

# CARE+ COPAY

Accessible care at an affordable price.



COMPREHENSIVE COVERAGE

## PLAN SUMMARY

Your health plan covers essential health benefits and allows you to see specialists without a referral. There are no limits on pre-existing conditions for covered services, and the deductible is waived for copay services. Review your plan details, find plan documents, and get started with your benefits by scanning the code.



30% COINSURANCE

## PLAN OPTIONS

	Deductible		Out-of-Pocket Max	
<b>1500</b>	\$1,500 Ind	\$3,000 Fam	\$3,100 Ind	\$6,500 Fam
<b>2500</b>	\$2,500 Ind	\$5,000 Fam	\$5,100 Ind	\$10,500 Fam
<b>3500</b>	\$3,500 Ind	\$7,000 Fam	\$7,100 Ind	\$14,500 Fam
	Rx Deductible		Rx Out-of-Pocket Max	
<b>All Levels</b>	\$1,000 Ind	\$2,000 Fam	\$1,200 Ind	\$2,100 Fam



NO NETWORK

## FAIR-PRICE HEALTHCARE

See any provider, without worrying about network limitations. The plan pays claims based on the most reasonable or fair rates for your area. To learn more [click here](#).



COPAYS WITH DEDUCTIBLE WAIVED

## COPAYS

Service	Copay	Service	Copay
Primary Care Visit	\$50	Specialist Care Visit	\$100
Urgent Care Visit	\$100	Emergency Care	\$500



PLANSTINRX

## PRESCRIPTIONS

Home delivery and significant discounts. Visit [planstinrx.com](http://planstinrx.com) to get started.

Prescription Tier	Retail (30)	Mail (90)
Tier 1: Generic	\$10	\$20
Tier 2: Preferred Brand	\$50	\$100
Tier 3: Non-Preferred Brand	\$100	\$100

Tier 4: Specialty | 30% coinsurance after Rx deductible | \$500 max paid per Rx, per month

# FAIR-PRICE HEALTHCARE

## MAKING BEST USE OF YOUR HEALTH PLAN

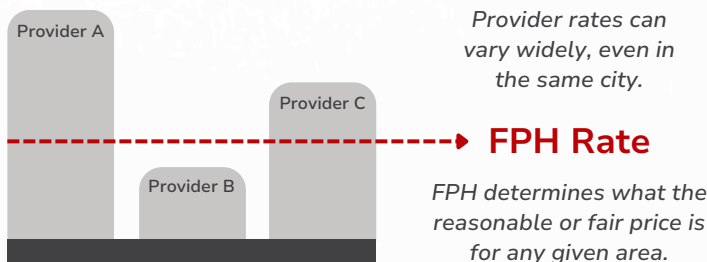
### WHAT IS FAIR-PRICED HEALTHCARE?

Your health plan uses fair-priced healthcare to determine what the most fair price is for a service in any given area by examining average prices, cash prices, or using other reference points, such as the Medicare rates.

Fair-price healthcare is a no-network, proactive pricing strategy that relies on a care coordination team to match members with providers that work best with their plan.

### WHY USE FAIR-PRICED HEALTHCARE?

Typically, prices can vary dramatically depending on the provider or facility—even in the same area. Your health plan uses a fair-priced healthcare approach to ensure your plan pays a reasonable rate rather than accepting unnecessarily inflated costs.



This healthcare pricing strategy improves transparency for both plan sponsors and members alike, allowing both groups to benefit from fair prices for healthcare services.

### LESS GUESSWORK

Fair-price healthcare relies on a care coordination team with detailed knowledge of how your health plan works, so you can receive the care you need without fear of unexpected bills.

Having a health plan that uses fair-price healthcare means less guesswork, less stress, and more flexibility.



### Confirm Your Coverage

888-920-7526  
member@planstin.com

If you are unsure what benefits you have, first contact a Benefit Advocate to confirm your coverage details.



### Contact Care Coordination

435-281-2273  
primestinsupport@primestin.care

Before you make an appointment or visit your provider, call our Care Coordination team. They will help make sure your provider will work with your benefits.

They can also

- help you find fair-price providers, and
- make appointments.



### Receive Care

Once your care coordinator confirms the details of your appointment, including costs, all that's left is to visit your provider and receive care. You will receive an explanation of benefits (EOB) in the mail.

