



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-855-315-5386 or <https://www.communityhealthchoice.org/health-insurance-marketplace/know-the-details-2026/>. 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 1-855-315-5386 to request a copy.

| Important Questions                                                                   | Answers                                                                                                                                                                                                            | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | \$0 / individual; \$0 / 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> , <a href="#">Urgent Care</a> , Mental/Behavioral Health and Substance Use Disorder services, and generic drugs are covered before you meet your <a href="#">deductible</a> . | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/preventive-care-benefits">https://www.healthcare.gov/preventive-care-benefits</a> .                                                                                           |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | No.                                                                                                                                                                                                                | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | \$8,400 / individual; \$16,800 / 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="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.                                                                                       | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>               | Yes. See <a href="#">Find A Provider</a> or call 1-855-315-5386 for a list of <a href="#">network providers</a> .                                                                                                  | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>    | No.                                                                                                                                                                                                                | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

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

| Common Medical Event                                                                                                                                                                                                                                                                                                                                   | Services You May Need                                  | What You Will Pay                                                                                           |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                        |                                                        | Network Provider<br>(You will pay the least)                                                                | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                                                                                                                                                          | Primary care visit to treat an injury or illness       | \$30 <a href="#">copay</a>                                                                                  | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                        | <a href="#">Specialist</a> visit                       | \$65 <a href="#">copay</a>                                                                                  | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                        | <a href="#">Preventive care/screening/immunization</a> | No charge                                                                                                   | Not covered                                        | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.                                                                                                                                                                                                                                                                                                                                       |
| <b>If you have a test</b>                                                                                                                                                                                                                                                                                                                              | <a href="#">Diagnostic test</a> (x-ray, blood work)    | \$30 <a href="#">copay</a>                                                                                  | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                        | Imaging (CT/PET scans, MRIs)                           | \$500 <a href="#">copay</a>                                                                                 | Not covered                                        | Requires <a href="#">preauthorization</a> for certain services. Failure to obtain an authorization may result in denial of benefits.                                                                                                                                                                                                                                                                                                                                                                            |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://www.communityhealthchoice.org/wp-content/uploads/2025/05/formulary-premier-2026.pdf">https://www.communityhealthchoice.org/wp-content/uploads/2025/05/formulary-premier-2026.pdf</a> | Generic drugs                                          | \$25 <a href="#">copay</a> /prescription (retail); \$62.50 <a href="#">copay</a> /prescription (mail order) | Not covered                                        | Covers up to 30-day supply (retail). Covers up to 90-day supply (mail order). Please refer to formulary for cost share tiers. Tier 1 includes preferred generics and some lower cost brand products.                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                        | Preferred brand drugs                                  | \$40 <a href="#">copay</a> /prescription (retail); \$100 <a href="#">copay</a> /prescription (mail order)   | Not covered                                        | Covers up to 30-day supply (retail). Covers up to 90-day supply (mail order). <a href="#">Preauthorization</a> may be required for a branded medication when the generic equivalent is preferred on the formulary. Failure to obtain <a href="#">preauthorization</a> to show medical necessity may increase your costs. Note: If a generic drug is available and you choose to buy the preferred brand drug, you will pay the generic <a href="#">copay</a> plus the cost difference between the preferred and |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.communityhealthchoice.org/wp-content/uploads/2025/08/eoc-gold-off-exchange-2026.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) |                                                                                                                                                                                                                                                          |
|                                                                           |                                                  |                                                                                                                     |                                                    | generic. Tier 2 includes high cost generics and preferred brand.                                                                                                                                                                                         |
|                                                                           | Non-preferred brand drugs                        | \$80 <a href="#">copay</a> /prescription (retail); \$200 <a href="#">copay</a> /prescription (mail order)           | Not covered                                        | Covers up to 30-day supply (retail). Covers up to 90-day supply (mail order). Tier 3 includes non-preferred formulary products (can include non-preferred generic products).                                                                             |
|                                                                           | <a href="#">Specialty drugs</a>                  | 30% <a href="#">coinsurance</a> /prescription (retail)                                                              | Not covered                                        | Covers up to 30-day supply (retail) Tier 4 includes <a href="#">specialty drugs</a> .                                                                                                                                                                    |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | \$300 <a href="#">copay</a>                                                                                         | Not covered                                        | Requires <a href="#">preauthorization</a> for certain services, failure to obtain <a href="#">preauthorization</a> may result in denial of benefits.                                                                                                     |
|                                                                           | Physician/surgeon fees                           | \$300 <a href="#">copay</a>                                                                                         | Not covered                                        | None                                                                                                                                                                                                                                                     |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$500 <a href="#">copay</a>                                                                                         | \$500 <a href="#">copay</a>                        | None                                                                                                                                                                                                                                                     |
|                                                                           | <a href="#">Emergency medical transportation</a> | \$65 <a href="#">copay</a> /transportation                                                                          | \$65 <a href="#">copay</a> /transportation         | Requires <a href="#">preauthorization</a> for certain services such as air transportation, non-emergency ground transportation, facility-to-facility transfers, out-of-network and out of area transfers.                                                |
|                                                                           | <a href="#">Urgent care</a>                      | \$65 <a href="#">copay</a> /visit                                                                                   | Not covered                                        | None                                                                                                                                                                                                                                                     |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | \$800 <a href="#">copay</a> /day for days 1-5                                                                       | Not covered                                        | Requires <a href="#">preauthorization</a> for certain services, failure to obtain <a href="#">preauthorization</a> may result in denial of benefits.                                                                                                     |
|                                                                           | Physician/surgeon fees                           | No charge                                                                                                           | Not covered                                        | None                                                                                                                                                                                                                                                     |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$30 <a href="#">copay</a> /office visit and \$300 <a href="#">copay</a> /visit for other outpatient services/visit | Not covered                                        | Requires <a href="#">preauthorization</a> for certain services, failure to obtain <a href="#">preauthorization</a> may result in denial of benefits. Depending on type of service, a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. |

