**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services **Coverage Period: 07/01/2023-2/29/2024**

**Santa Monica UNITE HERE Health Benefit Fund – MLK Care Coverage for: Family | Plan Type: EPO**

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| Picture of exclamation point to label important information**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, request the plan or policy document by calling 1-833-961-3021. 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.](http://www/)healthcare.gov/sbc-glossary or call 1-866-345-5189 or  1-562-463-5075 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 covers. |
| **Are there services covered before you meet your** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | There is no deductible. | You do not have to meet a deductible. |
| **Are there other** [**deductibles**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | No. | You don’t have to meet deductibles 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)**?** | ***Medical out-of-pocket limit:*** $1,500 individual/$3,000 family  ***Prescription drug out-of-pocket limit:*** *(applicable to prescription drugs from network pharmacies, except certain specialty drugs)****:* $750** individual / **$1,500**/family | The [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#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,](https://www.healthcare.gov/sbc-glossary/#plan) they have to meet their own [out-of-pocket limits](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) until the overall family [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) has been met. |
| **What is not included in the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)**?** | ***Medical out-of-pocket limit:*** [Premiums,](https://www.healthcare.gov/sbc-glossary/#premium) prescription drug costs, [balance-billing](https://www.healthcare.gov/sbc-glossary/#balance-billing) charges, health care this [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn’t cover, and services indicated in chart starting on page 3.  ***Prescription drug out-of-pocket limit:*** premiums, amounts (other than copayment) paid for brand drug when generic is available, [balance-billing](https://www.healthcare.gov/sbc-glossary/#balance-billing) charges and health care this [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn’t cover. Copayments for certain specialty drugs that are not essential health benefits (though eligible for reimbursement by the manufacturer at no cost to you) do not apply towards satisfying your out-of-pocket limit and will not be reimbursed at 100% once the out-of-pocket limit is reached. | Even though you pay these expenses, they don’t count toward the [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit). |
| **Will you pay less if you use a** [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** | Yes. Call 1-833-961-3021 or go to <http://www.mlkcare.org/> for a list of [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider). Additionally, call 1-888-479-6606 or go to <http://www.achievesolutions.net/santamonicauhh> for a list of mental health or substance abuse [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider) | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) uses a [provider](https://www.healthcare.gov/sbc-glossary/#provider) [network](https://www.healthcare.gov/sbc-glossary/#network). You will pay less if you use a [provider](https://www.healthcare.gov/sbc-glossary/#provider) in the [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) [network.](https://www.healthcare.gov/sbc-glossary/#network) You will pay the most if you use an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider), and you might receive a bill from a [provider](https://www.healthcare.gov/sbc-glossary/#provider) for the difference between the [provider’s](https://www.healthcare.gov/sbc-glossary/#provider) charge and what your [plan](https://www.healthcare.gov/sbc-glossary/#plan) pays [(balance](https://www.healthcare.gov/sbc-glossary/#balance-billing) [billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). Be aware, your [network provider](https://www.healthcare.gov/sbc-glossary/#network-provider) might use an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) for some services (such as lab work). Check with your [provider](https://www.healthcare.gov/sbc-glossary/#provider) before you get services. |
| **Do you need a** [**referral**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)**?** | Yes. | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) will pay some or all of the costs to see a [specialist](https://www.healthcare.gov/sbc-glossary/#specialist) for covered services. You need a [referral](https://www.healthcare.gov/sbc-glossary/#referral) to see a [[specialist](https://www.healthcare.gov/sbc-glossary/#specialist) for medical treatment with the exception of gynecology..](https://www.healthcare.gov/sbc-glossary/#specialist) You do not need a [referral](https://www.healthcare.gov/sbc-glossary/#referral) to see a [specialist for mental health/substance use disorder.](https://www.healthcare.gov/sbc-glossary/#specialist) |

