# GUIDE

# The Summary of Benefits and Coverage: Understanding the Layout and Language

A Summary Benefits and Coverage (SBC) is a standardized document that health insurance issuers must provide for all private health plans they offer, including ACA marketplace plans. The SBC provides an overview of a health plan's benefits, coverage, limitations, and exceptions (although not its premiums, as these can vary based on an enrollee's income, age, and whether they use tobacco). While the information contained in an SBC is only a summary and can change, the standardized format makes it easier for people to compare health plans. This resource provides an overview of the layout and key terms used in the Summary of Benefits and Coverage.

## 1 Sample Summary of Benefits and Coverage

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services

**Coverage Period: 01/01/2024 – 12/31/2024**

CareSource Marketplace Low Premium Silver

**Coverage for: Individual and Family** **Plan Type: HMO**

**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, contact www.caresource.com/marketplace or call 844-539-1733. 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 healthcare.gov/sbc-glossary.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | $6,500 individual/$13,000 family per Benefit Year | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| Are there services covered before you meet your deductible? | Yes. Preventive care. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. |
| Are there other deductibles for specific services? | No | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | $9,100 individual/$18,200 family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billing charges and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| Will you pay less if you use a network provider? | Yes. See www.caresource.com/marketplace or call 844-539-1733 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | No | You can see the specialist you choose without a referral. |

*CareSource Marketplace Low Premium Silver, Ohio 2024*

Coverage year (There is a different SBC for each coverage year.)

Plan type (EPO, HMO, PPO, POS, etc.) For definitions of plan types, see: https://www.healthcare.gov/glossary

Plan name (There is a different SBC for each plan at each metal tier and each Silver cost-sharing level.)

Health insurance issuers are required to provide an SBC to people upon their initial enrollment (including during open enrollment or following enrollment during a Special Enrollment Period), by request, and at the time of renewal or re-enrollment in a plan. In states that use HealthCare.gov, there is also a link to each ACA marketplace plan's SBC on HealthCare.gov (click on the name of the plan, then click on "Plan documents" to view the link to the SBC). While both paper and digital copies should be made available, the digital version includes links to a standard glossary of terminology. As shown in the examples in this guide, many terms are underlined and in blue. On the digital version of the SBC, the user can click these to access the glossary and the definition of each term.

## 2 The First Page of the SBC: Important Questions & Common Medical Events

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services — Coverage Period: 01/01/2024 – 12/31/2024

CareSource Marketplace Low Premium Silver — Coverage for: Individual and Family | Plan Type: HMO

**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, contact www.caresource.com/marketplace or call 844-539-1733. 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 healthcare.gov/sbc-glossary.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $6,500 individual/$13,000 family per Benefit Year | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. |
| **Are there other deductibles for specific services?** | No | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | $9,100 individual/$18,200 family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.caresource.com/marketplace or call 844-539-1733 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No | You can see the specialist you choose without a referral. |

*CareSource Marketplace Low Premium Silver, Ohio 2024*

Page 1 of the SBC contains important questions, answers and explanations about the health plan.

This includes, in order:

1. The overall deductible
   - Individual & Family
2. Services covered pre-deductible
3. Deductibles for specific services
   - Some plans have a separate drug deductible
4. The out-of-pocket limit
   - Individual & Family
5. Costs not included in the out-of-pocket limit
6. Information about the provider network
7. If a referral is needed to go to a specialist
   - Many HMOs require refferrals, but some do not

## 3 Primary, Specialty, Tests & Drugs

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 Plan Provider (You will pay the least) | What You Will Pay Non-Plan Provider (You will pay the most) | 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 | $15 / visit | Not covered | None |
| | Specialist visit | $25 / visit | Not covered | None |
| | Preventive care/ screening/ immunization | No charge | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | X-ray: $40 / encounter; Lab tests: $20 / encounter | Not covered | None |
| | Imaging (CT/PET scans, MRI's) | $100 / procedure | Not covered | None |
| **If you need drugs to treat your illness or condition** More information about prescription drug coverage is available at www.kp.org/formulary | Generic drugs (Tier 1) | $5 / prescription (retail) $10 / prescription (mail order). | Not covered | Up to 30-day supply retail and 100-day supply mail order. Female contraceptives are no charge. Subject to formulary guidelines. |
| | Preferred brand drugs (Tier 2) | $25 / prescription (retail) $50 / prescription (mail order). | Not covered | Up to 30-day supply retail and 100-day supply mail order. Female contraceptives are no charge. Subject to formulary guidelines. |
| | Non-preferred brand drugs (Tier 2) | $25 / prescription (retail) $50 / prescription (mail order). | Not covered | The cost-sharing for non-preferred brand drugs under this plan aligns with the cost-sharing for preferred brand drugs (Tier 2), when approved through the formulary exception process. |
| | Specialty drugs (Tier 4) | 15% coinsurance up to $150 / prescription. | Not covered | Up to 30-day supply (retail). Subject to formulary guidelines. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | Not covered | None |
| | Physician/surgeon fees | 20% coinsurance | Not covered | None |

