



## Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

**Coverage for:** Individual and/or Family | **Plan Type:** HMO



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

<http://www.fhcp.com/documents/coc/2026-large-group.pdf>. 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.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-877-615-4022 to request a copy.

| Important Questions                                                 | Answers                                                                                                                                                                   | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | <u>Network providers</u> : \$1,500 Individual/<br>\$4,500 Family<br><u>Out-of-network providers</u> : Not covered                                                         | Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                                                               |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Preventive care</u> , and services not subject to the deductible                                                                                                  | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</u> services without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive</u> services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                              |
| Are there other <u>deductibles</u> for specific services?           | No.                                                                                                                                                                       | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | <u>Network providers</u> : \$5,500 Individual/<br>\$11,000 Family<br><u>Out-of-network providers</u> : Not covered                                                        | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                              |
| What is not included in the <u>out-of-pocket limit</u> ?            | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.                                                                         | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Will you pay less if you use a <u>network provider</u> ?            | Yes. See <a href="http://www.fhcp.com/find-providers/physician">www.fhcp.com/find-providers/physician</a> or call 1-877-615-4022 for a list of <u>network providers</u> . | This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?          | Yes.                                                                                                                                                                      | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .                                                                                                                                                                                                                                                                                                                                                                       |

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event                                          | Services You May Need                            | What You Will Pay                                                                                                                                                                                                                                                                                                                                |                                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                     |
|---------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               |                                                  | <u>Network Provider</u><br>(You will pay the least)                                                                                                                                                                                                                                                                                              | <u>Out-of-Network Provider</u><br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                            |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$30 <u>Copay</u> /Visit                                                                                                                                                                                                                                                                                                                         | Not covered                                               | Additional <u>cost share</u> may apply for Allergy shots, Injections and Infusions. See schedule of benefits for telehealth benefit specific cost sharing through designated <u>provider</u> .                                                                                                                                             |
|                                                               | <u>Specialist</u> visit                          | \$55 <u>Copay</u> /Visit                                                                                                                                                                                                                                                                                                                         | Not covered                                               | Additional <u>cost share</u> may apply for Allergy shots, Injections and Infusions.                                                                                                                                                                                                                                                        |
|                                                               | <u>Preventive care/screening/immunization</u>    | No charge                                                                                                                                                                                                                                                                                                                                        | Not covered                                               | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.                                                                                                                                                    |
| If you have a test                                            | <u>Diagnostic test</u> (x-ray, blood work)       | No charge for laboratory & professional services at an independent clinical lab.<br><br>\$50 <u>Copay</u> for x- ray & diagnostic imaging at an independent diagnostic testing center.<br><br>\$25 <u>Copay</u> for laboratory & professional services and \$100 <u>Copay</u> for x-ray & diagnostic imaging at an outpatient hospital facility. | Not covered                                               | Prior authorization is required.<br><br>Tests in hospitals, or facilities owned or operated by hospitals are subject to the outpatient hospital facility cost share.<br><br>Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. See your policy for more details. |
|                                                               | Imaging (CT/PET scans, MRIs)                     | \$200 <u>Copay</u> at an independent facility / \$400 <u>Copay</u> at an outpatient hospital facility.                                                                                                                                                                                                                                           | Not covered                                               |                                                                                                                                                                                                                                                                                                                                            |