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| Picture of exclamation point to label important informationAll [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) and [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) costs shown in this chart are after your [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) has been met, if a [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) applies. |

| **Common Medical Event** | **Services You May Need** | **What You Will Pay** | | **Limitations, Exceptions, & Other Important Information** |
| --- | --- | --- | --- | --- |
| **Network Provider (You will pay the least)** | **Out-of-Network 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 | Not covered | None. |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit | No charge | Not covered | Requires referral from your primary care provider and prior authorization, otherwise not covered. |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)/[screening](https://www.healthcare.gov/sbc-glossary/#screening)/ immunization | No charge | Not covered | 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 | Not covered | Requires referral from your primary care provider and prior authorization, otherwise not covered. |
| Imaging (CT/PET scans, MRIs) | No charge | Not covered |
| **If you need drugs to treat your illness or condition**  More information about [**prescription drug coverage**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) is available at [www.express-scripts.com](http://www.express-scripts.com) or call 1-800-451-6245. | Generic drugs | $3 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) / [prescription](https://www.healthcare.gov/sbc-glossary/#prescription-drugs)  (retail or mail order) | Not covered | You must use a pharmacy in Express Scripts’ Prime Network (within the United States) to fill your prescription or no coverage. Each retail prescription limited to a maximum 30-day supply. For maintenance medications, up to a 90-day supply is available using mail order.  For maintenance drugs, you must decide whether to use mail order or a retail pharmacy. Two retail fills are allowed before you must notify Express Scripts of your decision. Except in case of urgent medical need, specialty medications must be filled through the Accredo pharmacy.  Some drugs require preauthorization.  If you use a brand name drug when a generic is available, you will pay the difference in price between the brand name and the generic drug, plus the applicable [copay](https://www.healthcare.gov/sbc-glossary/#copayment). No charge for ACA-required preventive care drugs if purchased at a network pharmacy with a prescription from a physician.  For information on drugs not covered by the plan, call 1-800-451-6245, visit [www.express-scripts.com](http://www.express-scripts.com), or download the Express Scripts app.  Certain specialty drugs have substantially higher copays than shown. If you are on one of these specialty drugs and you participate in the SaveOn SP program through Express Scripts, you will not have to pay the higher copays. However, if your specialty drug is on the SaveOn SP Drug list and you do not participate in the SaveOn SP program, you will be responsible for the full copay. The specialty drugs on the SaveOn SP Drug list, and the copays for those drugs, are subject to change. You will receive notification from SaveOn SP if you are on a specialty drug that is part of the SaveOn SP program. Please see “Important Questions” on page 1 for more information regarding the prescription drug out-of-pocket limit. |
| Brand name drugs | $ 6 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) / [prescription](https://www.healthcare.gov/sbc-glossary/#prescription-drugs) (retail) $5 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) / prescription (mail order) | Not covered |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) | $3 copay for generic (retail or mail order)  $ 6 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) / brand [prescription](https://www.healthcare.gov/sbc-glossary/#prescription-drugs) (retail)  $5 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) / brand prescription (mail order) | Not covered |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | Not covered | Requires referral from your primary care provider and prior authorization, otherwise not covered. |
| Physician/surgeon fees | No charge | Not covered | Requires referral from your primary care provider and prior authorization, otherwise not covered. |
| **If you need immediate medical attention** | [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) | $150 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit | $150 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit | Copay waived if admitted as inpatient. Emergency medical transportation covered only when medically necessary. Out-of-network coverage subject to 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 | Not covered |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge | Not covered | All hospitalizations, except Emergency and childbirth, require referral from your primary care provider and prior authorization or no coverage.  Maximum benefit for hospitalization is $100,000 per hospitalization. |
| Physician/surgeon fees | No charge | Not covered | –––––––––––none––––––––––– |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge | Not covered | None. Carelon also provides Applied Behavioral Analysis, intensive outpatient, partial hospitalization, and residential treatment services. |
| Inpatient services | No charge | Not covered |
| **If you are pregnant** | Office visits | No charge | Not covered | [Cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) does not apply for [preventive](https://www.healthcare.gov/sbc-glossary/#preventive-care) [services](https://www.healthcare.gov/sbc-glossary/#preventive-care). Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization required if hospital stay more than 48 hours (vaginal delivery) or 96 hours (C-section). |
| Childbirth/delivery professional services | No charge | Not covered |
| Childbirth/delivery facility services | No charge | Not covered |
| **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 | Not covered | Requires referral from your primary care provider and prior authorization, otherwise not covered. Homemaker services not covered. |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | No charge | Not covered | Requires referral from your primary care provider and prior authorization, otherwise not covered. |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) | No charge | Not covered |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | No charge | Not covered | Requires referral from your primary care provider and prior authorization, otherwise not covered. Limited to 100 days per calendar year. |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) | No charge | Not covered | Corrective footwear is not covered. Requires referral from your primary care provider and prior authorization, otherwise not covered. |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) | No charge | Not covered | Requires referral from your primary care provider and prior authorization, otherwise not covered. |
| **If your child needs dental or eye care** | Children’s eye exam | ***MLK Care***: Not covered  ***VSP***: No charge. | All costs above $45 allowance. | For vision coverage through Vision Service Plan (VSP), call 1-855-866-0942 for benefit information. Eye exams limited to one exam every 12 months. (Eye exams may be obtained through the MLK Program with a $5 copay until October 31, 2021). |
| Children’s glasses | ***MLK Care***: Not covered  ***VSP:*** 80% of costs above $120 allowance for basic frames. No charge for most standard lenses. | ***MLK Care***: Not covered  ***VSP:*** Frames: All costs above $70 allowance.  Lenses: All costs above $30 (single vision lenses), $50 (bifocals and standard progressives), and $65 (trifocals) allowances. | For vision coverage through Vision Service Plan (VSP), call 1-855-866-0942 for benefit information. Lenses and frames limited to once every 24 months. Charges apply for lens add-ons and premium progressive lenses. |
| Children’s dental check-up | Not covered | Not covered | You may have other dental coverage not described here. |