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| 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) |                                                                                                                                                                                                                                                                                                                                                                |
|                                                                | Inpatient services                        | \$800 <a href="#">copay</a> /day for days 1-5 | Not covered                                        | Requires <a href="#">preauthorization</a> for certain services, failure to obtain <a href="#">preauthorization</a> may result in denial of benefits.                                                                                                                                                                                                           |
| If you are pregnant                                            | Office visits                             | \$65 <a href="#">copay</a> /occurrence        | Not covered                                        | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply.                                                                                                                                  |
|                                                                | Childbirth/delivery professional services | \$800 <a href="#">copay</a> /day for days 1-5 | Not covered                                        | Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Requires <a href="#">preauthorization</a> for certain services, failure to obtain <a href="#">preauthorization</a> may result in denial of benefits. Depending on the type of services, a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. |
|                                                                | Childbirth/delivery facility services     | \$800 <a href="#">copay</a> /day for days 1-5 | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | \$65 <a href="#">copay</a>                    | Not covered                                        | Requires <a href="#">preauthorization</a> for certain services, failure to obtain <a href="#">preauthorization</a> may result in denial of benefits. Limited to 60 visits per year.                                                                                                                                                                            |
|                                                                | <a href="#">Rehabilitation services</a>   | \$65 <a href="#">copay</a>                    | Not covered                                        | Requires <a href="#">preauthorization</a> for certain services, failure to obtain <a href="#">preauthorization</a> may result in denial of benefits.                                                                                                                                                                                                           |
|                                                                | <a href="#">Habilitation services</a>     | \$65 <a href="#">copay</a>                    | Not covered                                        | Requires <a href="#">preauthorization</a> for certain services, failure to obtain <a href="#">preauthorization</a> may result in denial of benefits.                                                                                                                                                                                                           |
|                                                                | <a href="#">Skilled nursing care</a>      | \$800 <a href="#">copay</a> /day for days 1-5 | Not covered                                        | Requires <a href="#">preauthorization</a> for certain services, failure to obtain <a href="#">preauthorization</a> may result in denial of benefits. Limited to 25 days per year.                                                                                                                                                                              |
|                                                                | <a href="#">Durable medical equipment</a> | 30% <a href="#">coinsurance</a>               | Not covered                                        | Requires <a href="#">preauthorization</a> for certain services, failure to obtain <a href="#">preauthorization</a>                                                                                                                                                                                                                                             |

