



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 including your plan's Plan document/Summary plan description, visit www.zenith-american.com or call the Administrative Office (Zenith) at 1-702-734-8601. 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 or call the Administrative Office (Zenith) at 1-702-734-8601 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Providers per calendar year: \$500/individual; \$1,500/family. Out-of-Network Providers per calendar year: \$1,500/individual; \$4,500/family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. 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> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> performed by <u>network providers</u> , LiveHealth Online visit, hospitalist services, and outpatient <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	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. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes, \$100 <u>deductible</u> /person per <u>network</u> hospital admission. \$1,000 <u>deductible</u> /person for out-of- <u>network</u> hospital admission. \$500 <u>deductible</u> /person for air ambulance trip. There are other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical <u>Plan Network Provider</u> : \$5,600/individual; \$11,200/family per calendar year. <u>Out-of-Network Provider</u> : No <u>out-of-pocket limit</u> . Outpatient <u>prescription drugs</u> per calendar year: \$1,000/individual; \$2,000/family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	For the Medical <u>Plan</u> : <u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain <u>preauthorization</u> , dental & vision <u>plan</u> expenses, outpatient retail/mail order drug expenses (which have a separate <u>out-of-pocket limit</u>), and out-of- <u>network</u> <u>cost sharing</u> except an ER visit in case of an emergency, The outpatient <u>prescription drug</u> <u>out-of-pocket limit</u> does not include <u>premiums</u> , <u>balance-billing</u> charges, medical <u>plan</u> , dental <u>plan</u> or vision <u>plan</u> expenses, plus drugs and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. Medical <u>network</u> , see www.anthem.com or call Anthem at 702-734-8601. Mental health/substance abuse <u>network</u> , see www.harmonyhc.com or call Harmony Health Care at 702-251-8000 or 1-800-363-4874. <u>Network Health Services Coalition (HSC) Hospitals</u> in Southern Nevada call 1-702-734-8601. Vision <u>network</u> : see www.vsp.com or call VSP 1-800-877-7195.	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>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a <u>health care provider's office</u> or <u>clinic</u>	Primary care visit to treat an injury or illness	\$10 <u>copayment</u> /visit.	50% <u>coinsurance</u> .	<u>Preauthorization</u> of certain diagnostic tests and medical procedures required to avoid a 50% reduction in <u>plan</u> payment. LiveHealth Online Doctor visit: \$10 <u>copayment</u> /visit; <u>Deductible</u> does not apply. No charge when you visit the near-site clinic. <u>Plan</u> covers required <u>preventive services</u> and supplies described at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/ . Age and frequency guidelines apply to covered <u>preventive care</u> . You may have to pay for services that aren't <u>preventive care</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	<u>Specialist</u> visit	\$15 <u>copayment</u> /visit.	50% <u>coinsurance</u> .	
	<u>Preventive care/screening/im</u> munization	No charge. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> .	
If you have a <u>test</u>	<u>Diagnostic test</u> (x-ray, blood work)	Lab services: \$5 <u>copayment</u> per visit. Radiology services: \$15 <u>copayment</u> per visit.	50% <u>coinsurance</u> .	Physician/ <u>provider's</u> professional fees may be billed separately.
	Imaging (CT/PET scans, MRIs)	\$50 <u>copayment</u> per test.	50% <u>coinsurance</u> .	<u>Preauthorization</u> of MRI, CT and PET scans is required to avoid a 50% reduction in <u>plan</u> payment. Physician/ <u>provider's</u> professional fees may be billed separately.

