



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 833-440-4367 or visit [join.collectivehealth.com/catimes](https://join.collectivehealth.com/catimes). For 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](https://www.healthcare.gov/sbc-glossary) or call 833-440-4367 to request a copy.

| Important Questions                                                       | Answers                                                                                                                                                                                                                                                                                         | Why This Matters                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <u>deductible</u>?</b>                             | For in- <u>network</u> services:<br>\$1,000/Individual, \$2,000/Family<br>For out-of- <u>network</u> services:<br>\$3,000/Individual, \$6,000/Family                                                                                                                                            | Generally, you must pay all of 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 <u>deductible</u>?</b> | Yes. In- <u>network</u> <u>preventive care</u> and certain other services are covered before you meet your <u>deductible</u> . See services marked " <u>Deductible</u> does not apply" in the Limits, Exceptions & Other Important Information column of the Common Medical Events table below. | 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 certain <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 <u>deductibles</u> for specific services?</b>          | No.                                                                                                                                                                                                                                                                                             | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | For in- <u>network</u> services:<br>\$3,000/Individual, \$6,000/Family<br>For out-of- <u>network</u> services:<br>\$6,000/Individual, \$12,000/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 <u>out-of-pocket limit</u>?</b>            | <u>Premiums</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover are not included.                                                                                                                                                                               | 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 <u>network provider</u>?</b>   | Yes. See <a href="http://join.collectivehealth.com/catimes">join.collectivehealth.com/catimes</a> or call 833-440-4367 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 charge</u> 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 <u>referral</u> to see a <u>specialist</u>?</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                                                                                                                                                                                                                                                |
|----------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                      |                                                  | <u>Network Provider</u><br>(You will pay the least)      | <u>Out-of-Network Provider</u><br>(You will pay the most)     |                                                                                                                                                                                                                                                                                                       |
| <b>If you visit a health care <u>provider's office</u> or clinic</b> | Primary care visit to treat an injury or illness | \$25 <u>copay</u> /visit                                 | 40% <u>coinsurance</u>                                        | In-network: <u>Deductible</u> does not apply.<br>Out-of-network: Subject to <u>deductible</u> and <u>balance billing</u> .                                                                                                                                                                            |
|                                                                      | <u>Specialist</u> visit                          | \$40 <u>copay</u> /visit                                 | 40% <u>coinsurance</u>                                        | In-network: <u>Deductible</u> does not apply.<br>Out-of-network: Subject to <u>deductible</u> and <u>balance billing</u> .                                                                                                                                                                            |
|                                                                      | <u>Preventive care/screening/immunization</u>    | No charge                                                | 40% <u>coinsurance</u>                                        | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.<br>In-network: <u>Deductible</u> does not apply.<br>Out-of-network: Subject to <u>deductible</u> and <u>balance billing</u> . |
| <b>If you have a test</b>                                            | <u>Diagnostic test</u> (x-ray, blood work)       | 20% <u>coinsurance</u>                                   | 40% <u>coinsurance</u>                                        | Subject to <u>deductible</u> .<br>Out-of-network: Subject to <u>balance billing</u> .<br>May require <u>prior authorization</u> .                                                                                                                                                                     |
|                                                                      | Imaging (CT/PET scans, MRIs)                     | 20% <u>coinsurance</u>                                   | 40% <u>coinsurance</u>                                        | Subject to <u>deductible</u> .<br>Out-of-network: Subject to <u>balance billing</u> .<br>May require <u>prior authorization</u> .                                                                                                                                                                     |
|                                                                      | Generic drugs                                    | Retail (30-day) & Mail order (90-day): \$10 <u>copay</u> | Retail (30-day): \$10 <u>copay</u><br>Mail order: Not covered | <u>Deductible</u> does not apply.                                                                                                                                                                                                                                                                     |
|                                                                      | Preferred brand drugs                            | Retail (30-day): 30% <u>coinsurance</u> (Minimum         | Retail (30-day): 30% <u>coinsurance</u> (Minimum              | Your plan requires that maintenance medications be filled at a 90-day supply                                                                                                                                                                                                                          |

