# **Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services Coverage Period: 01/01/2025-12/31/2025

**Insurance Company 1: AI/AN Zero Cost Sharing Coverage for: Individual + Spouse | Plan Type: PPO**

****

**The Summary of Benefits and Coverage (SBC) document will help you choose a health** [**plan.**](https://www.healthcare.gov/sbc-glossary/#plan) **The SBC shows you how you and the** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **would share the cost for covered health care services. NOTE: Information about the cost of this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **(called the** [**premium**](https://www.healthcare.gov/sbc-glossary/#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, [insert contact

information]. For general definitions of common terms, such as [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) [balance billing,](https://www.healthcare.gov/sbc-glossary/#balance-billing) [coinsurance,](https://www.healthcare.gov/sbc-glossary/#coinsurance) [copayment,](https://www.healthcare.gov/sbc-glossary/#copayment) [deductible](https://www.healthcare.gov/sbc-glossary/#deductible), [provider,](https://www.healthcare.gov/sbc-glossary/#provider) or other underlined terms, see the Glossary. You can view the Glossary at [www.insert.com] or call 1-800-[insert] to request a copy.

|  |  |  |
| --- | --- | --- |
| **Important Questions** | **Answers** | **Why This Matters:** |
| **What is the overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | $0 | See the Common Medical Events chart below for your costs for services this [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers. |
| **Are there services covered before you meet your** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | Yes. | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers some items and services even if you haven’t yet met the [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount. But a [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) or [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) may apply. |
| **Are there other** [**deductibles**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | No. | You don’t have to meet [deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) for specific services. |
| **What is the** [**out-of-pocket**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)[**limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) **for this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**?** | Not Applicable. | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) does not have an [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) on your expenses. |
| **What is not included in the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)**?** | Not Applicable. | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) does not have an [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) on your expenses. |
| **Will you pay less if you use a** [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** | Not Applicable. | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) does not use a [provider](https://www.healthcare.gov/sbc-glossary/#provider) [network.](https://www.healthcare.gov/sbc-glossary/#network) You can receive covered services from any [provider.](https://www.healthcare.gov/sbc-glossary/#provider) |
| **Do you need a** [**referral**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)**?** | No. | You can see the [specialist](https://www.healthcare.gov/sbc-glossary/#specialist) you choose without a [referral.](https://www.healthcare.gov/sbc-glossary/#referral) |

