



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, visit <https://exchange.communityfirsthealthplans.com/plan-documents/>. 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 [SBC Uniform Glossary | HealthCare.gov](#) or call 1-888-512-2347 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                       | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$7,500 individual / \$15,000 family                                                                                                                                                                          | See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. In-Network <a href="#">Preventive care</a> services with a <a href="#">copayment</a> , and some <a href="#">prescription drugs</a> are covered before you meet your <a href="#">deductible</a> .         | 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 services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No                                                                                                                                                                                                            | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$12,000 individual / \$24,000 family                                                                                                                                                                         | 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 limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="https://exchange.communityfirsthealthplans.com/network">https://exchange.communityfirsthealthplans.com/network</a> or call 1-888-512-2347 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . 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 <a href="#">network provider</a> 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                                  | What You Will Pay                                              |                                                     |                                                             | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                        |                                                        | Indian Health Care Provider (IHCP)<br>(You will pay the least) | Non-IHCP In-Network Provider<br>(You will pay more) | Non-IHCP Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>                                                                                                                                                                                                          | Primary care visit to treat an injury or illness       | No charge                                                      | \$50 <a href="#">copay</a> per visit                | Not Covered                                                 | Virtual visits are available with some PCPs                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                                        | <a href="#">Specialist</a> visit                       | No charge                                                      | \$100 <a href="#">copay</a> per visit               | Not Covered                                                 | <a href="#">Referrals</a> not required.                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                        | <a href="#">Preventive care/screening/immunization</a> | No charge                                                      | No charge                                           | Not Covered                                                 | 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.                                                                                                                                                                                                                                           |
| <b>If you have a test</b>                                                                                                                                                                                                                                                              | <a href="#">Diagnostic test</a> (x-ray, blood work)    | No charge                                                      | 50% <a href="#">coinsurance</a> per test            | Not Covered                                                 | <a href="#">Preauthorization</a> is required for sleep studies and video EEG monitoring.                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                        | Imaging (CT/PET scans, MRIs)                           | No charge                                                      | 50% <a href="#">coinsurance</a> per test            | Not Covered                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://exchange.communityfirstthehealthplans.com/formulary">https://exchange.communityfirstthehealthplans.com/formulary</a> | Zero Cost Share (Tier 1)                               | No charge                                                      | \$0 <a href="#">copay</a> /30-day supply            | Not Covered                                                 | Limited to a 30-day supply at retail (or a 90-day supply at a <a href="#">network</a> of select retail pharmacies). Up to a 90-day supply at mail order. <a href="#">Specialty drugs</a> limited to a 30-day supply. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. <a href="#">Preauthorization</a> may apply to select specialty medications. |
|                                                                                                                                                                                                                                                                                        | Generic drugs (Tier 2)                                 | No charge                                                      | \$25 <a href="#">copay</a> /30-day supply           | Not Covered                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                                                                        | Preferred brand drugs (Tier 3)                         | No charge                                                      | \$50 <a href="#">copay</a> /30-day supply           | Not Covered                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                                                                        | Non-preferred brand drugs (Tier 4)                     | No charge                                                      | \$100 <a href="#">copay</a> /30-day supply          | Not Covered                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                                                                        | <a href="#">Specialty drugs</a> (Tier 5)               | No charge                                                      | \$500 <a href="#">copay</a> /30-day supply          | Not Covered                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                                                  | Facility fee (e.g., ambulatory surgery center)         | No charge                                                      | 50% <a href="#">coinsurance</a> per visit           | Not Covered                                                 | <a href="#">Preauthorization</a> may be required.                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                        | Physician/surgeon fees                                 | No charge                                                      | 50% <a href="#">coinsurance</a>                     | Not Covered                                                 | <a href="#">Preauthorization</a> may be required. For Outpatient Infusion Therapy, see policy document*. Any procedure that could be deemed as cosmetic requires authorization.                                                                                                                                                                                                                                                     |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://exchange.communityfirstthehealthplans.com/plan-documents/>

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                           |                                                  |                                                          | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | No charge                                                   | 50% <a href="#">coinsurance</a> per visit        | 50% <a href="#">coinsurance</a> per visit                | Emergency room <a href="#">coinsurance</a> waived if admitted. <a href="#">Preauthorization may be required for non-emergency and air transportation; see policy document*</a> .                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                           | <a href="#">Emergency medical transportation</a> | No charge                                                   | 50% <a href="#">coinsurance</a> per visit        | 50% <a href="#">coinsurance</a> per visit                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                           | <a href="#">Urgent care</a>                      | No charge                                                   | \$75 <a href="#">copay</a> per visit             | Not Covered                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | No charge                                                   | 50% <a href="#">coinsurance</a> per stay         | Not Covered                                              | <a href="#">Preauthorization</a> is required; see policy document*. All usual hospital services and supplies, including semiprivate room, intensive care, and coronary care units.                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                           | Physician/surgeon fees                           | No charge                                                   | No charge                                        | Not Covered                                              | <a href="#">Preauthorization</a> is required; see policy document*.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | No charge                                                   | \$50 <a href="#">copay</a> per visit             | Not Covered                                              | <a href="#">Preauthorization</a> is required; see policy document*.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                           | Inpatient services                               | No charge                                                   | 50% <a href="#">coinsurance</a> per stay         | Not Covered                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| If you are pregnant                                                       | Office visits                                    | No charge                                                   | \$50 <a href="#">copay</a>                       | Not Covered                                              | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Prenatal and Postnatal Visits – After the initial office visit, subsequent office visits are covered in full. Will cover 48-hour hospital stay for uncomplicated vaginal delivery and 96-hour hospital stay for uncomplicated caesarean section. Stays longer than the “global stay” requires <a href="#">Preauthorization</a> . |
|                                                                           | Childbirth/delivery professional services        | No charge                                                   | No copay                                         | Not Covered                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                           | Childbirth/delivery facility services            | No charge                                                   | 50% <a href="#">coinsurance</a>                  | Not Covered                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://exchange.communityfirsthealthplans.com/plan-documents/>