**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)**.)** | | |
| --- | --- | --- |
| * Bariatric surgery * Cosmetic surgery * Hearing aids * Infertility Treatment | * Long-term care * Non-emergency care when traveling outside the U.S. * Private-duty nursing | * Routine foot care * Weight loss programs |

| **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 (Requires referral from your primary care provider and prior authorization, otherwise not covered) * Chiropractic care (Requires referral from your primary care provider and prior authorization, otherwise not covered) | * Dental care (Adult) - (available through separate standalone plan) * Digital musculoskeletal care – (available through Hinge Health; call 1-855-902-2777 for benefit information) | * Routine eye care (Adult) – (eye exams and materials available through VSP plan). |

**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 the U.S. Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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](https://www.healthcare.gov/sbc-glossary/#plan) for 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](https://www.healthcare.gov/sbc-glossary/#grievance) for any reason to your [plan.](https://www.healthcare.gov/sbc-glossary/#plan) For more information about your rights, this notice, or assistance, contact: Design Benefit Administrators, the Fund’s Claims Administrator at 1-833-961-3021. You may also contact the U.S. Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**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](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits) to help you pay for a [plan](https://www.healthcare.gov/sbc-glossary/#plan) through the [Marketplace.](https://www.healthcare.gov/sbc-glossary/#marketplace)

**Language Access Services:**

[Spanish (Español): Para obtener asistencia en Español, llame al 1-833-961-3021.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-961-3021.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-961-3021.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-961-3021.

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| ***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.*** |

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**About these Coverage Examples:**

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| Picture of exclamation point to label important information**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) | $10 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$70** |

**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/#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-drug-coverage)

[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) | $100 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$120** |

**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/" \l "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) | $200 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$200** |

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