## FAIR-PRICE HEALTHCARE RESOURCES



### Coverage Questions?

Scan the code to email a Benefit Advocate. Or call **888-920-7526**.



### Need a Care Coordinator?

Scan the code to email a Care Coordinator. Or call **435-281-2273**.



### Plan Documents

Scan the code, click on “plan documents,” and type in the plan name on your ID card.



### Preventive Care

Scan the code to access the full list of preventive services covered by your plan.



### No Surprises Act

Scan the code to read more about healthcare consumer protections under the (NSA).

## Know Your Benefits

Not every service will be covered by your plan. Be sure to check your coverage as needed. You can find your plan details by scanning to code for the Help Center below. You can also contact a Benefit Advocate to verify your coverage.

## Preventive Care

Your Planstin-managed health plan includes coverage for preventive care as outlined by the Affordable Care Act.

If you receive preventive care covered by your plan, your health plan will take care of the bill. If, for any reason, you receive a bill for preventive care from your provider, contact a Benefit Advocate.

## Emergencies

If your plan has “preventive” in the name, it does not have coverage for emergency care. However, if you have a Care+ plan, you do have coverage for emergency care.

Since you cannot predict when or where you will need emergency care, it is unlikely you will be able to contact a care coordinator before receiving care. As a result, you may be more likely to receive a balance bill for emergency care. However, the No Surprises Act offers you some protection against being balance billed for certain emergency services including transport and stabilizing care.

If you receive a balance bill for emergency care, first reach out to the provider. If they will not adjust the bill, reach out to Planstin at **888-920-7526** and our team can work with the provider to determine if the services fall under the NSA.


## Appeals

If, after checking your plan details, you feel like you’ve received a bill in error, first contact our Benefit Advocate team. They will be able to help you understand your benefits and what course of action you can take. One of those steps may be filing an appeal. If that is the case, you can find information about appeals at [planstin.com/for-providers#appeals](https://planstin.com/for-providers#appeals).



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, call a Benefit Advocate at (888) 920-7526. 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.com](http://www.healthcare.gov/sbc-glossary.com) or call 888-920-7526 to request a copy.

Important Questions	Answers	Why This Matters:		
<b>What is the overall <a href="#">deductible</a>?</b>	<table border="1"> <tr> <td data-bbox="464 459 661 609"><u>MEDICAL</u> \$2,500 / Individual or \$5,000 / Family</td> <td data-bbox="661 459 863 609"><u>PHARMACY</u> \$1,000 / Individual or \$2,000 / Family</td> </tr> </table>	<u>MEDICAL</u> \$2,500 / Individual or \$5,000 / Family	<u>PHARMACY</u> \$1,000 / Individual or \$2,000 / Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual deductible until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<u>MEDICAL</u> \$2,500 / Individual or \$5,000 / Family	<u>PHARMACY</u> \$1,000 / Individual or \$2,000 / Family			
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. In-Network <a href="#">Preventive care</a> is covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount, but a <a href="#">copayment</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .		
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet deductibles for specific services.		
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<table border="1"> <tr> <td data-bbox="464 889 661 1036"><u>MEDICAL</u> \$5,100 / Individual or \$10,500 / Family</td> <td data-bbox="661 889 863 1036"><u>PHARMACY</u> \$1,200 / Individual or \$2,100 / Family</td> </tr> </table>	<u>MEDICAL</u> \$5,100 / Individual or \$10,500 / Family	<u>PHARMACY</u> \$1,200 / Individual or \$2,100 / 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 on 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.
<u>MEDICAL</u> \$5,100 / Individual or \$10,500 / Family	<u>PHARMACY</u> \$1,200 / Individual or \$2,100 / Family			
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Copayments</a> on certain services, <a href="#">premiums</a> , <a href="#">balance billing</a> charges, services not covered by this <a href="#">plan</a> , fees above RBP rates and/or UCR rates.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .		
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Not Applicable	This <a href="#">plan</a> does not use a <a href="#">provider network</a> . You can receive covered services from any <a href="#">provider</a> .		
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .		

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

[Copayment](#) for office visits apply to visits only. In-office procedures may not be covered.

