

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services  
**JetBlue: Partnership Option** (available in Orlando, FL; Tampa, FL; South Florida; NYC Metro area; Long Island; portions of CT, NJ and PA; and Southern CA including Los Angeles and San Diego metro areas, including Orange County)

**Coverage Period:** 01/01/2027-12/31/2027  
**Coverage for:** Individual/Family | **Plan Type:** EPO



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, visit <https://my.centivo.com/> or call 1-855-521-8155 or contact your Human Resources Department. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-800-318-2596 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                        | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | For <a href="#">network providers</a> :<br>\$0/individual and \$0/family                                                                                                                                                                                                       | See, the Common Medical Events Chart below for your costs for services this <a href="#">plan</a> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Not Applicable                                                                                                                                                                                                                                                                 | This <a href="#">plan</a> does not have a <a href="#">deductible</a> , but a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. This <a href="#">plan</a> covers certain <a href="#">preventive</a> services without cost sharing. See a list of covered <a href="#">preventive</a> services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                                                                                                                                                              |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                                                                                                            | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For <a href="#">network providers</a> :<br>\$2,500 individual / \$5,000 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.                                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, services not deemed <a href="#">medically necessary</a> , penalties for failure to obtain <a href="#">preauthorization</a> , and health care or pharmacy services 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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="https://jetblue.centivo.com/">https://jetblue.centivo.com/</a> or call 1-855-521-8155 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. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | Yes.                                                                                                                                                                                                                                                                           | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</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 <a href="#">provider's</a> office or clinic</b>                                                                                                                           | Primary care visit to treat an injury or illness       | No charge                                    | Not covered                                        | Virtual visits and telephonic visits are the same copay as in-office visits.                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                         | <a href="#">Specialist</a> visit                       | \$50 <a href="#">copayment</a> /visit        | Not covered                                        | Virtual visits and telephonic visits are the same copay as in-office visits.                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                         | <a href="#">Preventive care/screening/immunization</a> | No charge                                    | Not covered                                        | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . 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)    | No charge                                    | Not covered                                        | None.                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                         | Imaging (CT/PET scans, MRIs)                           | \$100 <a href="#">copayment</a> /test        | Not covered                                        | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits may be reduced.                                                                                                                                                                                                        |
| <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="http://www.caremark.com">www.caremark.com</a> | Generic drugs (Tier 1)                                 | Retail: 50% <a href="#">coinsurance</a>      | Not covered                                        | Retail \$8 max for 30 day, mail order \$24 max for 90 day generic drugs. <a href="#">Provider</a> means pharmacy for the purposes of this section. See the website listed for information on drugs covered by your <a href="#">plan</a> . Not all drugs are covered.                                                              |
|                                                                                                                                                                                                         | Brand drugs (Tier 2)                                   | Retail: 50% <a href="#">coinsurance</a>      | Not covered                                        | If no generic available: Retail \$100 max for 30 day, mail order \$300 max for 90 day single source brand name drugs.<br><br>If a generic is available: Generic copay of \$10 for 30 day at retail and generic copay of \$30 for 90 day at mail plus cost difference between brand and generic for multi-source brand name drugs. |

| 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) |                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                         | <a href="#">Specialty drugs</a> (Tier 3)         | <p>\$0 if member is enrolled in the Prudent Rx program.</p> <p>30% <a href="#">coinsurance</a> if not enrolled in the PrudentRx program.</p>           | Not covered (retail and home delivery)             | <p>Covers 30-day supply.</p> <p>\$0 copay for PrudentRx eligible drugs. PrudentRx is a specialty drug copay coupon program that applies to all Crewmembers and dependents in this plan. Most specialty drugs are covered under this program. Fertility medications are not included in the PrudentRx program.</p> <p>You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by CVS Caremark.</p> |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center)   | \$500 <a href="#">copayment</a> /visit                                                                                                                 | Not covered                                        | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits may be reduced.                                                                                                                                                                                                                                                                                                                    |
|                                         | Physician/surgeon fees                           | No charge                                                                                                                                              | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| If you need immediate medical attention | <a href="#">Emergency room care</a>              | \$200 <a href="#">copayment</a> /visit                                                                                                                 | \$200 <a href="#">copayment</a> /visit             | Emergency Room <a href="#">copayment</a> waived if admitted.                                                                                                                                                                                                                                                                                                                                                                                  |
|                                         | <a href="#">Emergency medical transportation</a> | \$200 <a href="#">copayment</a>                                                                                                                        | \$200 <a href="#">copayment</a>                    | All <a href="#">Emergency Services</a> are considered In-network.                                                                                                                                                                                                                                                                                                                                                                             |
|                                         | <a href="#">Urgent care</a>                      | \$100 <a href="#">copayment</a> /visit                                                                                                                 | \$100 <a href="#">copayment</a> /visit             | <p><a href="#">Preauthorization</a> is required for non-emergent Air Ambulance.</p> <p><a href="#">Urgent Care</a> is same as in-<a href="#">network</a> when outside of service area.</p>                                                                                                                                                                                                                                                    |
| If you have a hospital stay             | Facility fee (e.g., hospital room)               | <p>Without surgical procedure:<br/>\$100 <a href="#">copayment</a>/visit</p> <p>With surgical procedure:<br/>\$700 <a href="#">copayment</a>/visit</p> | Not covered                                        | <p>Inpatient Medical Rehabilitation is limited to 120 days per calendar year and is combined with Skilled Nursing Facility.</p> <p><a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a>, benefits may be reduced.</p>                                                                                                                                                                              |
|                                         | Physician/surgeon fees                           | No charge                                                                                                                                              | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                          |

