



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 [bsca.com/policies](https://bsca.com/policies) or call 1-855-599-2657. 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](https://www.healthcare.gov/sbc-glossary) or call 1-866-444-3272 to request a copy.

| Important Questions                                                       | Answers                                                                                                                                                   | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <u>deductible</u>?</b>                             | \$100 per individual / \$300 per family. Does not apply to <u>preventative care</u> and <u>prescription drugs</u> .                                       | 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> .                                                                                                                                                                 |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. <u>Preventative care</u> , primary care, and <u>prescription drug coverage</u> services 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                            |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No.                                                                                                                                                       | 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.                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | For <u>network providers</u> : \$1,000 individual / \$3,000 family for medical. \$1,500 individual / \$2,500 family for <u>prescription drug coverage</u> | 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.                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <u>Copayments</u> for certain services, <u>premiums</u> , <u>balance-billing</u> charges, 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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. For a list of <u>network providers</u> , see <a href="https://blueshieldca.com/fad">blueshieldca.com/fad</a> or call 1-855-599-2657.                 | 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</u> charge 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. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>          | 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><br>(You will pay the least)                                             | <u>Out-of-network provider</u><br>(You will pay the most)                                                                                                              |                                                                                                                                                                                                                                                                                                                                                  |
| <b>If you visit a health care <u>provider's</u> office or clinic</b>                                                                                                                                | Primary care visit to treat an injury or illness | \$0 / visit (first three visits)<br>\$20 / visit thereafter<br><u>Deductible</u> does not apply | 50% <u>coinsurance</u>                                                                                                                                                 | None                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                     | <u>Specialist</u> Visit                          | \$20 / visit<br><u>Deductible</u> does not apply                                                | 50% <u>coinsurance</u>                                                                                                                                                 | None                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                     | <u>Preventive care/screening/immunization</u>    | No Charge<br><u>Deductible</u> does not apply                                                   | Not Covered                                                                                                                                                            | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.                                                                                                                                                          |
| <b>If you have a test</b>                                                                                                                                                                           | <u>Diagnostic test</u> (x-ray, blood work)       | No Charge                                                                                       | Not Covered                                                                                                                                                            | The services listed are at a freestanding location.                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                     | Imaging (CT/PET scans, MRIs)                     | No Charge                                                                                       | <i>Outpatient Radiology Center:</i><br>50% <u>coinsurance</u><br><i>Outpatient Hospital:</i> 50% <u>coinsurance</u> of up to \$350/day plus 100% of additional charges | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. The following maximums are for services received from a participating outpatient hospital.<br>Colonoscopy: \$1,500/procedure<br>Upper GI Endoscopy with Biopsy: \$1,250/procedure<br>Upper GI Endoscopy: \$1,000/procedure |
| <b>If you need drugs to treat your illness or condition</b><br><b>More information about <u>prescription drug coverage</u> is available at <a href="http://www.navitus.com">www.navitus.com</a></b> | Generic drugs                                    | Retail 30-Days:<br>Costco: \$0/Rx<br>Other: \$7/Rx<br>Mail 90-Days: \$0/Rx                      | Member must pay the entire cost up front and apply for reimbursement. Net cost may be greater than if member uses an <u>in-network provider</u> .                      | Some narcotic pain medications and cough medications require the regular retail <u>copayment</u> at Costco and 3 times the regular <u>copayment</u> at Mail.                                                                                                                                                                                     |
|                                                                                                                                                                                                     | Preferred brand drugs                            | Retail 30-Days:<br>Costco: \$25/Rx<br>Other: \$25/Rx<br>Mail 90-Days: \$60/Rx                   |                                                                                                                                                                        | If a brand drug is dispensed when a generic equivalent is available, then the member will be responsible for the generic <u>copayment</u> plus the cost difference between the generic and brand.                                                                                                                                                |

