



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, [www.communitycarehealth.org](http://www.communitycarehealth.org) or by calling 1-559-724-4995. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-559-724-4995 to request a copy.

| Important Questions                                                                   | Answers                                                                                                                                                                                           | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | \$2,250 Individual / \$4,500 Family                                                                                                                                                               | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                            |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes. <a href="#">Preventive care</a> and the other services listed in the “What you will pay” column of the chart starting on page 2, indicates services covered before you meet your deductible. | 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> .                                                                       |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | Yes. Generic, brand and specialty prescription drugs. <b>\$300</b> Individual / <b>\$600</b> Family. There are no other specific <a href="#">deductibles</a> .                                    | You must pay all of the cost for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | \$8,900 Individual / \$17,800 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.                                                                                                                                                                                                                                                                                                                                                             |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | <a href="#">Copayment</a> for certain services, <a href="#">premiums</a> , <a href="#">balancing-billing</a> charges, and health care this plan doesn’t cover.                                    | Even though you pay these expenses, they don’t count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>               | Yes. See <a href="http://www.communitycarehealth.org">www.communitycarehealth.org</a> or call 1-559-724-4995 for a list of <a href="#">network providers</a> .                                    | This <a href="#">plan</a> uses a provider <a href="#">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. |

| Important Questions                                                          | Answers | Why This Matters:                                                                                                                                                                                                    |
|------------------------------------------------------------------------------|---------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | Yes.    | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</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                                                                                                                                                                                                                                                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                           |                                                        | Network Provider<br>(You will pay the least)                                                                                               | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                             |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                    | Primary care visit to treat an injury or illness       | \$50 / visit, <a href="#">deductible</a> does not apply                                                                                    | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                           | <a href="#">Specialist</a> visit                       | \$85 / visit, <a href="#">deductible</a> does not apply                                                                                    | Not covered                                        | <a href="#">Referral</a> is required. This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services, but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> . Preauthorization may be required for some procedures and services provided by specialists, but is not required for the specialist visit itself. |
|                                                                                                                                           | <a href="#">Preventive care/screening/immunization</a> | No Charge, <a href="#">deductible</a> does not apply                                                                                       | Not covered                                        | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.                                                                                                                                                                                 |
| If you have a test                                                                                                                        | <a href="#">Diagnostic test</a> (x-ray, blood work)    | X-ray: \$85/ encounter, <a href="#">deductible</a> does not apply<br>Lab test: \$40 / encounter, <a href="#">deductible</a> does not apply | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                           | Imaging (CT/PET scans, MRIs)                           | \$300 / procedure, <a href="#">deductible</a> does not apply                                                                               | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                        |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at | Generic drugs                                          | Retail: \$17 / <a href="#">prescription</a><br>Mail order: \$34 / <a href="#">prescription</a> ,                                           | Not covered                                        | Up to a 30-day supply (retail <a href="#">prescription</a> ); 90-day supply (mail order <a href="#">prescription</a> ). Subject to <a href="#">formulary</a> guidelines.                                                                                                                                                                                                                                    |
|                                                                                                                                           | Preferred brand drugs                                  | Retail: \$65 / <a href="#">prescription</a><br>Mail order: \$130 /                                                                         | Not covered                                        | Up to a 30-day supply (retail <a href="#">prescription</a> ); 90-day supply (mail order <a href="#">prescription</a> ).                                                                                                                                                                                                                                                                                     |