*Kaiser Permanente, Covered CA Silver 87 HMO, California 2024*

Page 2 of the SBC contains copayment and coinsurance information for:

- Primary care visits
- Specialist visits
- Preventive care/screening/ immunization
- Tests
- Drugs

Information that does not fit on the first page may instead appear at the top of the second page.

For some plans, drug cost information may appear on page 3.

## 4 Cost Sharing for Other Services

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.cigna.com/ifp-drug-lists | Generic drugs | Preferred Generic: No charge (retail/home delivery). Generic: $20 copayment (retail)/ $60 copayment (home delivery); deductible does not apply. | Not covered. | Generic, Preferred, and Non-Preferred Drugs: Limited to up to a 30-day supply (retail) or a 90-day supply (Designated 90-day retail pharmacy/home delivery). You pay a copayment for each 30-day supply (retail), if applicable. Specialty Drugs: Limited to up to a 30-day supply (retail) or a 30-day supply (Designated 90-day retail pharmacy/home delivery). Cigna Healthcare's specialty pharmacy can assist you in obtaining your specialty drugs. Call Accredo, at 877.826.7657 to talk to a representative. |
| | Preferred brand drugs | $75 copayment (retail)/ $225 copayment (home delivery); deductible does not apply. | Not covered. | |
| | Non-preferred drugs | 50% coinsurance (retail/home delivery) | Not covered. | |
| | Specialty drugs and other high cost drugs | 50% coinsurance (retail/home delivery) | Not covered. | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 50% coinsurance | Not covered. | None. |
| | Physician/surgeon fees | 50% coinsurance | Not covered. | None. |
| **If you need immediate medical attention** | Emergency room care | 50% coinsurance | 50% coinsurance | You pay the same level as In-network if it is an emergency as defined in your plan, otherwise Not covered. |
| | Emergency medical transportation | 50% coinsurance | 50% coinsurance | |
| | Urgent care | $35 copayment/visit; deductible does not apply. | $35 copayment/visit; deductible does not apply. | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 50% coinsurance | Not covered. | None. |
| | Physician/surgeon fees | 50% coinsurance | Not covered. | None. |

*Cigna Connect Silver 5000, Pennsylvania 2024*

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | | generic. Tier 2 includes high cost generics and preferred brand. |
| | Non-preferred brand drugs | $80 copay/prescription (retail); $200 copay/prescription (mail order) | Not covered | Covers up to 30-day supply (retail). Covers up to 90-day supply (mail order). Tier 3 includes non-preferred formulary products (can include non-preferred generic products). |
| | Specialty drugs | 50% coinsurance/prescription (retail) | Not covered | Covers up to 30-day supply (retail) Tier 4 includes specialty drugs. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | Not covered | Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. |
| | Physician/surgeon fees | 30% coinsurance | Not covered | None |
| **If you need immediate medical attention** | Emergency room care | 30% coinsurance | 30% coinsurance | None |
| | Emergency medical transportation | $80 copay/transportation | $80 copay/transportation | Requires preauthorization for certain services such as air transportation, non-emergency ground transportation, facility-to-facility transfers, out-of-network and out of area transfers. |
| | Urgent care | $80 copay/visit; deductible does not apply | Not covered | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance | Not covered | Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. |
| | Physician/surgeon fees | No charge | Not covered | None |
| **If you need mental health, behavioral health, or substance** | Outpatient services | $30 copay/office visit; deductible does not apply. 30% coinsurance after deductible for other | Not covered | Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. Depending on type of service, a copayment or |