| **Common Medical Event** | **Services You May Need** | **What You Will Pay** | | **Limitations, Exceptions, & Other Important  Information** |
| --- | --- | --- | --- | --- |
| **Indian Health Care Provider (IHCP) (You will pay the least)** | **Non-IHCP Provider (You will pay the most)** |
| **If you visit a health care** [**provider’s**](https://www.healthcare.gov/sbc-glossary/#provider) **office or clinic** | Primary care visit to treat an injury or illness | No charge | No charge | If an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) charges more than the [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) you may have to pay the difference ([balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit | No charge | No charge | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required. If you don't get [preauthorization,](https://www.healthcare.gov/sbc-glossary/#preauthorization) benefits could be reduced by 50% of the total cost of the service. If an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) charges more than the [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) you may have to pay the difference ([balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)[/screening/](https://www.healthcare.gov/sbc-glossary/#screening) immunization | No charge | No charge | You may have to pay for services that aren’t preventive. Ask your [provider](https://www.healthcare.gov/sbc-glossary/#provider) if the services needed are preventive. Then check what your [plan](https://www.healthcare.gov/sbc-glossary/#plan) will pay for. |
| **If you have a test** | [Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (x-ray, blood work) | No charge | No charge | If an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) charges more than the [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) you may have to pay the difference ([balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). |
| Imaging (CT/PET scans, MRIs) | No charge | No charge |
| **If you need drugs to treat your illness or condition**  More information about [**prescription drug**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage)[**coverage**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage)is available at [www.insert.com] | Generic drugs | No charge | No charge | Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). If an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) charges more than the [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) you may have to pay the difference ([balance](https://www.healthcare.gov/sbc-glossary/#balance-billing) [billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). |
| Preferred brand drugs | No charge | No charge |
| Non-preferred brand drugs | No charge | No charge |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) | No charge | No charge |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | No charge | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required. If you don't get [preauthorization,](https://www.healthcare.gov/sbc-glossary/#preauthorization) benefits could be reduced by 50% of the total cost of the service. If an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) charges more than the [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) you may have to pay the difference ([balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). |
| Physician/surgeon fees | No charge | No charge | If an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) charges more than the [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) you may have to pay the difference ([balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). |
| **If you need immediate medical attention** | [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) | No charge | No charge | If an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) charges more than the [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) you may have to pay the difference ([balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). |
| [Emergency medical](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) [transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) | No charge | No charge |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) | No charge | No charge |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge | No charge | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required. If you don't get [preauthorization,](https://www.healthcare.gov/sbc-glossary/#preauthorization) benefits could be reduced by 50% of the total cost of the service. If an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) charges more than the [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) you may have to pay the difference ([balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). |
| Physician/surgeon fees | No charge | No charge | If an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) charges more than the [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) you may have to pay the difference ([balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge | No charge | If an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) charges more than the [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) you may have to pay the difference ([balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). |
| Inpatient services | No charge | No charge |
| **If you are pregnant** | Office visits | No charge | No charge | Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). If an [out-of-network](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider)  [provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) charges more than the [allowed](https://www.healthcare.gov/sbc-glossary/#allowed-amount) [amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) you may have to pay the difference ([balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). |
| Childbirth/delivery professional services | No charge | No charge |
| Childbirth/delivery facility services | No charge | No charge |
| **If you need help recovering or have other special health needs** | [Home health care](https://www.healthcare.gov/sbc-glossary/#home-health-care) | No charge | No charge | 60 visits/year. If an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) charges more than the [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) you may have to pay the difference ([balance](https://www.healthcare.gov/sbc-glossary/#balance-billing) [billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | No charge | No charge | 60 visits/year. Includes physical therapy, speech therapy, and occupational therapy. If an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) charges more than the [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) you may have to pay the difference ([balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) | No charge | No charge |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | No charge | No charge | 60 visits/calendar year. If an [out-of-network](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider)  [provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) charges more than the [allowed](https://www.healthcare.gov/sbc-glossary/#allowed-amount) [amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) you may have to pay the difference ([balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) | No charge | No charge | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. If an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) charges more than the [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) you may have to pay the difference ([balance](https://www.healthcare.gov/sbc-glossary/#balance-billing) [billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) | No charge | No charge | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required. If you don't get [preauthorization,](https://www.healthcare.gov/sbc-glossary/#preauthorization) benefits could be reduced by 50% of the total cost of the service. If an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) charges more than the [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) you may have to pay the difference ([balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). |
| **If your child needs dental or eye care** | Children’s eye exam | No charge | No charge | Coverage limited to one exam/year. If an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) charges more than the [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) you may have to pay the difference ([balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). |
| Children’s glasses | No charge | No charge | Coverage limited to one pair of glasses/year. If an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) charges more than the [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) you may have to pay the difference ([balance](https://www.healthcare.gov/sbc-glossary/#balance-billing) [billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). |
| Children’s dental check-up | No charge | No charge | If an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) charges more than the [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) you may have to pay the difference ([balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). |

## **Excluded Services & Other Covered Services**:

|  |  |  |
| --- | --- | --- |
| **Services Your** [**Plan**](https://www.healthcare.gov/sbc-glossary/#plan) **Generally Does NOT Cover (Check your policy or** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services)**.)** | | |
| * Abortion (except in cases of rape, incest, or when the life of the mother is endangered) * Cosmetic surgery * Dental care (Adult) | * Infertility treatment * Long-term care * Non-emergency care when traveling outside the U.S. | * Private-duty nursing * Routine eye care (Adult) * Routine foot care |

|  |  |  |
| --- | --- | --- |
| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document.)** | | |
| * Acupuncture (if prescribed for rehabilitation purposes) | * Bariatric surgery * Chiropractic care | * Hearing aids * Weight loss programs |