| Common Medical Event                                                                                                                                                                                       | Services You May Need                         | What You Will Pay                                                                                                                     |                                                                                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                            |                                               | <u>Network Provider</u><br>(You will pay the least)                                                                                   | <u>Out-of-Network Provider</u><br>(You will pay the most)                                                             |                                                                                                                                                                                                                                    |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b><u>prescription drug coverage</u></b> is available by calling Collective Health Member Advocates at 833-440-4367. |                                               | payment of \$25, maximum payment of \$50)<br>Mail order (90-day): \$100 <u>copay</u>                                                  | payment of \$25, maximum payment of \$50)<br>Mail order: Not covered                                                  | either through mail order or through participating Smart90 Walgreens Retail Locations. Otherwise, you will not be able to pick up your medication the 3rd time you fill at a retail pharmacy.                                      |
|                                                                                                                                                                                                            | Non-preferred brand drugs                     | Retail (30-day): 45% <u>coinsurance</u> (Minimum payment of \$40, maximum payment of \$80)<br>Mail order (90-day): \$160 <u>copay</u> | Retail (30-day): 45% <u>coinsurance</u> (Minimum payment of \$40, maximum payment of \$80)<br>Mail order: Not covered | If you or your <u>provider</u> choose a brand-name medication when a generic version is available, you will have to pay the generic <u>cost sharing</u> and the difference in cost when you fill this medication.                  |
|                                                                                                                                                                                                            | <u>Specialty drugs</u>                        | Retail (30-day) & Mail order (90-day): \$125 <u>copay</u>                                                                             | Not covered                                                                                                           | Your plan will require you to obtain specialty medications through Express Scripts' home delivery service (Accredo, or Freedom for fertility medications) or you will owe the full cost of the drug when you fill this medication. |
| <b>If you have outpatient surgery</b>                                                                                                                                                                      | Facility fee (e.g. ambulatory surgery center) | 20% <u>coinsurance</u>                                                                                                                | 40% <u>coinsurance</u>                                                                                                | Subject to <u>deductible</u> .<br>Out-of-network: Subject to <u>balance billing</u> .<br>May require <u>prior authorization</u> .                                                                                                  |
|                                                                                                                                                                                                            | Physician/surgeon fees                        | 20% <u>coinsurance</u>                                                                                                                | 40% <u>coinsurance</u>                                                                                                | Subject to <u>deductible</u> .<br>Out-of-network: Subject to <u>balance billing</u> .<br>May require <u>prior authorization</u> .                                                                                                  |
| <b>If you need immediate medical attention</b>                                                                                                                                                             | <u>Emergency room care</u>                    | \$150 <u>copay</u> /visit                                                                                                             | \$150 <u>copay</u> /visit                                                                                             | <u>Deductible</u> does not apply.<br><u>Copay</u> waived if admitted.                                                                                                                                                              |
|                                                                                                                                                                                                            | <u>Emergency medical transportation</u>       | 20% <u>coinsurance</u>                                                                                                                | 20% <u>coinsurance</u>                                                                                                | Subject to in-network <u>deductible</u> .<br>Non-emergency transportation may require <u>prior authorization</u> .                                                                                                                 |
|                                                                                                                                                                                                            | <u>Urgent care</u>                            | 20% <u>coinsurance</u>                                                                                                                | 40% <u>coinsurance</u>                                                                                                | Subject to <u>deductible</u> .<br>Out-of-network: Subject to <u>balance billing</u> .                                                                                                                                              |
| <b>If you have a hospital stay</b>                                                                                                                                                                         | Facility fee (e.g. hospital room)             | 20% <u>coinsurance</u>                                                                                                                | 40% <u>coinsurance</u>                                                                                                | Subject to <u>deductible</u> .<br>Out-of-network: Subject to <u>balance billing</u> .<br>May require <u>prior authorization</u> .                                                                                                  |
|                                                                                                                                                                                                            | Physician/surgeon fees                        | 20% <u>coinsurance</u>                                                                                                                | 40% <u>coinsurance</u>                                                                                                | Subject to <u>deductible</u> .<br>Out-of-network: Subject to <u>balance billing</u> .                                                                                                                                              |

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay                                                                       |                                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                    |
|----------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                           | <u>Network Provider</u><br>(You will pay the least)                                     | <u>Out-of-Network Provider</u><br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                           |
|                                                                                  |                                           |                                                                                         |                                                           | May require <u>prior authorization</u> .                                                                                                                                                                                                                                                                                                  |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | Office Visits: \$25 <u>copay</u> /visit<br>Intensive Outpatient: 20% <u>coinsurance</u> | 40% <u>coinsurance</u>                                    | Office Visits:<br>In- <u>network</u> : <u>Deductible</u> does not apply.<br>Out-of- <u>network</u> : Subject to <u>deductible</u> and <u>balance billing</u> .<br><br>Intensive Outpatient:<br>Subject to <u>deductible</u> .<br>Out-of- <u>network</u> : Subject to <u>balance billing</u> .<br>May require <u>prior authorization</u> . |
|                                                                                  | Inpatient services                        | 20% <u>coinsurance</u>                                                                  | 40% <u>coinsurance</u>                                    | Subject to <u>deductible</u> .<br>Out-of- <u>network</u> : Subject to <u>balance billing</u> .<br>May require <u>prior authorization</u> .                                                                                                                                                                                                |
| <b>If you are pregnant</b>                                                       | Office visits                             | PCP Visits: \$25 <u>copay</u> /visit<br>Specialist Visits: \$40 <u>copay</u> /visit     | 40% <u>coinsurance</u>                                    | In- <u>network</u> : <u>Deductible</u> does not apply.<br>Out-of- <u>network</u> : Subject to <u>deductible</u> and <u>balance billing</u> .<br>Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound). <u>Cost sharing</u> does not apply for <u>preventive services</u> .                       |
|                                                                                  | Childbirth/delivery professional services | 20% <u>coinsurance</u>                                                                  | 40% <u>coinsurance</u>                                    | Subject to <u>deductible</u> .<br>Out-of- <u>network</u> : Subject to <u>balance billing</u> .<br>May require <u>prior authorization</u> .                                                                                                                                                                                                |
|                                                                                  | Childbirth/delivery facility services     | 20% <u>coinsurance</u>                                                                  | 40% <u>coinsurance</u>                                    | Subject to <u>deductible</u> .<br>Out-of- <u>network</u> : Subject to <u>balance billing</u> .<br>May require <u>prior authorization</u> .                                                                                                                                                                                                |
| <b>If you need help recovering or have other special needs</b>                   | <u>Home health care</u>                   | 20% <u>coinsurance</u>                                                                  | 40% <u>coinsurance</u>                                    | Subject to <u>deductible</u> .<br>Out-of- <u>network</u> : Subject to <u>balance billing</u> .<br>120 day limit every year.<br>For private duty nursing, a separate 60 day limit applies.<br>May require <u>prior authorization</u> .                                                                                                     |