| 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 need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$50 <a href="#">copayment</a> /visit                                                                                                       | Not covered                                        | <a href="#">Preauthorization</a> is required for Inpatient, Residential, and Partial Day Programs. If you don't get <a href="#">preauthorization</a> , benefits may be reduced.                                                                                                                                                                                                                                                                                        |
|                                                                                  | Inpatient services                        | Inpatient Hospital and Residential Treatment:<br>\$100 <a href="#">copayment</a><br>Partial Day Program:<br>\$500 <a href="#">copayment</a> | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>If you are pregnant</b>                                                       | Office visits                             | No charge                                                                                                                                   | 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> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Failure to obtain <a href="#">preauthorization</a> for childbirth if inpatient stay exceeds 48 hours for normal delivery and 96 hours after a cesarean delivery may result in benefits being reduced. |
|                                                                                  | Childbirth/delivery professional services | No charge                                                                                                                                   | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                  | Childbirth/delivery facility services     | \$700 <a href="#">copayment</a> /visit                                                                                                      | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | \$50 <a href="#">copayment</a> /visit                                                                                                       | Not covered                                        | Limited to 40 visits per calendar year and is combined with Private Duty Nursing in home setting.<br><br><a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits may be reduced.                                                                                                                                                                                                                                    |
|                                                                                  | <a href="#">Rehabilitation services</a>   | \$50 <a href="#">copayment</a> /visit                                                                                                       | Not covered                                        | Limited to 75 visits per calendar year and is combined Occupational Therapy, Physical Therapy, and Speech Therapy.                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                  | <a href="#">Habilitation services</a>     | \$50 <a href="#">copayment</a> /visit                                                                                                       | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                  | <a href="#">Skilled nursing care</a>      | \$100 <a href="#">copayment</a>                                                                                                             | Not covered                                        | Limited to 120 days per calendar year and is combined with Inpatient Medical Rehabilitation.<br><a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits may be reduced.                                                                                                                                                                                                                                             |

| 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) |                                                                                                                                                                                                                  |
|                                        | <a href="#">Durable medical equipment</a> | \$100 <a href="#">copayment</a>              | Not covered                                        | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits may be reduced. |
|                                        | <a href="#">Hospice services</a>          | No charge                                    | Not covered                                        | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits may be reduced.                                                                                       |
| If your child needs dental or eye care | Children's eye exam                       | No charge                                    | Not covered                                        | <a href="#">Plan</a> covers up to 1 screening per calendar year.                                                                                                                                                 |
|                                        | Children's glasses                        | Not covered                                  | Not covered                                        | Children's glasses are not a covered service under this <a href="#">plan</a> .                                                                                                                                   |
|                                        | Children's dental check-up                | Not covered                                  | Not covered                                        | Coverage is limited to an oral risk assessment each year as required by PPACA.                                                                                                                                   |

#### 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> .) |                                                                                                                              |                                                                                                   |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--|
| <ul style="list-style-type: none"> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> </ul>                                                                                                   | <ul style="list-style-type: none"> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>Routine foot care</li> <li>Weight loss programs</li> </ul> |  |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                                              |                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                        |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <ul style="list-style-type: none"> <li>Abortion</li> <li>Acupuncture (20 visit limit per calendar year combined with ASH benefit)</li> <li>Hearing Aids (only bone anchored &amp; middle ear implants covered)</li> </ul> | <ul style="list-style-type: none"> <li>Bariatric Surgery (Must be 18 years of age or older)</li> <li>Chiropractic Care (20 visit limit per calendar year combined with Osteopath Manipulations)</li> <li>Routine eye care (Adult) - (1 screening per calendar year)</li> </ul> | <ul style="list-style-type: none"> <li>Infertility Treatment (\$25,000 max per lifetime, for all infertility / fertility benefits combined)</li> <li>Private Duty Nursing (40 visit limit per calendar year combined with Home Health Care)</li> </ul> |  |

**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: your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [Affordable Care Act | U.S. Department of Labor \(dol.gov\)](#) or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or [www.CMS.gov](#). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](#) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Centivo at 1-855-521-8155. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA x3272 or [dol.gov/ebsa/healthreform](https://dol.gov/ebsa/healthreform).

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

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

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

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

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

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## 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>                          | \$50   |
| ■ Hospital (facility) <a href="#">copayment</a> *               | \$700  |
| ■ Other <a href="#">coinsurance</a>                             | 50% Rx |

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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$0          |
| <a href="#">Copayments</a>        | \$700        |
| <a href="#">Coinsurance</a>       | \$10         |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Peg would pay is</b> | <b>\$710</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>                          | \$50   |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$100  |
| ■ Other <a href="#">coinsurance</a>                             | 50% Rx |

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> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$100          |
| <a href="#">Coinsurance</a>       | \$2,100        |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$2,200</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>                          | \$50   |
| ■ Hospital (facility) <a href="#">copayment</a> *               | \$100  |
| ■ Other <a href="#">coinsurance</a>                             | 50% Rx |

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> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$1,100        |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,100</b> |

\*Examples are based on non-surgical inpatient hospital stays.

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