| 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) |                                                                                                                                                                                                                                               |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="https://fm.formularynavigator.com/FBO/126/2026_NGF_Formulary.pdf">prescription drug coverage</a> is available at <a href="https://fm.formularynavigator.com/FBO/126/2026_NGF_Formulary.pdf">https://fm.formularynavigator.com/FBO/126/2026_NGF_Formulary.pdf</a> | Generic drugs – preferred / non-preferred                                                 | Retail: \$3 <u>Copay</u> per <u>prescription</u> for Preferred at FHCP / Mail Order: \$6 <u>Copay</u> per <u>prescription</u> for Preferred / Retail: \$10 <u>Copay</u> per <u>prescription</u> for Non-Preferred at FHCP / Mail Order: \$27 <u>Copay</u> per <u>prescription</u> for Non-Preferred / Retail: \$15 <u>Copay</u> per <u>prescription</u> at select Non-Preferred Retail Pharmacies. | Not covered                                        | 31 Days per Benefit Period. Available at Preferred-FHCP and select Non-Preferred Retail Pharmacies Only. Up to 93-day Mail Order available through FHCP Only. Refer to the schedule of benefits for cost sharing at Non-Preferred Pharmacies. |
|                                                                                                                                                                                                                                                                                                                                                                 | Preferred brand drugs                                                                     | Retail: \$30 <u>Copay</u> per <u>prescription</u> at FHCP / Mail Order: \$87 <u>Copay</u> per <u>prescription</u> / Retail: \$35 <u>Copay</u> per <u>prescription</u> at select Non-Preferred Retail Pharmacies.                                                                                                                                                                                   | Not covered                                        |                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                 | Non-preferred brand drugs                                                                 | Retail: \$55 <u>Copay</u> per <u>prescription</u> at FHCP / Mail Order: \$162 <u>Copay</u> per <u>prescription</u> / Retail: \$60 <u>Copay</u> per <u>prescription</u> at select Non-Preferred Retail Pharmacies.                                                                                                                                                                                  | Not covered                                        |                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                 | <a href="#">Specialty drugs</a> – preferred / non-preferred                               | Retail: 15% <u>Coinsurance</u> for Preferred Specialty at FHCP. 25% <u>Coinsurance</u> for Non-Preferred Specialty at FHCP.                                                                                                                                                                                                                                                                        | Not covered                                        | 31 Days per Benefit Period. Available at FHCP Pharmacy Only. Mail Order not available.                                                                                                                                                        |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                                                                                                                           | Facility fee (e.g., ambulatory surgery center (ASC) / outpatient hospital facility (OHF)) | \$200 <u>Copay</u> – ASC / \$400 <u>Copay</u> – OHF                                                                                                                                                                                                                                                                                                                                                | Not covered                                        | Pre-certification/pre-authorization of coverage required for non-emergency outpatient surgical care. Your benefits / services may be denied.                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                 | Physician/surgeon fees                                                                    | No charge                                                                                                                                                                                                                                                                                                                                                                                          | Not covered                                        | Prior approval required. Your benefits / services may be denied.                                                                                                                                                                              |

For more information about limitations and exceptions, see the plan or policy document at <http://www.fhcp.com/documents/coc/2026-large-group.pdf>

| 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 need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$250 <u>Copay</u> /Visit                    | \$250 <u>Copay</u> /Visit                          | Waived if admitted.                                                                                                                   |
|                                                                           | <a href="#">Emergency medical transportation</a> | <u>Deductible</u> + 30% <u>Coinsurance</u>   | <u>Deductible</u> + 30% <u>Coinsurance</u>         | —————none—————                                                                                                                        |
|                                                                           | <a href="#">Urgent care</a>                      | \$75 <u>Copay</u> /Visit                     | \$75 <u>Copay</u> /Visit                           | —————none—————                                                                                                                        |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | <u>Deductible</u> + 30% <u>Coinsurance</u>   | Not covered                                        | Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.        |
|                                                                           | Physician/surgeon fees                           | <u>Deductible</u> + 30% <u>Coinsurance</u>   | Not covered                                        | —————none—————                                                                                                                        |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$55 <u>Copay</u> /Visit                     | Not covered                                        | The cost share displayed applies to outpatient office visits only, other outpatient services may be subject to additional cost share. |
|                                                                           | Inpatient services                               | <u>Deductible</u> + 30% <u>Coinsurance</u>   | Not covered                                        | Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.        |
| If you are pregnant                                                       | Office visits                                    | \$55 <u>Copay</u> /Visit                     | Not covered                                        | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)                                       |
|                                                                           | Childbirth/delivery professional services        | <u>Deductible</u> + 30% <u>Coinsurance</u>   | Not covered                                        | Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.        |
|                                                                           | Childbirth/delivery facility services            | <u>Deductible</u> + 30% <u>Coinsurance</u>   | Not covered                                        | Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.        |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | <u>Deductible</u> + 30% <u>Coinsurance</u>   | Not covered                                        | Prior approval required. Your benefits / services may be denied. Prior approval required. Coverage limited to 60 days.                |
|                                                                           | <a href="#">Rehabilitation services</a>          | <u>Deductible</u> + 30% <u>Coinsurance</u>   | Not covered                                        | Coverage limited to 20 visits. Includes                                                                                               |