| 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)                                                                                                                                                                                                                           |                                                                                                                                                                     |
|                                                                           | <u>Specialty drugs</u>                         | 30-Days: \$25/Rx                                                                      | Not Covered                                                                                                                                                                                                                                                                  | Member must use Navitus Specialty Rx. Supplies of more than 30 days are not allowed                                                                                 |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center) | No Charge                                                                             | No Charge up to \$350 per day plus 100% of additional charges                                                                                                                                                                                                                | The following maximums are for services received from a participating outpatient hospital.<br>Arthroscopy: \$4,500/procedure<br>Cataract Surgery: \$2,000/procedure |
|                                                                           | Physician/surgeon fees                         | No Charge                                                                             | 50% <u>coinsurance</u>                                                                                                                                                                                                                                                       | None                                                                                                                                                                |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                     | \$100 / visit                                                                         | \$100 / visit                                                                                                                                                                                                                                                                | None                                                                                                                                                                |
|                                                                           | <u>Emergency medical transportation</u>        | \$100 / trip                                                                          | \$100 / trip                                                                                                                                                                                                                                                                 | This payment is for emergency or authorized transport.                                                                                                              |
|                                                                           | <u>Urgent care</u>                             | \$20 / visit<br><u>Deductible</u> does not apply                                      | 50% <u>coinsurance</u>                                                                                                                                                                                                                                                       | None                                                                                                                                                                |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)             | No Charge                                                                             | No Charge up to \$600 per day plus 100% of additional charges                                                                                                                                                                                                                | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.                                               |
|                                                                           | Physician/surgeon fees                         | No Charge                                                                             | 50% <u>coinsurance</u>                                                                                                                                                                                                                                                       | None                                                                                                                                                                |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                            | Office Visit: \$20 / visit<br><u>Deductible</u> does not apply<br>Facility: No Charge | <i>Office Visit:</i> 50% <u>coinsurance</u><br><i>Other Outpatient Services:</i> 50% <u>coinsurance</u><br><i>Partial Hospitalization:</i> 50% <u>coinsurance</u> of up to \$350/day plus 100% of additional charges<br><i>Psychological Testing:</i> 50% <u>coinsurance</u> | <u>Preauthorization</u> is required except for office visits. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.                      |
|                                                                           | Inpatient services                             | No Charge                                                                             | <i>Physician Inpatient Services:</i> 50% <u>coinsurance</u><br><i>Hospital Services/Residential Care:</i> No Charge up to \$600 per day plus 100% of additional charges                                                                                                      | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.                                               |
| If you are pregnant                                                       | Office visits                                  | \$20 / visit                                                                          | 50% <u>coinsurance</u>                                                                                                                                                                                                                                                       | 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)                                                                             |                                                                                                                                                                                    |
|                                                                |                                           | <u>Deductible</u> does not apply             |                                                                                                                                |                                                                                                                                                                                    |
|                                                                | Childbirth/delivery professional services | No Charge                                    | 50% <u>coinsurance</u>                                                                                                         | None                                                                                                                                                                               |
|                                                                | Childbirth/delivery facility services     | No Charge                                    | No Charge up to \$600 per day plus 100% of additional charges                                                                  | Non-Preferred facility are subject to a maximum benefit payment up to \$600 per day.                                                                                               |
| If you need help recovering or have other special health needs | <u>Home health care</u>                   | No Charge                                    | 50% <u>coinsurance</u>                                                                                                         | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. Coverage limited to 100 visits per member per calendar year. |
|                                                                | <u>Rehabilitation services</u>            | No Charge                                    | Not Covered                                                                                                                    | None                                                                                                                                                                               |
|                                                                | <u>Habilitation services</u>              | No Charge                                    | Not Covered                                                                                                                    | None                                                                                                                                                                               |
|                                                                | <u>Skilled nursing care</u>               | No Charge                                    | <i>Freestanding SNF:</i> No Charge<br><i>Hospital-based SNF:</i> No Charge up to \$600 per day plus 100% of additional charges | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. Coverage limited to 150 days per member per benefit period.  |
|                                                                | <u>Durable medical equipment</u>          | No Charge                                    | Not Covered                                                                                                                    | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.                                                              |
|                                                                | <u>Hospice services</u>                   | No Charge                                    | 50% <u>coinsurance</u>                                                                                                         | <u>Preauthorization</u> is required except for pre-hospice consultation. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.                          |
| If your child needs dental or eye care                         | Children's eye exam                       | Not Covered                                  | Not Covered                                                                                                                    | None                                                                                                                                                                               |
|                                                                | Children's glasses                        | Not Covered                                  | Not Covered                                                                                                                    | None                                                                                                                                                                               |
|                                                                | Children's dental check-up                | Not Covered                                  | Not Covered                                                                                                                    | None                                                                                                                                                                               |