**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: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance](https://www.healthcare.gov/sbc-glossary/#health-insurance) [Marketplace.](https://www.healthcare.gov/sbc-glossary/#marketplace) For more information about the [Marketplace,](https://www.healthcare.gov/sbc-glossary/#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 f](https://www.healthcare.gov/sbc-glossary/#plan)or a denial of a [claim.](https://www.healthcare.gov/sbc-glossary/#claim) This complaint is called a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) or [appeal.](https://www.healthcare.gov/sbc-glossary/#appeal) For more information about your rights, look at the explanation of benefits you will receive for that medical [claim.](https://www.healthcare.gov/sbc-glossary/#claim) Your [plan](https://www.healthcare.gov/sbc-glossary/#plan) documents also provide complete information on how to submit a [claim,](https://www.healthcare.gov/sbc-glossary/#claim) [appeal,](https://www.healthcare.gov/sbc-glossary/#appeal) or a [grievance f](https://www.healthcare.gov/sbc-glossary/#grievance)or any reason to your [plan.](https://www.healthcare.gov/sbc-glossary/#plan) For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

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

[Minimum Essential Coverage](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) generally includes [plans,](https://www.healthcare.gov/sbc-glossary/#plan) [health insurance](https://www.healthcare.gov/sbc-glossary/#health-insurance) available through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#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,](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) you may not be eligible for the [premium tax credit.](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits)

**Does this plan meet the Minimum Value Standards? Yes.**

If your [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn’t meet the [Minimum Value Standards,](https://www.healthcare.gov/sbc-glossary/#minimum-value-standard) you may be eligible for a [premium tax credit t](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits)o help you pay for a [plan t](https://www.healthcare.gov/sbc-glossary/#plan)hrough the [Marketplace.](https://www.healthcare.gov/sbc-glossary/#marketplace)

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[insert telephone number].

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf [insert telephone number] uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala’au mai i le numera telefoni [insert telephone number].

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye [insert telephone number].

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å’gang [insert telephone number].

***To see examples of how this*** [***plan***](https://www.healthcare.gov/sbc-glossary/#plan) ***might cover costs for a sample medical situation, see the next section.***

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

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](https://www.healthcare.gov/sbc-glossary/#plan) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](https://www.healthcare.gov/sbc-glossary/#provider) charge, and many other factors. Focus on the [cost-sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) amounts ([deductibles,](https://www.healthcare.gov/sbc-glossary/#deductible) [copayments](https://www.healthcare.gov/sbc-glossary/#copayment) and [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance)) and [excluded services](https://www.healthcare.gov/sbc-glossary/#excluded-services) under the [plan.](https://www.healthcare.gov/sbc-glossary/#plan) Use this information to compare the portion of costs you might pay under different health [plans.](https://www.healthcare.gov/sbc-glossary/#plan) 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**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$0**
* [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)[**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) **$0**
* **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **0%**
* **Other** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **0%**

**This EXAMPLE event includes services like:**

[Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) office visits *(prenatal care)*

Childbirth/Delivery Professional Services

Childbirth/Delivery Facility Services

[Diagnostic tests](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) *(ultrasounds and blood work)*

[Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
| --- | --- |
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $0 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $0 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$0** |

**Managing Joe’s Type 2 Diabetes** (a year of routine in-network care of a well- controlled condition)

* **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$0**
* [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)[**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) **$0**
* **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **0%**
* **Other [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) 0%**

**This EXAMPLE event includes services like:**

[Primary care physician](https://www.healthcare.gov/sbc-glossary/#primary-care-physician) office visits *(including disease education)*

[Diagnostic tests](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) *(blood work)*

[Prescription drugs](https://www.healthcare.gov/sbc-glossary/#prescription-drugs)

[Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) *(glucose meter)*

| **Total Example Cost** | **$5,600** |
| --- | --- |
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $0 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $0 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$0** |

**Mia’s Simple Fracture**

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

* **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$0**
* [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)[**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) **$0**
* **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **0%**
* **Other** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **0%**

**This EXAMPLE event includes services like:**

[Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) *(including medical supplies)*

[Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (*x-ray*)

[Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) *(crutches)*

[Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) *(physical therapy)*

| **Total Example Cost** | **$2,800** |
| --- | --- |
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $0 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $0 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$0** |

The [plan](https://www.healthcare.gov/sbc-glossary/#plan) would be responsible for the other costs of these EXAMPLE covered services.