

**To: All Participants and Beneficiaries in the Health and Benefit Trust Fund of the International Union of the Operating Engineers Local Union No. 94-94A-94B, AFL-CIO**

**From: The Plan Administrator of the Health and Benefit Trust Fund of the International Union of the Operating Engineers Local Union No. 94-94A-94B, AFL-CIO**

**Re: Summary of Benefits and Coverage (SBC) - Active PPO Coverage for the Commercial Division**

**Date: November 28, 2017**

Enclosed you will find the Summary of Benefits and Coverage (“SBC”) for the Health and Benefit Trust Fund of the International Union of Operating Engineers Local 94-94A-94B, AFL-CIO (“Fund”) that pertains to the benefit coverage option offered to active participants in the Commercial Division. Accordingly, this SBC summarizes available benefits for this benefit coverage option; and is intended to comply with the applicable disclosure requirements under the Patient Protection Affordable Care Act (“ACA” or the “Affordable Care Act”). Please share this SBC with your family members who are eligible for this health coverage under the Fund.

*Please note that if you have coverage under a different coverage option, you will receive a separate SBC describing that coverage. As such, there are separate SBCs that describe the Fund’s benefits for the School Actives, Commercial Medicare Retirees, Commercial Basic Retirees, Commercial Retiree PPO and School Retirees.*

The federal government developed a model SBC form primarily to help people who will shop for individual health coverage on the health care exchanges. The SBC is designed so that individuals can conduct an “apples to apples” assessment of the material benefits and costs when *comparing* different health plan coverage. For that reason, we were not allowed to customize much of the enclosed SBC and, therefore, some aspects of it may not be relevant to the Fund’s benefit coverage option for the Commercial Division.

Fortunately, you have affordable and adequate coverage under the Fund. Generally speaking, under ACA, your coverage is considered “affordable” if the premium cost for participant-only coverage is not more than 9.5% of your wages. For example, if your wages from covered employment are \$40,000, your coverage would be considered affordable if your participant-only coverage does not cost you more than \$3,800 a year. Since you don’t pay a premium for the Fund’s participant-only coverage, it is deemed affordable. In addition, the Fund’s coverage meets the minimum value standard under the Affordable Care Act in that at least 60% of the benefits are covered by it. As a result, as a participant in the Fund, you don’t need to shop for different or additional coverage with the healthcare exchanges. Also, please remember that because the Fund’s coverage is considered affordable and of minimum value, you are not eligible for federal premium subsidies.

#### *SBC Disclosure Requirement under ACA*

Generally speaking, the Affordable Care Act has some very strict disclosure requirements for the SBC - the maximum number of pages, the font size, the colors, etc. To best understand the benefits provided by the Fund’s benefit coverage option for the Commercial Division, we recommend that you refer to the benefit materials that you are use to seeing from the Fund - our website, [www.local94.com](http://www.local94.com), the Open Enrollment Materials, the Summary Plan Description (“SPD”) and other Fund documents - in conjunction with your review of the enclosed SBC and for comparative purposes to SBCs issued by other plans or insurers.

In accordance with the applicable disclosure requirements under ACA, the SBC includes three examples - one for having a baby, one for managing type 2 diabetes, and one for a simple fracture emergency room visit and follow up care. The examples show the health care costs for you and the Fund associated with each of these three situations. As you read these examples, it’s very important to note that these costs are national averages; they do not reflect what the actual services might cost in your area. Similarly, your course of treatment might also be very different depending on whether you receive care from an In-Network Provider or an Out-of-Network Provider (the examples only show costs for In-Network Providers), your doctor’s approach, your age, your other health issues, and many

other factors. These examples are included to help someone compare how different health plans might cover the same condition - not for predicting your own actual health care expenses.

You may find that the SBC discusses the Fund's benefits in ways that may seem unfamiliar to you. For instance, there may be terms you haven't seen before, or terms that you have seen before but are being used differently. The SBC also refers to a "Glossary of Health Coverage and Medical Terms," which cannot be customized for the Fund. If you read the SBC or the Glossary and find yourself confused at any time, we recommend that you refer to your SPD, the Local 94 website ([www.local94.com](http://www.local94.com)) and the other materials describing your benefits that you have received or may be eligible to receive from the Fund; or contact the Fund Office at (212) 541-9880.

*For More Information*

Please keep this SBC with your copy of the SPD for easy reference. Please note that receipt of this document does not constitute a determination of your eligibility for benefits under the Fund. If you have any questions about Fund-provided coverage, please call the Fund Office at (212) 541-9880. If you have general questions about the SBC or the Glossary, you may want to contact the Employee Benefits Security Administration of the U.S. Department of Labor at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 Ext. 61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

**IMPORTANT NOTICE REGARDING THE FUND'S GRANDFATHERED PLAN STATUS**

The Board of Trustees believes that the Fund is a "grandfathered plan" as such term is defined under the Affordable Care Act. As permitted by this law, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the Affordable Care Act was enacted. Being a grandfathered health plan means that the medical coverage that you have elected under the plan may not include certain consumer protections of the Affordable Care Act that apply to other group health plans, for example, the requirement for the provision of preventive health services without any cost sharing (i.e., copayments, coinsurance, deductibles). However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits and extension of coverage to dependents until age 26. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Administrator during normal business hours at: 331-337 West 44th Street, New York, New York, 10036, telephone number: (212) 541-9880. You may also contact the Department of Labor at (866) 444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered plans.