## Excluded services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) |                         |                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------|
| • Cosmetic surgery                                                                                                                                                     | • Long-term care        | • Routine eye care (Adult/Child)                 |
| • Dental care (Adult/Child)                                                                                                                                            | • Routine foot care     | • Services not deemed <u>medically necessary</u> |
| • Infertility treatment                                                                                                                                                | • Private -duty nursing | • Weight loss programs                           |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)                                    |                         |                                                  |
| • Acupuncture                                                                                                                                                          | • Bariatric surgery     | • Chiropractic care                              |
| • Hearing aids                                                                                                                                                         |                         |                                                  |

**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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [cciio.cms.gov](https://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](https://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: Blue Shield Customer Service at 1-855-599-2657 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) 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.

## Language Access Services:

English: For assistance in English at no cost, call 1-866-346-7198.

Spanish (Español): Para obtener asistencia en Español sin cargo, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulong sa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的免费帮助, 请拨打这个号码 1-866-346-7198.

Navajo (Dine): Diné k'ehjí doo bąąh ílínígó shika' at'oowól nínízingo, kwijí' hodíílnih 1-866-346-7198.

Vietnamese (Tiếng Việt): Để được hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

Korean (한국어): 한국어도움이 필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերեն լեզվով անվճար օգնություն ստանալու համար խնդրում ենք զանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): 日本語支援が必要な場合 1-866-346-7198 に電話をかけてください。無料で提供します。

Persian (فارسی): برای دریافت کمک رایگان زبان فارسی، لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿਚ ਸਹਾਇਤਾ ਲਈ ਕਿਰਪਾ ਕਰਕੇ 1-866-346-7198 'ਤੇ ਕਾਲ ਕਰੋ।

Khmer (ភាសាខ្មែរ): សូមជំនួយភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198។

Arabic (العربية): للحصول على المساعدة في اللغة العربية مجاناً، تفضل باتصال على هذا الرقم: 1-866-346-7198.

Hmong (Hmoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दी में बिना खर्च के सहायता के लिए, 1-866-346-7198 पर कॉल करें।

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198

Laotian (ພາສາລາວ): ສໍາລັບການຊ່ວຍເຫຼືອເປັນພາສາລາວແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທ 1-866-346-7198.

***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 <u>plan's</u> overall <u>deductible</u> | \$100 |
| ■ <u>Specialist copayment</u>                 | \$20  |
| ■ Hospital (facility) <u>coinsurance</u>      | 0%    |
| ■ Other <u>coinsurance</u>                    | 0%    |

**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:**

| <u>Cost sharing</u> |       |
|---------------------|-------|
| <u>Deductibles</u>  | \$100 |
| <u>Copayments</u>   | \$10  |
| <u>Coinsurance</u>  | \$0   |

| <u>What isn't covered</u>         |              |
|-----------------------------------|--------------|
| Limits or exclusions              | \$60         |
| <b>The total Peg would pay is</b> | <b>\$170</b> |

### 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> | \$100 |
| ■ <u>Specialist copayment</u>                 | \$20  |
| ■ Hospital (facility) <u>coinsurance</u>      | 0%    |
| ■ Other <u>coinsurance</u>                    | 0%    |

**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:**

| <u>Cost sharing</u> |       |
|---------------------|-------|
| <u>Deductibles</u>  | \$100 |
| <u>Copayments</u>   | \$690 |
| <u>Coinsurance</u>  | \$0   |

| <u>What isn't covered</u>         |              |
|-----------------------------------|--------------|
| Limits or exclusions              | \$20         |
| <b>The total Joe would pay is</b> | <b>\$810</b> |

### Mia's Simple Fracture

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

|                                               |       |
|-----------------------------------------------|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$100 |
| ■ <u>Specialist copayment</u>                 | \$20  |
| ■ Hospital (facility) <u>coinsurance</u>      | 0%    |
| ■ Other <u>coinsurance</u>                    | 0%    |

**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:**

| <u>Cost sharing</u> |       |
|---------------------|-------|
| <u>Deductibles</u>  | \$100 |
| <u>Copayments</u>   | \$210 |
| <u>Coinsurance</u>  | \$0   |

| <u>What isn't covered</u>         |              |
|-----------------------------------|--------------|
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$310</b> |

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