| Common Medical Event                                                         | Services You May Need                            | What You Will Pay                                                                                                                                                            |                                                          | Limitations, Exceptions, & Other Important Information                                                                                                                   |
|------------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                              |                                                  | Network Provider<br>(You will pay the least)                                                                                                                                 | Out-of-Network Provider<br>(You will pay the most)       |                                                                                                                                                                          |
| <a href="http://www.communitycarehealth.org">www.communitycarehealth.org</a> |                                                  | <a href="#">prescription</a> , after drug <a href="#">deductible</a>                                                                                                         |                                                          | Subject to <a href="#">formulary</a> guidelines.                                                                                                                         |
|                                                                              | Non-preferred brand drugs                        | Retail: \$90 / <a href="#">prescription</a><br>Mail order: \$180 / <a href="#">prescription</a> , after drug <a href="#">deductible</a>                                      | Not covered                                              | Up to a 30-day supply (retail <a href="#">prescription</a> ); 90-day supply (mail order <a href="#">prescription</a> ). Subject to <a href="#">formulary</a> guidelines. |
|                                                                              | <a href="#">Specialty drugs</a>                  | 20% <a href="#">coinsurance</a> , up to \$250 per <a href="#">prescription</a> , after drug <a href="#">deductible</a>                                                       | Not covered                                              | Up to a 30-day supply (retail <a href="#">prescription</a> ). Subject to <a href="#">formulary</a> guidelines.                                                           |
| If you have outpatient surgery                                               | Facility fee (e.g., ambulatory surgery center)   | 20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply                                                                                                  | Not covered                                              | <a href="#">Preauthorization</a> is required.                                                                                                                            |
|                                                                              | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply                                                                                                  | Not covered                                              | None                                                                                                                                                                     |
| If you need immediate medical attention                                      | <a href="#">Emergency room care</a>              | \$400 / visit                                                                                                                                                                | \$400 / visit                                            | <a href="#">Copayment</a> waived if admitted to hospital as inpatient.                                                                                                   |
|                                                                              | <a href="#">Emergency medical transportation</a> | \$250 / trip                                                                                                                                                                 | \$250 / trip                                             | None                                                                                                                                                                     |
|                                                                              | <a href="#">Urgent care</a>                      | \$50 / visit, <a href="#">deductible</a> does not apply                                                                                                                      | \$50 / visit, <a href="#">deductible</a> does not apply. | Non- <a href="#">Plan Providers</a> covered when temporarily outside the service area.                                                                                   |
| If you have a hospital stay                                                  | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a>                                                                                                                                              | Not covered                                              | <a href="#">Preauthorization</a> is required.                                                                                                                            |
|                                                                              | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply                                                                                                  | Not covered                                              | None                                                                                                                                                                     |
| If you need mental health, behavioral health, or substance abuse services    | Outpatient services                              | \$50 / individual visit; <a href="#">deductible</a> does not apply<br>\$50 / individual visit for other outpatient services visit, <a href="#">deductible</a> does not apply | Not covered                                              | <b><a href="#">Mental / Behavioral Health/ Substance Abuse</a></b><br>\$25 / group visit, <a href="#">deductible</a> does not apply                                      |
|                                                                              | Inpatient services                               | 20% <a href="#">coinsurance</a>                                                                                                                                              | Not covered                                              | None                                                                                                                                                                     |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                                           |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                  |
|----------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | Network Provider<br>(You will pay the least)                                | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                         |
| If you are pregnant                                            | Office visits                             | No Charge, <a href="#">deductible</a> does not apply                        | Not covered                                        | Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                | Childbirth/delivery professional services | 20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply | Not covered                                        | None                                                                                                                                                                                                                                    |
|                                                                | Childbirth/delivery facility services     | 20% <a href="#">coinsurance</a>                                             | Not covered                                        | None                                                                                                                                                                                                                                    |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | \$45 / visit, <a href="#">deductible</a> does not apply                     | Not covered                                        | Up to 2 hours / visit, up to 3 visits per day / up to 100 visits per benefit year.                                                                                                                                                      |
|                                                                | <a href="#">Rehabilitation services</a>   | Outpatient: \$50 / visit, <a href="#">deductible</a> does not apply         | Not covered                                        | None                                                                                                                                                                                                                                    |
|                                                                | <a href="#">Habilitation services</a>     | Outpatient: \$50 / visit, <a href="#">deductible</a> does not apply         | Not covered                                        | None                                                                                                                                                                                                                                    |
|                                                                | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>                                             | Not covered                                        | Up to 100 days limit / benefit period                                                                                                                                                                                                   |
|                                                                | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply | Not covered                                        | <a href="#">Preauthorization</a> is required.                                                                                                                                                                                           |
|                                                                | <a href="#">Hospice services</a>          | No Charge, <a href="#">deductible</a> does not apply                        | Not covered                                        | <a href="#">Preauthorization</a> is required.                                                                                                                                                                                           |
| If your child needs dental or eye care                         | Children's eye exam                       | No Charge, <a href="#">deductible</a> does not apply                        | Not covered                                        | Coverage limited to one exam/year.                                                                                                                                                                                                      |
|                                                                | Children's glasses                        | No Charge, <a href="#">deductible</a> does not apply                        | Not covered                                        | Limited to one pair of glasses / year from select frames and lenses.                                                                                                                                                                    |
|                                                                | Children's dental check-up                | No Charge, <a href="#">deductible</a> does not apply                        | Not covered                                        | Limited to two check-ups / year.                                                                                                                                                                                                        |

## Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                               |                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Cosmetic Surgery</li><li>• Dental Care (Adults)</li><li>• Hearing Aids</li></ul>                                                                          | <ul style="list-style-type: none"><li>• Long Term Care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul> | <ul style="list-style-type: none"><li>• Private Duty Nursing</li><li>• Routine eye care (Adult)</li><li>• Routine Foot Care</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 <a href="#">plan</a> document.)                                                      |                                                                                                                               |                                                                                                                                                                      |
| <ul style="list-style-type: none"><li>• Abortion</li><li>• Chiropractic Care</li></ul>                                                                                                            | <ul style="list-style-type: none"><li>• Acupuncture (plan provider preferred)</li><li>• Infertility Treatment</li></ul>       | <ul style="list-style-type: none"><li>• Bariatric Surgery</li></ul>                                                                                                  |

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

|                                                                                              |                                                                                                           |
|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| Community Care Health Plan                                                                   | 1-559-724-4995 or <a href="http://www.communitycarehealth.org">www.communitycarehealth.org</a>            |
| Department of Labor's Employee Benefits Security Administration                              | 1-866-444-EBSA (3273) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a> |
| Department of Health & Human Services, Center for Consumer Information & Insurance oversight | 1-877-267-2323 X61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a>                         |
| California Department of Insurance                                                           | 1-850-927-HELP (4357) or <a href="http://www.insurance.ca.gov">www.insurance.ca.gov</a>                   |
| California Department of Managed Health Care                                                 | 1-888-466-2219 or <a href="http://www.healthhelp.ca.gov/">www.healthhelp.ca.gov/</a>                      |

## 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 1-559-724-4995.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-559-724-4995.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-559-724-4995.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-559-724-4995.

*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 **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 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> | \$2,250 |
| ■ <a href="#">Specialist copayment</a>                          | \$85    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other (blood work) <a href="#">copayment</a>                  | \$40    |

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

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

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,300        |
| <a href="#">Copayments</a>        | \$700          |
| <a href="#">Coinsurance</a>       | \$1,000        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,060</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> | \$2,250 |
| ■ <a href="#">Specialist copayment</a>                          | \$85    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other (blood work) <a href="#">copayment</a>                  | \$40    |

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:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$300          |
| <a href="#">Copayments</a>        | \$1,600        |
| <a href="#">Coinsurance</a>       | \$200          |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,120</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> | \$2,250 |
| ■ <a href="#">Specialist copayment</a>                          | \$85    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other (x-ray) <a href="#">copayment</a>                       | \$85    |

This EXAMPLE event includes services like:

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

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

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,300        |
| <a href="#">Copayments</a>        | \$700          |
| <a href="#">Coinsurance</a>       | \$60           |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,060</b> |

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