



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, see your Human Resources Department. 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.umar.com or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$1,250 per person for network providers and for out-of-network providers combined. Doesn't apply to certain preventive care at Pana Community Hospital or network providers , and second surgical opinions. Copayments don't apply towards the deductible .	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care and primary care services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	There are no additional specific deductible amounts before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	\$6,000 per person / \$12,000 per family for Home Hospital, network providers and out-of-network providers combined.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, pre-certification penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. Employees can use Pana Community Hospital (call UMR at 1-800-826-9781) for the highest level of reimbursement) Or contact www.umar.com or call 1-800-826-9786) for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No. You do not need a referral to see a specialist.	A referral is not required to see a specialist for covered services.



All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Home Hospital (Includes services at Pana Community Hospital)	Network Providers	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge after deductible	20% coinsurance	40% coinsurance	None
	Specialist visit	10% coinsurance	20% coinsurance	40% coinsurance	None
	Preventive care/screening / immunization	No charge, no deductible		40% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge after deductible	20% coinsurance	40% coinsurance	Preauthorization is required for MRI, CT and PET scans, or benefits could be reduced.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available from: OptumRx at 1-800-711-4555	Generic drugs	30-day supply/90-day supply Retail: \$10/\$30 copayment			Covered at participating pharmacy only. Certain prescribed medications have a \$0 copayment under the Affordable Care Act and are subject to ACA limitations and guidelines.
	Preferred brand drugs	Retail: \$50/\$150 copayment			
	Non-preferred brand drugs	Retail: \$110/\$330 copayment			
	Specialty drugs	30-day supply Retail: \$110 copayment			Specialty drugs must go through OptumRx at 1-800-711-4555 . Please see Prescription Drug Benefit section in Plan Document for details. Limited to 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	20% coinsurance	40% coinsurance	Preauthorization is required for outpatient surgeries requiring anesthesia, or benefits could be reduced
	Physician/surgeon fees	No charge after deductible	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	No charge after \$100 copayment for visit			Copayment waived if admitted to hospital. Once admitted, applicable benefits apply.
	Emergency medical transportation	No charge after deductible	20% coinsurance	40% coinsurance	None
	Urgent care	10% coinsurance	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	20% coinsurance	40% coinsurance	Preauthorization is required or benefits could be reduced
	Physician/surgeon fees	10% coinsurance	20% coinsurance	40% coinsurance	

	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Home Hospital (Includes services at Pana Community Hospital)	Network Providers	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after deductible	No charge after deductible	No charge after deductible	None
	Inpatient services	No charge after deductible	20% coinsurance	40% coinsurance	Preauthorization is required
If you are pregnant	Office visits	No charge after deductible	20% coinsurance	40% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound) for employee or spouse only. Preauthorization is required for some maternity hospital stays.
	Childbirth/delivery professional services	No charge after deductible	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge after deductible	20% coinsurance	NA	None
	Rehabilitation services	No charge after deductible	20% coinsurance	40% coinsurance	None
	Habilitation services	No charge after deductible	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance		40% coinsurance	Preauthorization is required or benefits could be reduced.
	Durable medical equipment	10% coinsurance	20% coinsurance	40% coinsurance	Preauthorization required for equipment over \$500 or benefits could be reduced. Items must serve medical purpose. Benefits provided for purchase and rental up to purchase price. Excludes vehicle/home modifications, and exercise/bathroom equipment.
	Hospice services	No Charge	20% coinsurance	NA	Preauthorization is required for inpatient services or benefits could be reduced.
If your child needs dental or eye care	Children's eye exam	Not Covered			At least once between the ages of 3-5 to detect the presence of amblyopia or its risk factors. Refer to Human Resources for Vision services available through VSP.
	Children's glasses	Not Covered			Refer to Human Resources for Vision services available through VSP.
	Children's dental check-up	Not Covered			Limited to one exam every 6 months and \$1,500 per calendar year for Class I, II, and III combined.

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 .)		
• Bariatric surgery	• Infertility treatment	• Routine eye care (adult)
• Cosmetic surgery	• Long-term care	• Routine foot care, with the exception of person with diagnosis of diabetes.
• Eye Exam (child)	• Routine Eye Care (Adult)	• Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic (limited to 10 visits per calendar year)	• Private Duty Nursing	
• Hearing Aids (limited to \$2,000 per ear per person every two years)	• Non-emergency care when traveling outside the U.S. (member must pay for services up front and have bill translated to English language and dollars)	

*** Pana Community Hospital Tier also refers to services rendered at BJC HealthCare's Center of Excellence Program for optional second opinion, review of complex care cases, and treatment.**

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: UMR at 1-800-826-9781. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or 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 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: UMR at 1-800-826-9781

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 1-800-798-2422

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-798-2422

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-798-2422

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-798-2422

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

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

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

Peg is Having a Baby

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

■ The plan's overall deductible	\$1,250
■ Specialist copayment	NA
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

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

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,250
Copayments	\$0
Coinsurance	\$2,290
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$3,540

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,250
■ Specialist copayment	NA
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

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

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,250
Copayments	\$120
Coinsurance	\$846
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,216

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,250
■ ER & Specialist copayment	\$90
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

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

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,250
Copayments	\$90
Coinsurance	\$292
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,632



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Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$3,300 per person for network providers and \$6,600 per family for out-of-network providers combined. Doesn't apply to certain preventive care at Pana Community Hospital or network providers , and second surgical opinions.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	There are no additional specific deductible amounts before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	\$5,400 per person / \$9,500 per family for Home Hospital, network providers and out-of-network providers combined.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums , balance-billing charges, pre-certification penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. Employees can use Pana Community Hospital (call UMR at 1-800-826-9781) for the highest level of reimbursement) or for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You do not need a referral to see a specialist.	A referral is not required to see a specialist for covered services.



