



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 1-844-380-4554. 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.webtpa.com](http://www.webtpa.com) or call 1-844-380-4554 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$1,700/person \$3,400 /family - * Preferred Primary Care <a href="#">providers</a> and Preferred network (EHN) and \$3,200/person \$5,000/family - *Expanded Network(Aetna) \$7,500/person \$10,500/family <a href="#">Out-of-Network providers</a> *In-network <a href="#">deductibles</a> cross-apply.	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 plan, the overall family deductible must be met before the plan begins to pay. See the chart starting on page 2 for a description of when the deductible does not apply.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> is covered 100% before you meet your deductible when using an in-network <a href="#">provider</a> . Primary care is covered 100% before you meet your deductible when using a Preferred Primary Care <a href="#">Provider</a> . <a href="#">Urgent care</a> is covered 75% before you meet your <a href="#">deductible</a> if you use a Preferred <a href="#">provider</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> or <a href="#">coinsurance</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="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No. There are no other <a href="#">deductibles</a> .	You don't have to meet <a href="#">deductibles</a> for specific services, but see the chart starting on page 2 for other costs for services this <a href="#">plan</a> covers.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$3,325/person \$6,650/family – * Preferred Primary Care <a href="#">Providers</a> and Preferred network (EHN) \$6,650/person \$13,300/family- *Expanded Network (Aetna) \$13,300/person \$26,200/family - <a href="#">Out-of-Network Providers</a> *In-network <a href="#">out-of-pocket limits</a> cross-apply.	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. Once an individual meets his or her out-of-pocket limit, the plan will pay 100% of the covered expenses for that individual.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, health care this <a href="#">plan</a> doesn't cover, and penalties for failure to obtain <a href="#">preauthorization</a> for services.	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>	Yes. Preferred Network: <a href="https://members.ehnconnects.com/">https://members.ehnconnects.com/</a> Expanded Network <a href="http://www.aetna.com/asa">www.aetna.com/asa</a> or call 1-844-380-4554 for assistance with network <a href="#">providers</a> .	You pay the least if you use a Preferred Primary Care <a href="#">provider</a> . You will pay most if you use an <a href="#">out-of-network provider</a> . You may receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your plan 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.
<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> .

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.webtpa.com](http://www.webtpa.com)  
Contact WebTPA for a list of Preferred Primary Care [Providers](#) at 844-380-4554.



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
		Preferred Primary Care Providers (You will pay the least)	Preferred Network (EHN)	Expanded Network (Aetna)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	*No Charge	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	*Primary care visits provided by a Preferred Primary Care <a href="#">provider</a> that include Family Medicine, Internal Medicine, Pediatrics.
	<a href="#">Specialist</a> visit	Not Applicable	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care screening</a> immunization	No Charge	No Charge Not subject to <a href="#">deductible</a>	No Charge Not subject to <a href="#">deductible</a>	60% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	25% <a href="#">coinsurance</a> Certain services are not subject to <a href="#">deductible</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	Any Diagnostic service (including lab services) performed as part of a primary care visit with a Preferred Primary Care <a href="#">provider</a> such as Family Medicine, Pediatrics, Internal Medicine are not subject to the <a href="#">deductible</a> .
	Imaging (CT/PET Scans, MRIs)	Not Applicable	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	

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Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Preferred Primary Care Providers (You will pay the least)	Preferred Network (EHN)	Expanded Network (Aetna)	Out-of-Network Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition. More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.myprime.com">www.myprime.com</a>. 1-877-278-5206</b></p>	Generic drugs	No charge for Standard Preventive drugs and not subject to <a href="#">deductible</a> .  10% <a href="#">coinsurance</a> with \$2 min/\$25 max not subject to <a href="#">deductible</a> .	No charge for Standard Preventive drugs and not subject to <a href="#">deductible</a> .  10% <a href="#">coinsurance</a>	No charge for Standard Preventive drugs and not subject to <a href="#">deductible</a> .  10% <a href="#">coinsurance</a>	Not Covered	<p>Covers up to a 30-day supply (from in-<a href="#">network</a> retail pharmacy) or up to 90-day supply (from in-<a href="#">network</a> retail or mail order pharmacy). Specialty drugs are limited to a 30-day, specialty formulary and specialty network only. Certain medications may require <a href="#">preauthorization</a> from Prime Therapeutics at 1-877-278-5206.</p> <p>If you are eligible to receive a subsidy through a manufacturer copay program, your copayment under the FlexAccess program will be equal to the maximum subsidy available through that manufacturer copay program. Any manufacturer copay subsidy obtained under the FlexAccess program will not accumulate toward your deductible or out of pocket costs.</p>
	Preferred brand drugs	25% <a href="#">coinsurance</a> \$50 maximum	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	Not Covered	
	Non-preferred brand drugs	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Not Covered	
	<a href="#">Specialty drugs</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g ambulatory surgery center)	Not Applicable	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	Certain procedures require <a href="#">preauthorization</a> . If you don't get <a href="#">preauthorization</a> , a \$250 penalty will apply.