*This notice and the enclosed SBC contain highlights of certain features of the Fund's benefit coverage option for the Commercial Division. Full details of these benefits are contained in the Fund's SPD and other official plan documents (collectively "Official Plan Documents"). If there is a discrepancy between the attached SBC (or this letter) and the Official Plan Documents, the Official Plan Documents will govern in all cases. The Trustees have the sole an absolute discretion and reserve the right to amend, modify, or terminate the Fund at any time.*


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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 premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the completed terms of coverage, you can view this at [www.Local94.com](http://www.Local94.com) or by calling 1-212-541-9880. 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.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-212-541-9880 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>In-Network &amp; Out-of-Network combined: \$100 person/\$400 family. Doesn't apply to emergency room, exams/evaluations, preventive care, prescription drugs and for those benefits that are administered by the Fund Office. <u>Balance billing</u>, excluded services, <u>copayments</u> &amp; <u>coinsurance</u>, do not count toward the <u>deductible</u>.</p>	<p>If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
<p>Are there services covered before you meet your <u>deductible</u>?</p>	<p>Yes. Preventive care and primary care services are covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p>	<p>Not Applicable.</p>	<p>This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.</p>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>Not Applicable.</p>	<p>This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.</p>
<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>Yes. See <a href="http://www.Local94.com">www.Local94.com</a> or call 1-212-541-9880 for a list of <u>network providers</u>.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>).</p>
<p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>

 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*
		In-Network provider (You will pay the least)	Out-of-Network provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /visit	<a href="#">Deductible</a> and 20% <a href="#">coinsurance</a> + <a href="#">balance billing</a>	Clinics are not covered.
	<a href="#">Specialist</a> visit	\$30 <a href="#">copay</a> /visit	<a href="#">Deductible</a> and 20% <a href="#">coinsurance</a> + <a href="#">balance billing</a>	Clinics are not covered.
	Preventive care/screening/Immunization (You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive).	Preventive care and screening (adult) - \$30 <a href="#">copay</a> /visit,  Immunizations (adult) - <a href="#">Deductible</a> & 20% <a href="#">coinsurance</a> ; Well-child - No charge	<a href="#">Deductible</a> and 20% <a href="#">coinsurance</a> + <a href="#">balance billing</a>	Annual physical available In-Network only. Subject to frequency and age limits. Clinics are not covered.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-ray: <a href="#">Deductible</a> and 20% <a href="#">coinsurance</a> Blood work: \$10 <a href="#">copay</a> /visit	<a href="#">Deductible</a> and 20% <a href="#">coinsurance</a> + <a href="#">balance billing</a>	
	Imaging (CT/PET scans, MRIs/MRAs, Nuclear Stress Test and Echocardiogram)	<a href="#">Deductible</a> and 20% <a href="#">coinsurance</a>	<a href="#">Deductible</a> and 20% <a href="#">coinsurance</a> + <a href="#">balance billing</a>	Failure to precertify Imaging Services may result in a reduction or no benefits.
If you need drugs to treat your illness or condition	Generic drugs	Retail: \$10 <a href="#">copay</a> /prescription (30-day supply); Mail order: \$20 <a href="#">copay</a> /prescription (90-day supply)	Not covered	<a href="#">Plan</a> includes mandatory generic substitution policy, only two refills are available at retail and then must use mail order pharmacy or CVS pharmacy for maintenance choice at a CVS retail store
More information about prescription drug coverage is available at <a href="#">www.caremark.com</a>	Formulary brand drugs	20% <a href="#">coinsurance</a> (retail & mail order), max \$40/prescription	Not covered	
	Non-formulary brand drugs	40% <a href="#">coinsurance</a> (retail & mail order), max \$60/prescription	Not covered	
	<a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a> , max \$50/prescription (per 30-day supply)	Not covered	

