</a>                                                                                                                                      | 40% <a href="#">coinsurance</a>                    | Includes physical therapy, occupational therapy, aura and speech therapies.                                                                                                                                                                                                                                                    |
|                                                                           | <a href="#">Skilled nursing care</a>      | 10% <a href="#">coinsurance</a>                                                                                                                                      | 40% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                                                           |
|                                                                           | <a href="#">Durable medical equipment</a> | 10% <a href="#">coinsurance</a>                                                                                                                                      | 40% <a href="#">coinsurance</a>                    | \$100 / lifetime for wigs to replace hair loss caused by radiation therapy or chemotherapy for a covered condition, or with a transgender diagnosis.<br><a href="#">Preauthorization</a> may be required for certain Durable medical equipment as found on the <a href="#">Preauthorization</a> list.                          |
|                                                                           | <a href="#">Hospice services</a>          | No charge                                                                                                                                                            | No charge                                          | None.                                                                                                                                                                                                                                                                                                                          |

| Common Medical Event                   | Services You May Need      |                                                 |                                                    | Limitations, Exceptions, & Other Important Information |
|----------------------------------------|----------------------------|-------------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
|                                        |                            | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                        |
| If your child needs dental or eye care | Children's eye exam        | Not covered                                     | Not covered                                        | None                                                   |
|                                        | Children's glasses         | Not covered                                     | Not covered                                        |                                                        |
|                                        | Children's dental check-up | Not covered                                     | Not covered                                        |                                                        |

#### 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, except congenital anomalies
- Long-term care
- Weight loss programs
- Dental care
- Routine eye care

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

- Abortion
- Acupuncture, 60 visits / year
- Bariatric surgery
- Chiropractic care, 33 spinal manipulation visits/ year
- Fertility treatment, \$25,000 / lifetime except for artificial insemination services, additional limit of \$10,000 / lifetime for [prescription drugs](#)
- Hearing aids, 1 per ear / 36 months
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing, 130 visits / year (including home health 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: the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform) or your state insurance department. 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 the [plan](#) at 800-966-4086 or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform).

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

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

#### Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

## Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 800-966-4086.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-966-4086.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[ 800-966-4086.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 800-966-4086

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*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

## 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

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

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$100 |
| ■ <a href="#">Specialist Copayment</a>                          | \$20  |
| ■ Hospital (facility) <a href="#">Coinsurance</a>               | 10%   |
| ■ Other <a href="#">Coinsurance</a>                             | 10%   |

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$100        |
| <a href="#">Copayments</a>        | \$0          |
| <a href="#">Coinsurance</a>       | \$800        |
| What isn't covered                |              |
| Limits or exclusions              | \$60         |
| <b>The total Peg would pay is</b> | <b>\$960</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$100 |
| ■ <a href="#">Specialist Copayment</a>                          | \$20  |
| ■ Hospital (facility) <a href="#">Coinsurance</a>               | 10%   |
| ■ Other <a href="#">Coinsurance</a>                             | 10%   |

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$100        |
| <a href="#">Copayments</a>        | \$200        |
| <a href="#">Coinsurance</a>       | \$400        |
| What isn't covered                |              |
| Limits or exclusions              | \$200        |
| <b>The total Mia would pay is</b> | <b>\$900</b> |

### Mia's Simple Fracture

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

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$100 |
| ■ <a href="#">Specialist Copayment</a>                          | \$20  |
| ■ Hospital (facility) <a href="#">Coinsurance</a>               | 10%   |
| ■ Other <a href="#">Coinsurance</a>                             | 10%   |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$150        |
| <a href="#">Copayments</a>        | \$100        |
| <a href="#">Coinsurance</a>       | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$250</b> |

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