*Community Health Choice: Community Select Silver 019- 73% CSR, Texas 2024*

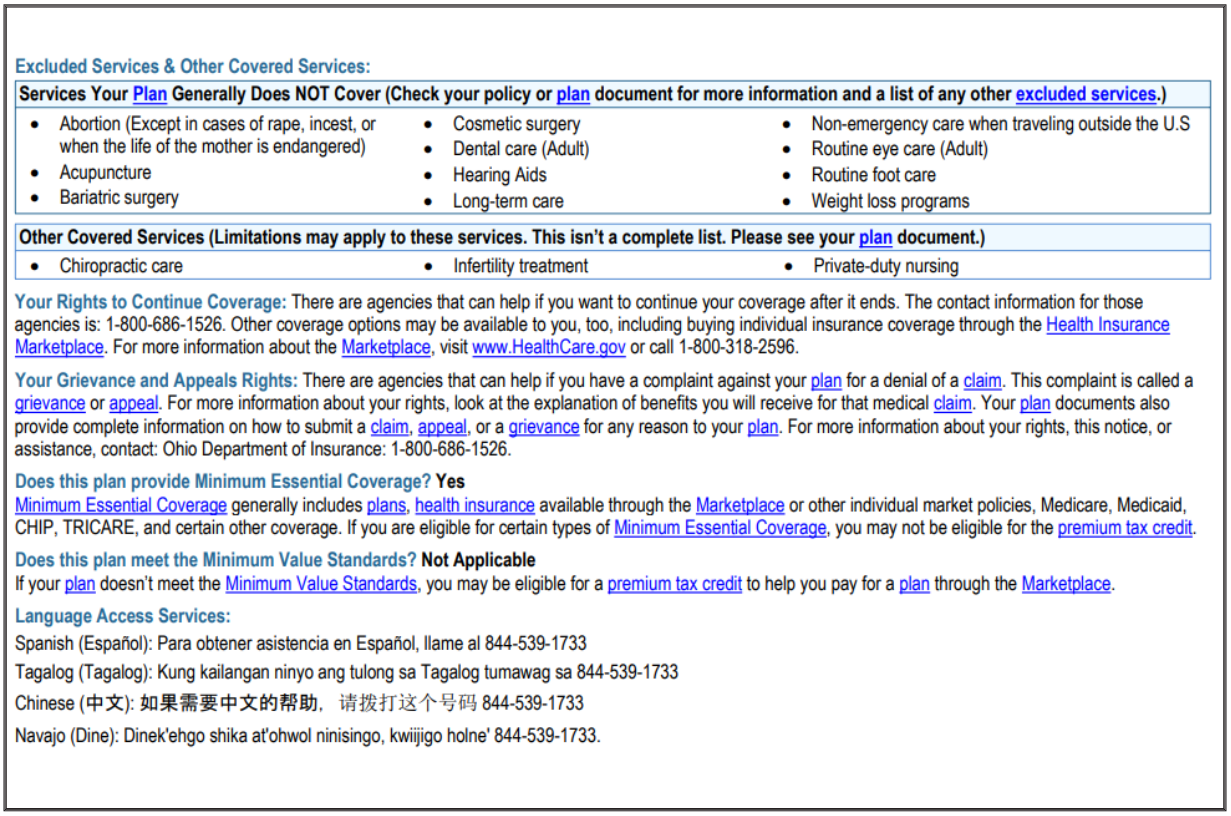
| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | $30 co-pay after deductible | Not Covered | Preauthorization Required. 40 visits per plan year |
| | Rehabilitation services | $30 co-pay after deductible | Not Covered | Preauthorization Required; 60 visits per condition, per plan year combined therapies |
| | Habilitation services | $30 co-pay after deductible | Not Covered | Preauthorization Required; 60 visits per condition, per plan year combined therapies |
| | Skilled nursing care | $1,500 co-pay per admission afterdeductible | Not Covered | Preauthorization Required; 200 days per plan year |
| | Durable medical equipment | 30% coinsurance after deductible | Not Covered | Preauthorization Required |
| | Hospice services | $1,500 co-pay per admission after deductible (Inpatient) or $30 Copayment after deductible (Outpatient) | Not Covered | Preauthorization Required; 210 days per plan year (inpatient); 5 Visits for Family Bereavement Counseling (outpatient) |
| **If your child needs dental or eye care** | Children's eye exam | $30 co-pay after deductible | Not Covered | One Exam Per 12-Month Period |
| | Children's glasses | 30% co-insurance after deductible | Not Covered | One Prescribed Lenses & Frames in a 12-Month Period. $100 Annual Allowance towards purchase of frames or contact lenses. |
| | Children's dental check-up | $30 co-pay after deductible | Not Covered | One Dental Exam & Cleaning Per 6-Month Period |