For more information about limitations and exceptions, see plan or policy document at [www.local94.com](#)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		<u>In-Network provider</u> (You will pay the least)	<u>Out-of-Network provider</u> (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Deductible and 20% <u>coinsurance</u> + <u>balance billing</u>	Failure to precertify may result in a reduction or no benefits.
	Physician/surgeon fees	<u>Deductible</u> and 20% <u>coinsurance</u>	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Failure to precertify may result in a reduction or no benefits.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$50 <u>copay</u> /visit, waived if admitted within 24 hours	\$50 <u>copay</u> /visit, waived if admitted within 24 hours	Urgent Care: In-Network <u>copay</u> applies to office visit only.
	<a href="#">Emergency medical transportation</a>	<u>Deductible</u> and 20% <u>coinsurance</u>	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	
	<a href="#">Urgent care</a>	\$30 <u>copay</u> /visit	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Failure to precertify may result in a reduction or no benefits.
	Physician/surgeon fees	<u>Deductible</u> and 20% <u>coinsurance</u>	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Failure to precertify may result in a reduction or no benefits.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Substance Abuse Care: No charge Mental Health Care: Doctor Service (outpatient/office visit) \$30 <u>copay</u> /visit.	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Clinics are not covered.
	Inpatient services	No Charge	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Failure to precertify may result in a reduction or no benefits.
If you are pregnant	Office visits	\$30 <u>copay</u> /initial visit then <u>deductible</u> and 20% <u>coinsurance</u>	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Failure to precertify may result in a reduction or no benefits.
	Childbirth/delivery professional services	<u>Deductible</u> and 20% <u>coinsurance</u>	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	
	Childbirth/delivery facility services	No charge	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	

For more information about limitations and exceptions, see plan or policy document at [www.local94.com](http://www.local94.com)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		<u>In-Network provider</u> (You will pay the least)	<u>Out-of-Network provider</u> (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Up to 200 visits per calendar year (a visit equals 4 hours of care) In-Network and Out-of-Network combined.
	<a href="#">Rehabilitation services</a>	Outpatient visit: \$30 <u>copay/visit</u> Inpatient facility: No charge	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Failure to precertify may result in a reduction or no benefits. Coverage for rehabilitation, physical therapy and medicine: Inpatient - up to 30 days/per calendar year; Outpatient - 30 visits/per calendar year (In-Network and Out-of-Network combined). Outpatient visits for speech/language and occupational therapy: up to 30 visits per calendar year (In-Network and Out-of-Network combined).
	<a href="#">Habilitation services</a>	Outpatient Visit: \$30 <u>copay/visit</u> Inpatient facility: No charge	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Failure to precertify may result in a reduction or no benefits. Coverage for rehabilitation, physical therapy and medicine: Inpatient - up to 30 days/per calendar year; Outpatient - 30 visits/per calendar year (In-Network and Out-of-Network combined). Outpatient visits for speech/language and occupational therapy: up to 30 visits per calendar year (In-Network and Out-of-Network combined).
	<a href="#">Skilled nursing care</a>	No charge	Not covered	Failure to precertify may result in a reduction or no benefits. Up to 60 days per calendar year.
	<a href="#">Durable medical equipment</a>	<u>Deductible</u> and 20% <u>coinsurance</u>	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Failure to precertify may result in a reduction or no benefits.
	<a href="#">Hospice services</a>	No charge	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Up to 210 days per lifetime.
If your child needs dental or eye care	Children's eye exam	No charge	All balances over \$20	One exam per calendar year.
	Children's glasses	No charge	All balances after \$50	One pair of glasses per calendar year.
	Children's dental check-up	No charge for Fund panel dentists; \$15	All balances over \$15	One exam per calendar year.

For more information about limitations and exceptions, see plan or policy document at [www.local94.com](http://www.local94.com)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network provider (You will pay the least)	Out-of-Network provider (You will pay the most)	
		<u>copay/exam for Sele-Dent providers</u>		Benefit allowance schedule applies.

**Excluded Services & Other Covered Services:**

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Acupuncture (except in limited circumstances up to 12 visits maximum per year)
- Bariatric surgery (except to treat morbid obesity as medically necessary)
- Clinics
- Cosmetic surgery (except reconstructive surgery related to functional defect present since birth or post-mastectomy; precertification required)
- 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](#) document.)

- Chiropractic care (Maximum 20 visits per calendar year; In-Network and Out-of-Network combined; covered for member and spouse only)
- Dental care (Adult) (Benefit allowance schedule applies)
- Hearing aids (Per ear once every 3 years) (Benefit allowance schedule applies)
- Infertility treatment (Limited to member and spouse up to \$12,500 combined between member and spouse lifetime maximum including drugs, subject to 20% coinsurance)
- Routine eye care (Adult)

**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: U.S. Department of Labor, Employee Benefits Security Administration a 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), U.S. Department of Health and Human Services at 1-877-267-2323x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the Health and Benefit Trust Fund of the I.U.O.E. Local 94-94A-94B, AFL-CIO, 337 West 44<sup>th</sup> Street, New York, NY 10036 via phone 212-541-9880 or U.S. Department of Labor, Employee Benefits Security Administration a 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

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

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

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

For more information about limitations and exceptions, see plan or policy document at [www.local94.com](http://www.local94.com)

## Language Access Services:

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office for all other services 212-541-9880.

Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office for all other services 212-541-9880.

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office 212-541-9880 for all other services.

French Creole ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office 212-541-9880 for all other services.

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

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

### Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:  
[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$90
<a href="#">Coinsurance</a>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$750</b>

### Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:  
 Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,280
<a href="#">Coinsurance</a>	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Joe would pay is</b>	<b>\$1,380</b>

### Mia's Simple Fracture (in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:  
 Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$150
<a href="#">Coinsurance</a>	\$280
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$530</b>