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Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Preferred Primary Care Providers (You will pay the least)	Preferred Network (EHN)	Expanded Network (Aetna)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	Not Applicable	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	Certain procedures require <a href="#">preauthorization</a> . If you don't get <a href="#">preauthorization</a> , a \$250 penalty will apply.
If you need immediate medical attention	Emergency room care	Not Applicable	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	Certain non-emergent procedures require <a href="#">preauthorization</a> . If you don't get <a href="#">preauthorization</a> , a \$250 penalty will apply. Non emergent air and ground ambulance require <a href="#">preauthorization</a> . If you don't get <a href="#">preauthorization</a> , a \$250 penalty will apply.
	Emergency medical transportation	Not Applicable	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	
	Urgent care	(MDLive) <a href="#">deductible</a> waived plan pays at 100%.	25% <a href="#">coinsurance</a> Not subject to <a href="#">deductible</a>	25% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g. hospital room)	Not Applicable	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , a \$250 penalty will apply.
	Physician/surgeon fees	Not Applicable	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , a \$250 penalty will apply.

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Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Preferred Primary Care Providers (You will pay the least)	Preferred Network (EHN)	Expanded Network (Aetna)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Applicable	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for some services. If you don't get <a href="#">preauthorization</a> , a \$250 penalty will apply.
	Inpatient services	Not Applicable	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , a \$250 penalty will apply.
If you are pregnant	Office visits	Not Applicable	No Charge Not subject to deductible	No Charge Not subject to deductible	60% <a href="#">coinsurance</a>	Non-routine pre-natal (non-preventive) services are subject to 25% coinsurance after deductible if services provided in-network.
	Childbirth/delivery professional services	Not Applicable	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
	Childbirth/delivery facility services	Not Applicable	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Not Applicable	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , a \$250 penalty will apply. Home health visits limited to 1 visit per day/100 visits per calendar year maximum. In and out of network combined.
	<a href="#">Rehabilitation services</a>	Not Applicable	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for inpatient rehabilitation. If you don't get <a href="#">preauthorization</a> , a \$250 penalty will apply. Outpatient therapies limited to 20 visits per year, in and out of network combined.
	<a href="#">Habilitation services</a>	Not Applicable	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	Therapies with a diagnosis code of autism will not have yearly limits.

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Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Preferred Primary Care Providers (You will pay the least)	Preferred Network (EHN)	Expanded Network (Aetna)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Skilled nursing care</a>	Not Applicable	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , a \$250 penalty will apply.
	<a href="#">Durable medical equipment</a>	Not Applicable	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	Hearing aids limited to single purchase every 3 years. <a href="#">Preauthorization</a> is required for Custom Fabricated Orthotics and Prosthetics (including for lower extremities, helmets, extremity prosthetic additions, electric prosthetic joints, facial prosthetics provided by non-physician, voice amplifiers, cranial remodeling orthosis, lower extremity orthosis, knee brace). If you don't get <a href="#">preauthorization</a> , a \$250 penalty will apply.
	<a href="#">Hospice services</a>	Not Applicable	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	
	Applied Behavioral Therapy (ABA Therapy)	Not Applicable	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required, reviewed every 4 months. If you don't get <a href="#">preauthorization</a> , a \$250 penalty will apply.
If your child needs dental or eye care	Children's eye exam	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Preventive care</a> is covered 100% before you meet your <a href="#">deductible</a> .
	Children's glasses	Not covered	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered	None

### 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](#).)

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility Treatment (diagnostic testing only)</li> <li>• Long Term Care</li> <li>• Non-Emergency Care when Traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private Duty Nursing</li> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</li> </ul> |
|--|---|---|

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

- Acupuncture (20 visit limit)
- Chiropractic Care (20 visit limit)
- Hearing Aids
- Routine Eye Care (Adults)
- ABA Therapy (No Limitations, precertification is required)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-833-682-6480 or [www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 X61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Whole Foods Market (512) 542-0433 or WebTPA at 1-844-380-4554 and you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)

**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 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 1-844-380-4554

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-380-4554

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-380-4554

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-844-380-4554

*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

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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.

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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 [plan's](#) overall [deductible](#) \$1700
- [Specialist coinsurance](#) 25%
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

**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>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,700
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,460</b>

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

- The [plan's](#) overall [deductible](#) \$1700
- [Specialist coinsurance](#) 25%
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

**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>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,700
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,620</b>

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

- The [plan's](#) overall [deductible](#) \$1700
- [Specialist coinsurance](#) 25%
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,700
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,000</b>