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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medimpact.com or call MedImpact at 1-800-361-4542.	Generic drugs	Retail Pharmacy for 30-day supply: No charge. Mail Order for 90-day supply: No charge. No charge for FDA-approved generic contraceptives.	Not covered.	<ul style="list-style-type: none"> • <u>Deductible</u> does not apply. • You pay the lesser of the <u>copayment</u> or the drug cost. • Some prescriptions are subject to <u>preauthorization</u> (to avoid non-payment), quantity limits or step therapy requirements. • Certain over-the-counter (OTC) and <u>prescription drugs</u> are payable at no charge with a prescription. • If you purchase a brand drug when a generic drug is available you pay the brand drug <u>cost sharing</u> plus the difference in cost between the brand drug and generic drug. • Your <u>cost sharing</u> counts toward the <u>prescription drug out-of-pocket limit</u>, not the medical <u>plan out-of-pocket limit</u>. • No charge for diabetic supplies purchased at an <u>In-Network</u> pharmacy. • Anti-Obesity Medication is covered only through participation in the Weight Management Program through Marathon Health and subject to a \$200 <u>copayment</u> per prescription • Certain CDC recommended vaccinations are payable at 100% when obtained at an in-<u>Network</u> retail pharmacy.
	Preferred brand drugs	Retail Pharmacy for 30-day supply: you pay the greater of 20% <u>coinsurance</u> or \$20 <u>copayment</u> per prescription. Mail Order for 90-day supply: \$30 <u>copayment</u> per prescription. No charge for FDA-approved brand name contraceptives if a generic is medically inappropriate.		
	Non-preferred brand drugs	Retail Pharmacy for 30-day supply: you pay the greater of 45% <u>coinsurance</u> or \$45 <u>copayment</u> per prescription; Mail Order for 90-day supply: \$60 <u>copayment</u> per prescription.		
	<u>Specialty drugs</u>	\$50 <u>copayment</u> per prescription for up to a 30-day supply.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50 <u>copayment</u> per visit.	Not covered.	<u>Preauthorization</u> of outpatient surgery is required to avoid a 50% reduction in <u>plan</u> payment. You pay 100% out-of- <u>network</u> services.
	Physician/surgeon fees	Surgeon: \$50 <u>copayment</u> per visit. Assistant surgeon: No charge after <u>deductible</u> met. Anesthesia services: \$100 <u>copayment</u> .	Not covered.	

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 need immediate medical attention	<u>Emergency room care</u>	\$25 <u>copayment</u> /visit for facility and \$25 <u>copayment</u> /visit for ER physician.	\$25 <u>copayment</u> /visit for facility and \$25 <u>copayment</u> /visit for ER physician.	Physician/ <u>provider</u> 's professional fees may be billed separately. ER visit <u>copayment</u> waived if hospitalized within 24 hrs. For non-emergency but medically necessary services received in an <u>emergency room</u> the <u>Plan</u> pays a maximum of \$75/visit.
	<u>Emergency medical transportation</u>	Ground: \$50 <u>copayment</u> per trip. Air: \$500 <u>deductible</u> per trip.	Ground: \$50 <u>copayment</u> /trip. Air: \$500 <u>deductible</u> /trip.	<u>Preauthorization</u> of non-emergency ambulance transportation is required to avoid a 50% reduction in <u>plan</u> payment. <u>Balance Billing</u> will not apply to covered air ambulance services.
	<u>Urgent care</u>	\$15 <u>copayment</u> /visit.	50% <u>coinsurance</u> .	Physician/ <u>provider</u> 's professional fees may be billed separately.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 inpatient <u>deductible</u> plus 10% <u>coinsurance</u> up to \$500/person (\$1,500/family) of <u>coinsurance</u> per year, then no charge.	\$1,000 inpatient <u>deductible</u> plus 50% <u>coinsurance</u> .	<u>Preauthorization</u> of elective hospital admission, transplant services, cochlear implant and certain other services is required to avoid a 50% reduction in <u>plan</u> payment. Private room payable only if <u>medically necessary</u> or the hospital only has private rooms.
	Physician/surgeon fees	Hospitalist: No charge. <u>Deductible</u> does not apply. Specialist visit: \$15 <u>copayment</u> per visit. Non-specialist visit: \$10 <u>copayment</u> per visit. Surgeon: \$50 <u>copayment</u> per visit. Assistant surgeon: No charge after <u>deductible</u> met. Anesthesia services: \$100 <u>copayment</u> .	50% <u>coinsurance</u> .	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Intake Assessment: \$10 <u>copayment</u> . Individual & Family therapy visits: no charge for the first 4 visits, then you pay a \$7.50 <u>copayment</u> /visit. Group therapy: \$5.50 <u>copayment</u> /visit.	50% <u>coinsurance</u> .	<u>Plan</u> covers up to 8 free EAP visits through Harmony Health Care at 702-251-8000 or 1-800-363-4874.
	Inpatient services	\$100 inpatient <u>deductible</u> plus 10% <u>coinsurance</u> up to \$500/person (\$1,500/family) of <u>coinsurance</u> per year, then no charge. Specialist visit: \$15 <u>copayment</u> / visit.	Hospital: \$1,000 inpatient <u>deductible</u> plus 50% <u>coinsurance</u> . Residential treatment facility: not covered.	<u>Preauthorization</u> of elective hospital admission and residential treatment program admission is required to avoid a 50% reduction in <u>plan</u> payment. You pay 100% for out-of- <u>network</u> residential treatment.