All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Home Hospital (Includes services at Pana Community Hospital)	Network Providers	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	20% coinsurance	40% coinsurance	None
	Specialist visit	10% coinsurance	20% coinsurance	40% coinsurance	None
	Preventive care/screening/immunization	No charge, no deductible		40% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge, after deductible	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge, after deductible	20% coinsurance	40% coinsurance	Preauthorization is required for MRI, CT and PET scans, or benefits could be reduced.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available from: OptumRx Health at 1-800-711-4555	Generic drugs Preferred brand drugs	10% coinsurance after deductible except for generic Preventive Medications allowed under the Affordable Care Act are paid at 100% without application of coinsurance or deductible .			Covered at participating pharmacy only.
	Non-preferred brand drugs Specialty drugs	10% coinsurance after deductible except for generic Preventive Medications allowed under the Affordable Care Act are paid at 100% without application of coinsurance or deductible			Specialty drugs must go through OptumRx. Please see Prescription Drug Benefit section in Plan Document for details. Limited to 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge, after deductible	20% coinsurance	40% coinsurance	Preauthorization is required for outpatient surgeries requiring anesthesia, or benefits could be reduced
	Physician/surgeon fees	No charge, after deductible	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	No charge after deductible			If admitted, applicable benefits apply.
	Emergency medical transportation	No charge, after deductible	20% coinsurance	40% coinsurance	None
	Urgent care	10% coinsurance	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge, after deductible	20% coinsurance	40% coinsurance	Preauthorization is required or benefits could be reduced
	Physician/surgeon fees	10% coinsurance	20% coinsurance	40% coinsurance	

	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Home Hospital (Includes services at Pana Community Hospital)	Network Providers	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	deductible	No charge, after deductible	No charge, after deductible	None
	Inpatient services	No charge, after deductible	20% coinsurance	40% coinsurance	Preauthorization is required
If you are pregnant	Office visits	No charge, after deductible	20% coinsurance	40% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound) for employee/spouse only. Preauthorization is required for some maternity hospital stays.
	Childbirth/delivery professional services	No charge, after deductible	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge, after deductible	20% coinsurance	NA	None
	Rehabilitation services	No charge, after deductible	20% coinsurance	40% coinsurance	None
	Habilitation services	No charge, after deductible	20% coinsurance	40% coinsurance	
	Skilled nursing care	10% coinsurance		40% coinsurance	Preauthorization is required or benefits could be reduced.
	Durable medical equipment	10% coinsurance	20% coinsurance	40% coinsurance	Preauthorization is required for equipment over \$500 or benefits could be reduced. Items must serve a medical purpose. Benefits provided for purchase and rental up to purchase price. Excludes vehicle/home modifications, and exercise/bathroom equipment.
	Hospice services	No charge, after deductible	20% coinsurance	NA	Preauthorization is required for inpatient services or benefits could be reduced.
If your child needs dental or eye care	Children's eye exam	Not Covered			At least once between the ages of 3-5 to detect the presence of amblyopia or its risk factors. Refer to Human Resources for Vision services available through VSP.
	Children's glasses	Not Covered			Refer to Human Resources for Vision services available through VSP.
	Children's dental check-up	Not Covered			Limited to one exam every 6 months and \$1,500 per calendar year for Class I, II, and III combined.

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](#).)

- | | | |
|---------------------|----------------------------|---|
| • Bariatric surgery | • Infertility treatment | • Routine eye care (adult) |
| • Cosmetic surgery | • Long-term care | • Routine foot care, with the exception of person with diagnosis of diabetes. |
| • Eye Exam (child) | • Routine Eye Care (Adult) | • Weight Loss Programs |

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

- | | |
|--|---|
| • Chiropractic (limited to 10 visits per calendar year) | • Private Duty Nursing |
| • Hearing Aids (limited to \$2,000 per ear per person every two years) | • Non-emergency care when traveling outside the U.S. (member must pay for services up front and have bill translated to English language and dollars) |

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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: UMR at 1-800-826-9781

Does this plan provide Minimum Essential Coverage? Yes

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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:

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[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-798-2422

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-798-2422

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

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For more information about limitations and exceptions, see the [plan](#) or policy document at www.consociatehealth.com

About these Coverage Examples:



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

Peg is Having a Baby

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

■ The plan's overall deductible	\$3,300
■ Specialist copayment	NA
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

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

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,300
Copayments	\$0
Coinsurance	\$1,900
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$5,200

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$3,300
■ Specialist copayment	NA
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

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

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$3,300
Copayments	\$0
Coinsurance	\$480
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$3,780

Mia's Simple Fracture

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

■ The plan's overall deductible	\$3,300
■ ER & Specialist copayment	NA
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

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

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$3,300
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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