For more information about limitations and exceptions, see the plan or policy document at <http://www.fhcp.com/documents/coc/2026-large-group.pdf>

| 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) |                                                                                                                                        |
|                                        |                                           |                                              |                                                    | Physical, Speech, Occupational Therapy                                                                                                 |
|                                        | <a href="#">Habilitation services</a>     | Not covered                                  | Not covered                                        |                                                                                                                                        |
|                                        | <a href="#">Skilled nursing care</a>      | <u>Deductible</u> + 30% <u>Coinsurance</u>   | Not covered                                        | Pre-certification/pre-authorization of coverage required. Your benefits / services may be denied. Coverage limited to 20 days.         |
|                                        | <a href="#">Durable medical equipment</a> | <u>Deductible</u> + 30% <u>Coinsurance</u>   | Not covered                                        | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. <a href="#">Prior authorization</a> is required. |
|                                        | <a href="#">Hospice services</a>          | <u>Deductible</u> + 30% <u>Coinsurance</u>   | Not covered                                        | —————none—————                                                                                                                         |
| If your child needs dental or eye care | Children's eye exam                       | Not covered                                  | Not covered                                        |                                                                                                                                        |
|                                        | Children's glasses                        | Not covered                                  | Not covered                                        |                                                                                                                                        |
|                                        | Children's dental check-up                | Not covered                                  | Not covered                                        |                                                                                                                                        |

### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)                                    |                                                                                                                                                                                                                                            |                                                                                                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Abortion with the Exception of Limited Services</li> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Dental care (Child)</li> </ul> | <ul style="list-style-type: none"> <li>• <a href="#">Habilitation services</a></li> <li>• Hearing aids</li> <li>• Infertility treatment</li> <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 eye care (Child)</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>• Chiropractic care</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: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-877-615-4022. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

**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 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 1-877-615-4022.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-615-4022.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-877-615-4022.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-615-4022.

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

## About these Coverage Examples:



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

### Peg is Having a Baby

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

|                                               |        |
|-----------------------------------------------|--------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$1500 |
| ■ <u>Specialist copayment</u>                 | \$55   |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%    |
| ■ Other <u>copayment</u>                      | \$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>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,500        |
| <u>Copayments</u>                 | \$200          |
| <u>Coinsurance</u>                | \$2,100        |
| <u>What isn't covered</u>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,860</b> |

### Managing Joe's type 2 Diabetes

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

|                                               |        |
|-----------------------------------------------|--------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$1500 |
| ■ <u>Specialist copayment</u>                 | \$55   |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%    |
| ■ Other <u>coinsurance</u>                    | 30%    |

This **EXAMPLE** event includes services like:

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

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

In this example, Joe would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$0            |
| <u>Copayments</u>                 | \$1,100        |
| <u>Coinsurance</u>                | \$0            |
| <u>What isn't covered</u>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,120</b> |

### Mia's Simple Fracture

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

|                                               |        |
|-----------------------------------------------|--------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$1500 |
| ■ <u>Specialist copayment</u>                 | \$55   |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%    |
| ■ Other <u>copayment</u>                      | \$250  |

This **EXAMPLE** event includes services like:

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

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

In this example, Mia would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,500        |
| <u>Copayments</u>                 | \$500          |
| <u>Coinsurance</u>                | \$30           |
| <u>What isn't covered</u>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,030</b> |

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