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 are pregnant	Office visits	Female employee, spouse, or daughter: No charge for office visits and ACA-required <u>preventive services</u> . <u>Deductible</u> does not apply.	For employee and spouse: 50% <u>coinsurance</u> .	<ul style="list-style-type: none"> • <u>Cost sharing</u> does not apply for <u>network preventive services</u>. • Depending on the type of services, a <u>copayment</u>, <u>coinsurance</u> or <u>deductible</u> may apply. • Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). • Prenatal care (other than office visits and ACA-required <u>preventive screening</u>) is not covered for dependent children.
	Childbirth delivery professional services	Physician obstetrical care: \$100 <u>copayment</u> . Anesthesia services: \$100 <u>copayment</u> . Hospitalist: No charge. <u>Deductible</u> does not apply. Specialist visit: \$15 <u>copayment</u> per visit. Non-specialist visit: \$10 <u>copayment</u> per visit.	For employee and spouse: 50% <u>coinsurance</u> .	You must pay 100%, even in- <u>network</u> , for delivery expenses for a dependent child. <u>Preauthorization</u> is required to avoid a financial penalty only if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section.
	Childbirth delivery facility services	\$100 inpatient <u>deductible</u> plus 10% <u>coinsurance</u> up to \$500/person (\$1,500/family) of <u>coinsurance</u> per year, then no charge.	\$1,000 inpatient <u>deductible</u> plus 50% <u>coinsurance</u> .	
Home health care	\$10 <u>copayment</u> /visit.	50% <u>coinsurance</u> .	<u>Plan</u> covers part-time or intermittent <u>skilled nursing care</u> . <u>Preauthorization</u> of home health and home infusion therapy services is required to avoid a 50% reduction in <u>plan</u> payment.	
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	Outpatient visits: \$15 <u>copayment</u> per therapy modality. Inpatient Rehab. admission: \$100 inpatient <u>deductible</u> plus 10% <u>coinsurance</u> up to \$500/person (\$1,500/family) of <u>coinsurance</u> per year, then no charge.	Outpatient visits: 50% <u>coinsurance</u> . Inpatient Rehab. admission: Not covered.	<ul style="list-style-type: none"> • Outpatient physical and speech therapy maximum benefit is 40 visits/calendar year. Outpatient occupational therapy maximum benefit is 40 visits/calendar year. • <u>Preauthorization</u> of speech therapy and inpatient rehabilitation admission is required to avoid a 50% reduction in <u>plan</u> payment. • For In-<u>Network</u> inpatient rehab admission: maximum benefit is 60 days/calendar year combined with skilled nursing facility admission. You pay 100% for out-of-<u>network</u> inpatient rehabilitation admission.