| Common Medical Event                   | Services You May Need            | What You Will Pay                                                |                                                                  | Limitations, Exceptions, & Other Important Information                                                                                                                          |
|----------------------------------------|----------------------------------|------------------------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                  | <u>Network Provider</u><br>(You will pay the least)              | <u>Out-of-Network Provider</u><br>(You will pay the most)        |                                                                                                                                                                                 |
|                                        | <u>Rehabilitation services</u>   | Physical, Occupational, & Speech Therapy: 20% <u>coinsurance</u> | Physical, Occupational, & Speech Therapy: 40% <u>coinsurance</u> | Subject to <u>deductible</u> .<br>Out-of-network: Subject to <u>balance billing</u> .<br>Occupational Therapy, Physical Therapy, and Speech Therapy: Combined 60 session limit. |
|                                        | <u>Habilitation services</u>     | \$25 <u>copay</u> /session                                       | 40% <u>coinsurance</u>                                           | In-network: <u>Deductible</u> does not apply.<br>Out-of-network: Subject to <u>deductible</u> and <u>balance billing</u> .                                                      |
|                                        | <u>Skilled nursing center</u>    | 20% <u>coinsurance</u>                                           | 40% <u>coinsurance</u>                                           | Subject to <u>deductible</u> .<br>Out-of-network: Subject to <u>balance billing</u> .<br>120 day limit every year.<br>May require <u>prior authorization</u> .                  |
|                                        | <u>Durable medical equipment</u> | 20% <u>coinsurance</u>                                           | 40% <u>coinsurance</u>                                           | Subject to <u>deductible</u> .<br>Out-of-network: Subject to <u>balance billing</u> .<br>May require <u>prior authorization</u> .                                               |
|                                        | <u>Hospice services</u>          | 20% <u>coinsurance</u>                                           | 40% <u>coinsurance</u>                                           | Subject to <u>deductible</u> .<br>Out-of-network: Subject to <u>balance billing</u> .<br>May require <u>prior authorization</u> .                                               |
| If your child needs dental or eye care | Children's eye exam              | Not covered                                                      | Not covered                                                      | Children's eye exams are covered as required under <u>preventive care</u> .<br>See vision <u>plan</u> for other coverage.                                                       |
|                                        | Children's glasses               | Not covered                                                      | Not covered                                                      | See vision <u>plan</u> for coverage.                                                                                                                                            |
|                                        | Children's dental check-up       | Not covered                                                      | Not covered                                                      | See dental <u>plan</u> for coverage.                                                                                                                                            |

### Excluded Services & Other Covered Services

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) |                                                                                                                                |                                                                                                                                                                       |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Glasses (Child)</li> <li>• Routine eye care (Adult)</li> </ul>                                    | <ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Long-term care</li> <li>• Routine foot care</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care (Child)</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Weight loss programs</li> </ul> |  |

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

- |                                             |                                                                              |                                                                     |
|---------------------------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------------|
| ● Acupuncture (12 session limit every year) | ● Bariatric surgery                                                          | ● Chiropractic care (30 session limit every year)                   |
| ● Hearing aids (\$2,000 limit every year)   | ● Infertility treatment (\$10,000 medical & \$5,000 pharmacy lifetime limit) | ● Private duty nursing (covered for home health only, 60 day limit) |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-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 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact Collective Health at 833-440-4367. You can also contact the Department of Labor's Employee Benefits Security Administration at 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 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 833-440-4367.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 833-440-4367.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 833-440-4367.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 833-440-4367.

*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 plan's overall deductible \$1,000
- Specialist copay \$40
- Hospital (facility) coinsurance 20%

#### 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:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,000        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$2,000        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,060</b> |

### Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$1,000
- Specialist copay \$40
- Hospital (facility) coinsurance 20%

#### 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, Joe would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$900          |
| <u>Copayments</u>                 | \$400          |
| <u>Coinsurance</u>                | \$900          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,220</b> |

### Mia's Simple Fracture

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

- The plan's overall deductible \$1,000
- Specialist copay \$40
- Hospital (facility) coinsurance 20%

#### 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:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,000        |
| <u>Copayments</u>                 | \$300          |
| <u>Coinsurance</u>                | \$100          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,400</b> |

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