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| 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) |                                                                                                                                                        |
|                                        |                                  |                                                                                          |                                                    | may result in denial of benefits. Limited to <a href="#">plan</a> requirements.                                                                        |
|                                        | <a href="#">Hospice services</a> | \$65 <a href="#">copay</a> /day<br>\$800 copay/day for days 1-5 in an inpatient setting. | Not covered                                        | Depending on the type of services, a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. Limited to <a href="#">plan</a> requirements. |
| If your child needs dental or eye care | Children's eye exam              | \$65 <a href="#">copay</a>                                                               | Not covered                                        | One routine eye exam annually.                                                                                                                         |
|                                        | Children's glasses               | \$65 <a href="#">copay</a>                                                               | Not covered                                        | For select frames, standard lenses, and contact lenses only, for children 18 years old and younger. Limited to <a href="#">plan</a> requirements.      |
|                                        | Children's dental check-up       | Not covered                                                                              | Not covered                                        | None                                                                                                                                                   |

#### 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> .) |                         |                                                      |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------|--|
| • Abortion with exception of limited services                                                                                                                                                     | • Cosmetic surgery      | • Non-emergency care when traveling outside the U.S. |  |
| • Acupuncture                                                                                                                                                                                     | • Dental care (Adult)   | • Routine eye care (Adult)                           |  |
| • Bariatric surgery                                                                                                                                                                               | • Infertility treatment | • Weight loss programs                               |  |
| • Children's dental check-up                                                                                                                                                                      | • Long-term care        | • Routine foot care                                  |  |
| • Private-duty nursing (inpatient)                                                                                                                                                                |                         |                                                      |  |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.) |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| • Chiropractic care (35 visits per year)                                                                                                     | • Hearing aids (each ear, every three years) |

**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: Texas Department of Insurance, 333 Guadalupe, Austin TX 78701 at 1-800-578-4677 or the issuer at 1-855-315-5386. 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

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assistance, contact: Texas Department of Insurance, 333 Guadalupe Austin, TX 78701 or 1-800-578-4677.

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Not Applicable.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Assistance:**

Community Health Choice is committed to providing high-quality, accessible healthcare services to a diverse population. Community Health Choice offers translated materials and interpretation services to ensure clear and effective communication with all members, regardless of their primary language. Community Health Choice trains staff to be mindful of cultural differences in communication styles, body language, and decision-making processes. Community Health Choice provides oral and written notice to consumers with limited English proficiency (LEP) in their preferred language informing them of their right to receive language assistance services and how to get them.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-315-5386.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-315-5386.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-315-5386.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-315-5386.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0       |
| ■ <a href="#">Specialist copayment</a>                          | \$65      |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$800/day |
| ■ Other <a href="#">coinsurance</a>                             | 0%        |

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> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| <a href="#">Deductibles</a>            | \$0             |
| <a href="#">Copayments</a>             | \$1,300         |
| <a href="#">Coinsurance</a>            | \$0             |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$60            |
| <b>The total Peg would pay is</b>      | <b>\$1,360</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> | \$0       |
| ■ <a href="#">Specialist copayment</a>                          | \$65      |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$800/day |
| ■ Other <a href="#">coinsurance</a>                             | 0%        |

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> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$0            |
| <a href="#">Copayments</a>             | \$1,000        |
| <a href="#">Coinsurance</a>            | \$200          |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$20           |
| <b>The total Joe would pay is</b>      | <b>\$1,220</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> | \$0       |
| ■ <a href="#">Specialist copayment</a>                          | \$65      |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$800/day |
| ■ Other <a href="#">coinsurance</a>                             | 0%        |

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> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$0            |
| <a href="#">Copayments</a>             | \$1,200        |
| <a href="#">Coinsurance</a>            | \$70           |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$1,270</b> |

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