| Common Medical Event                                                  | Services You May Need                     | What You Will Pay                                              |                                                     |                                                             | Limitations, Exceptions, & Other Important Information                                                 |
|-----------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
|                                                                       |                                           | Indian Health Care Provider (IHCP)<br>(You will pay the least) | Non-IHCP In-Network Provider<br>(You will pay more) | Non-IHCP Out-of-Network Provider<br>(You will pay the most) |                                                                                                        |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | No charge                                                      | \$50 <a href="#">copay</a>                          | Not Covered                                                 | 60 visits/year. <a href="#">Preauthorization required</a> ; see policy document*.                      |
|                                                                       | <a href="#">Rehabilitation services</a>   | No charge                                                      | \$50 <a href="#">copay</a>                          | Not Covered                                                 | 35 visits/year. <a href="#">Preauthorization required</a> ; see policy document*.                      |
|                                                                       | <a href="#">Habilitation services</a>     | No charge                                                      | \$50 <a href="#">copay</a>                          | Not Covered                                                 |                                                                                                        |
|                                                                       | <a href="#">Skilled nursing care</a>      | No charge                                                      | 50% <a href="#">coinsurance</a> per day             | Not Covered                                                 | 25 days/year. <a href="#">Preauthorization required</a> ; see policy document*.                        |
|                                                                       | <a href="#">Durable medical equipment</a> | No charge                                                      | \$50 <a href="#">copay</a>                          | Not Covered                                                 | <a href="#">Preauthorization</a> is required.                                                          |
|                                                                       | <a href="#">Hospice services</a>          | No charge                                                      | \$100 <a href="#">copay</a>                         | Not Covered                                                 | <a href="#">Preauthorization</a> may be required.                                                      |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | No charge                                                      | \$50 <a href="#">copay</a> per visit                | Not covered                                                 | Coverage limited to one exam/year. See policy document* for Pediatric Vision Care Benefits.            |
|                                                                       | Children's glasses                        | No charge                                                      | \$50 <a href="#">copay</a>                          | Not covered                                                 | Coverage limited to one pair of glasses/year. See policy document* for Pediatric Vision Care Benefits. |
|                                                                       | Children's dental check-up                | Not covered                                                    | Not covered                                         | Not covered                                                 | None                                                                                                   |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://exchange.communityfirsthealthplans.com/plan-documents/>

## 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](#).)

- Abortion (except for a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed)
- Acupuncture
- Bariatric surgery
- Non-emergency care when traveling outside the U.S.
- Cosmetic surgery (except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases when [medically necessary](#))
- Dental Care (Adult)
- Infertility treatment (diagnosis and treatment covered; invitro not covered)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (except in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency)
- Weight loss programs

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

- Chiropractic care (35 visits per year), \$100 [copay](#) per visit.
- Hearing aids (one hearing aid per ear every 36 months), \$100 [copay](#) per hearing aid
- Accidental Dental - 50% [coinsurance](#) after deductible

**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:

Community First Insurance Plans at 1-888-512-2347 or at <https://exchange.communityfirstthehealthplans.com/>.

Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>

State consumer assistance program contact information available from <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

Office of Personnel Management Multi State Plan Program: <https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/>.

Healthcare.gov: [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596 or state health insurance marketplace or SHOP.

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.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://exchange.communityfirstthehealthplans.com/plan-documents/>

**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: Texas Department of Insurance at 1-800-578-4677 or visit <https://tdi.texas.gov>.

**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? Not Applicable.**

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 1-888-512-2347.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-512-2347.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-512-2347

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-512-2347.

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

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.02** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://exchange.communityfirstthehealthplans.com/plan-documents/>

## 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> | \$7,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$100   |
| ■ Hospital (facility) <a href="#">copayment</a>                 | 50%     |
| ■ Other <a href="#">copayment</a>                               | \$50    |

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>\$12,675</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>         |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$7,500 |
| <a href="#">Copayments</a>  | \$200   |
| <a href="#">Coinsurance</a> | \$500   |

| <i>What isn't covered</i> |     |
|---------------------------|-----|
| Limits or exclusions      | \$0 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Peg would pay is</b> | <b>\$8,200</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> | \$7,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$100   |
| ■ Hospital (facility) <a href="#">copayment</a>                 | 50%     |
| ■ Other <a href="#">copayment</a>                               | \$50    |

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>\$7,650</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>           |         |
|-------------------------------|---------|
| <a href="#">Deductibles</a> * | \$900   |
| <a href="#">Copayments</a>    | \$1,100 |
| <a href="#">Coinsurance</a>   | \$0     |

| <i>What isn't covered</i> |     |
|---------------------------|-----|
| Limits or exclusions      | \$0 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Joe would pay is</b> | <b>\$2,000</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> | \$7,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$100   |
| ■ Hospital (facility) <a href="#">copayment</a>                 | 50%     |
| ■ Other <a href="#">copayment</a>                               | \$50    |

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>\$7,650</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>           |         |
|-------------------------------|---------|
| <a href="#">Deductibles</a> * | \$1,700 |
| <a href="#">Copayments</a>    | \$600   |
| <a href="#">Coinsurance</a>   | \$0     |

| <i>What isn't covered</i> |     |
|---------------------------|-----|
| Limits or exclusions      | \$0 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Mia would pay is</b> | <b>\$2,300</b> |
|-----------------------------------|----------------|

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