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)	
	<u>Habilitation services</u>	Outpatient visits: \$15 <u>copayment</u> /therapy modality.	Outpatient visits: 50% <u>coinsurance</u> .	Speech therapy for developmentally delayed individuals payable to a maximum of 20 visits/calendar year.
	<u>Skilled nursing care</u>	\$100 inpatient <u>deductible</u> plus 10% <u>coinsurance</u> up to \$500/person (\$1,500/family) of <u>coinsurance</u> per year, then no charge.	Not covered.	<ul style="list-style-type: none"> • <u>Preauthorization</u> of skilled nursing facility admission is required to avoid a 50% reduction in <u>coinsurance</u>. • For skilled nursing facility admission: maximum benefit is 60 days/calendar year combined with inpatient rehab admission. • You pay 100% for out-of-network inpatient skilled nursing facility admission.
	<u>Durable medical equipment</u>	\$50 <u>copayment</u> per device.	50% <u>coinsurance</u> .	<u>Preauthorization</u> of durable medical equipment over \$500/item is required to avoid a 50% reduction in <u>plan</u> payment. No charge from <u>network providers</u> for breastfeeding pump and supplies needed to operate pump.
	<u>Hospice services</u>	Home hospice: \$10 <u>copayment</u> /visit. Inpatient hospice: \$100 inpatient <u>deductible</u> plus 10% <u>coinsurance</u> up to \$500/person (\$1,500/family) of <u>coinsurance</u> per year, then no charge.	Home hospice: 50% <u>coinsurance</u> . Inpatient hospice: \$1,000 inpatient <u>deductible</u> plus 50% <u>coinsurance</u> .	Covered if terminally ill. <u>Deductible</u> waived if transferred directly from a hospital.
If your child needs dental or eye care	Children's eye exam	\$5 <u>copayment</u> /visit. Medical <u>plan deductible</u> does not apply.	You pay 100%. <u>Plan</u> reimburses up to \$45 per exam (minus the \$5 <u>copayment</u> for the exam & eyeglasses). You pay any amount over \$45 for exam. Medical <u>plan deductible</u> does not apply.	<ul style="list-style-type: none"> • If you elect vision coverage, it will be available under a separate vision <u>plan</u>. • One vision exam payable each 12 months. • One frame is payable each 24 months • One pair lenses payable each 12 months. • Your <u>cost sharing</u> for vision services does not count toward the medical <u>plan's out-of-pocket limit</u>.
	Children's glasses	No charge for lenses. No charge for frames up to \$200/frame. You pay frame costs over \$200/frame. Medical <u>plan deductible</u> does not apply.	You pay 100%. <u>Plan</u> reimburses up to \$70/frame and up to \$30/single lens. You pay any amount over \$70/frame and \$30/single lens. Medical <u>plan deductible</u> does not apply.	

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)	
	Children's dental check-up	20% <u>coinsurance</u> . Medical <u>plan deductible</u> does not apply to these dental services.	20% <u>coinsurance</u> . Medical <u>plan deductible</u> does not apply to these dental services.	If you elect dental coverage, it will be available under a separate dental <u>plan</u> . Your <u>cost sharing</u> for dental services does not count toward the medical <u>plan's out-of-pocket limit</u> .

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.)

- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (up to 15 visits/calendar year).
- Bariatric Surgery (limit to one bariatric surgery per lifetime)
- Chiropractic care (up to 15 visits/calendar year).
- Dental care (Adult) (if you elect dental coverage, payable up to \$2,500/calendar year)
- Hearing aids (up to \$600/ear every 5 years for adults and once every 3 years for a child)
- Routine eye care (Adult) (if you elect vision coverage).
- Routine foot care (covered when treating diabetic, neurological or vascular insufficiency affecting the feet.)
- Weight Loss Programs (managed through Marathon Health)

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 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 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 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 Administrative Office (Zenith) at 1-702-734-8601 or the 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. 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 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.

Language Access Services: Spanish (Español): Para obtener asistencia en Español, llame al 1-702-734-8601. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-702-734-8601. Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-702-734-8601. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-702-734-8601.

—————To see examples of how this plan might cover costs for a sample medical situation, see the next section. —————

About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u> (delivery)	\$100
■ Hospital (facility) <u>coinsurance</u>	10%
■ Hospital <u>deductible</u>	\$100

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	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$600
<u>Copayments</u>	\$440
<u>Coinsurance</u>	\$500
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Peg would pay is	\$1,560

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$15
■ Hospital (facility) <u>coinsurance</u>	10%
■ Hospital <u>deductible</u>	\$100

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	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$620
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,220

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$15
■ Hospital (facility) ER <u>copayment</u>	\$25
■ ER physician <u>copayment</u>	\$25

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	\$2,800
---------------------------	----------------

In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$330
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$830

The plan would be responsible for the other costs of these EXAMPLE covered services.