All covered services are paid at 150% of Medicare reimbursement rates (RBP). In the absence of a Medicare rate the [plan](#) will pay [UCR](#).

Common Medical Event	Services You May Need	What You Will Pay Out-of-Network Provider (this plan does not use a network)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$50 <a href="#">copay</a> /visit	<a href="#">Deductible</a> waived. <a href="#">Plan</a> will pay up to \$150 max/visit. Additional charges are member responsibility, will not be applied to <a href="#">deductible</a> or <a href="#">out-of-pocket limits</a> .
	<a href="#">Specialist</a> visit	\$100 <a href="#">copay</a> /visit	<a href="#">Deductible</a> waived. <a href="#">Plan</a> will pay up to \$300 max/visit. Additional charges are member responsibility, will not be applied to <a href="#">deductible</a> or <a href="#">out-of-pocket limits</a> .
	<a href="#">Preventive care/screening/immunization</a>	No Charge	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 receive a bill for preventive services, call a Benefit Advocate at (888) 920-7526.</b>
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Tier I: \$50 <a href="#">copay</a> /x-ray and \$20 <a href="#">copay</a> /lab Tier II: \$200 <a href="#">copay</a> /x-ray and \$50 <a href="#">copay</a> /lab	<a href="#">Deductible</a> waived. Tier I: Performed in a physician's office or free-standing facility. Tier II: Performed in a hospital or hospital-affiliated outpatient-facility. Diagnostic services are subject to annual limits. The plan pays up to \$250/x-ray and \$100/lab. Additional charges are member responsibility and will not be applied to <a href="#">deductible</a> or <a href="#">out-of-pocket limits</a> .
	Imaging (CT/PET scans, MRIs)	Tier I: \$350 <a href="#">copay</a> /test Tier II: \$500 <a href="#">copay</a> /test	<a href="#">Deductible</a> waived. Tier I: Performed in a physician's office or free-standing facility. Tier II: Performed in a hospital or hospital-affiliated outpatient-facility. Imaging services are subject to annual limits and the plan pays up to \$1,000/test. Additional charges are member responsibility and will not be applied to <a href="#">deductible</a> or <a href="#">out-of-pocket limits</a> .
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">PlanstinRx.com</a>	Generic drugs	\$10 <a href="#">copay</a> (retail) and \$20 <a href="#">copay</a> (mail order)	RX <a href="#">deductibles</a> are \$1,000 (individual) and \$2,000 (family). <a href="#">RX out-of-pocket limits</a> are \$1,200 (individual) and \$2,100 (family). ACA Preventive drugs are covered 100%. <a href="#">Plan</a> will pay up to <b>\$500 monthly max per specialty prescription</b> . Additional costs are the member's responsibility and will not be applied to the <a href="#">deductible</a> or to the <a href="#">out-of-pocket limits</a> .
	Preferred brand drugs	\$50 <a href="#">copay</a> (retail) and \$100 <a href="#">copay</a> (mail order)	
	Non-preferred brand drugs	\$100 <a href="#">copay</a> (retail) and \$100 <a href="#">copay</a> (mail order)	
	<a href="#">Specialty drugs</a>	30% <a href="#">Coinsurance</a>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">Coinsurance</a>	This <a href="#">plan</a> does not cover some types of facility charges. See the Summary Plan Description for more information regarding exclusions.



Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
		Out-of-Network Provider (this plan does not use a network)	
	Physician/surgeon fees	30% <a href="#">Coinsurance</a>	See the Summary Plan Description for details about services that may not be covered as part of outpatient surgery.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$500 <a href="#">copay</a> /visit	<b>Only covered in an emergency medical event.</b> <a href="#">Deductible</a> waived. See the Summary Plan Description for more details.
	<a href="#">Emergency medical transportation</a>	\$500 <a href="#">copay</a> /visit	<b>Only covered in an emergency medical event.</b> <a href="#">Deductible</a> waived. See the Summary Plan Description for more details.
	<a href="#">Urgent care</a>	\$100 <a href="#">copay</a> /visit	Coverage for <a href="#">Urgent care</a> facilities only. <a href="#">Deductible</a> waived. <a href="#">Plan</a> will pay up to \$300 max/visit. Additional charges are member responsibility and will not be applied to <a href="#">deductible</a> or <a href="#">out-of-pocket limits</a> .
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">Coinsurance</a>	Coverage is limited to items and services that are deemed <a href="#">medically necessary</a> and may be subject to limitation and conditions.
	Physician/surgeon fees	30% <a href="#">Coinsurance</a>	Coverage is limited to items and services that are deemed <a href="#">medically necessary</a> and may be subject to limitation and conditions.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <a href="#">Coinsurance</a>	Coverage is limited to items and services that are deemed <a href="#">medically necessary</a> and may be subject to limitation and conditions.
	Inpatient services	30% <a href="#">Coinsurance</a>	Coverage is limited to items and services that are deemed <a href="#">medically necessary</a> and may be subject to limitation and conditions.
If you are pregnant	Office visits	\$50 <a href="#">copay</a> /visit	<a href="#">Deductible</a> waived. <a href="#">Cost sharing</a> does not apply for covered <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> or <a href="#">deductible</a> may apply.
	Childbirth/delivery professional services	30% <a href="#">Coinsurance</a>	Charges for professional services at in-home births are not covered.
	Childbirth/delivery facility services	30% <a href="#">Coinsurance</a>	Charges for care received in birthing centers are not covered. See the Summary Plan Description for more details.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <a href="#">Coinsurance</a>	60 visit limit per plan year.
	<a href="#">Rehabilitation services</a>	30% <a href="#">Coinsurance</a>	120 visit limit (combined with habilitation services) per plan year.
	<a href="#">Habilitation services</a>	30% <a href="#">Coinsurance</a>	120 visit limit (combined with rehabilitation services) per plan year.
	<a href="#">Skilled nursing care</a>	30% <a href="#">Coinsurance</a>	120-day limit per plan year.
	<a href="#">Durable medical equipment</a>	30% <a href="#">Coinsurance</a>	\$1,000 limit per Item/Service per plan year.
	<a href="#">Hospice services</a>	30% <a href="#">Coinsurance</a>	Services are covered when prerequisites are satisfied. See the Summary Plan Description for more details.
If your child needs	Children's eye exam	No Charge	No Coverage for vision care, except as otherwise covered in Section VI

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://helpdesk.planstin.com/benefit-information>

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
		Out-of-Network Provider (this plan does not use a network)	
dental or eye care			of the Summary Plan Description.
	Children's glasses	Not Covered	Contacts, lenses, and frames are excluded.
	Children's dental check-up	No Charge	No Coverage for dental care, except as otherwise covered in Section VI of the Summary Plan Description.

### 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>Acupuncture</li> <li>Bariatric Surgery</li> <li>Dental Care (Adult)</li> <li>Experimental/Investigational Services</li> <li>Hearing Aids</li> </ul>	<ul style="list-style-type: none"> <li>Infertility Treatment</li> <li>Long-term Care</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty Nursing</li> </ul>	<ul style="list-style-type: none"> <li>Routine Eye Care (Adult)</li> <li>Routine Foot Care</li> <li>Services that are not Medically Necessary</li> <li>Sexual Dysfunction</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>Chiropractic Care (12 visit annual limit)</li> <li>Cosmetic Surgery</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: Department of Labor, Employee Benefits Security Administration, 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](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 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: Department of Labor, Employee Benefits Security Administration, 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**  
[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](#).

**Language Access Services:**  
[Spanish (Español): Para obtener asistencia en Español, llame al (888) 920-7526.  
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (888) 920-7526.  
[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (888) 920-7526.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (888) 920-7526.

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

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) 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](#) \$2,500
- [Specialist](#) visit [copayment](#) \$50
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

**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>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$2,700

<i>What isn't covered</i>	
Limits or exclusions	\$0

<b>The total Peg would pay is</b>	<b>\$5,500</b>
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### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist](#) visit [copayment](#) \$100
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

**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>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$2,400
<a href="#">Coinsurance</a>	\$140

<i>What isn't covered</i>	
Limits or exclusions	\$0

<b>The total Joe would pay is</b>	<b>\$5,040</b>
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### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist](#) visit [copayment](#) \$100
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

**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>\$2,500</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0

<b>The total Mia would pay is</b>	<b>\$2,500</b>
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.