*Healthfirst: Silver Leaf, New York 2024*

The next several pages of the SBC provide information on the costs of:

- Prescription drugs (may appear on page 2 if space allows)
- Outpatient surgery
- Immediate medical needs
    1. Emergency room care
    2. Emergency transportation
    3. Urgent care
- Hospital stay (including physicians' fees and hospital facility fees)
- Mental, behavioral, and substance use services (inpatient and outpatient)
- Pregnancy-related services
- Recovery or other special health needs
- Pediatric dental and vision services

## 5 Excluded and Other Covered Services



**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.)**

- Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Long-term care
- Non-emergency care when traveling outside the U.S
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Chiropractic care
- Infertility treatment
- Private-duty nursing

**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: 1-800-686-1526. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Ohio Department of Insurance: 1-800-686-1526.

**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? Not Applicable**

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 844-539-1733

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-539-1733

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 844-539-1733

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 844-539-1733.

*Cigna Connect Silver 5000, Pennsylvania 2024*

The final substantive pages of the SBC will include information on:

- Excluded services
- Other covered services

Services like bariatric surgery, chiropractic visits, infertility treatment, and weight loss services are often listed on these final pages. Some state laws require health plans to either cover or exclude these health services; otherwise, coverage will vary by plan.

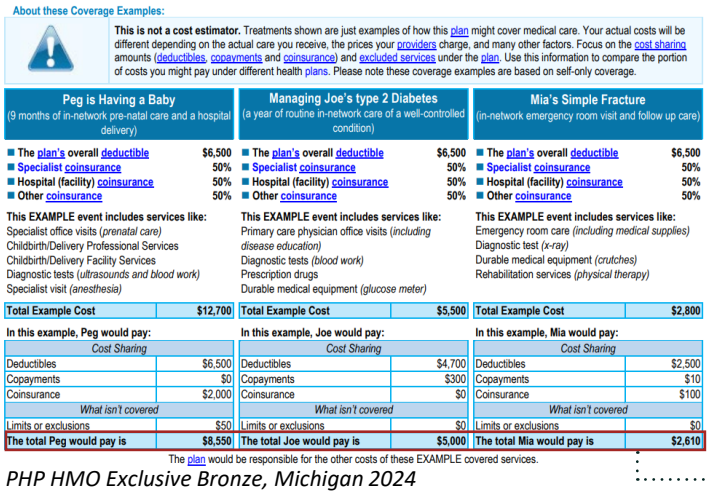
These pages will also include the enrollee's right to continue coverage, grievance and appeal rights, and the phone number for the specific state's Department of Insurance, as well as whether the plan is considered Minimum Essential Coverage (all ACA marketplace plans provide Minimum Essential Coverage), whether the plan meets the Minimum Value Standard (this standard only applies to employer sponsored insurance; SBCs for ACA marketplace plans will say "Not applicable" for this question), and an enrollee's rights to language access services (listed in multiple languages).

## 6 Coverage Examples

The last page of the SBC lists three Coverage Examples. These demonstrate how the health insurance plan could work in practice in three common health care situations: pregnancy and delivery, managing Type 2 diabetes, and caring for a simple broken bone. The examples assume the person gets care from in-network providers. While the actual costs for the medical services listed are for illustrative purposes only, the examples can be useful to help a potential enrollee understand the plan's cost sharing design (e.g. when the person would pay their deductible and what charges the coinsurance applies to). They can also be useful when helping a potential enrollee compare two or more plans, since the coverage examples are the same for every plan. The coverage examples in the SBC make it easier to compare the plans' cost sharing designs.

The example below, comparing coverage examples for Bronze and Silver CSR 87 plans in Michigan, although the bronze plan likely has a lower premium, the silver CSR plan provides much more financial protection to an enrollee when receiving health care services.

### Sample Coverage Example: Bronze Plan



About these Coverage Examples:

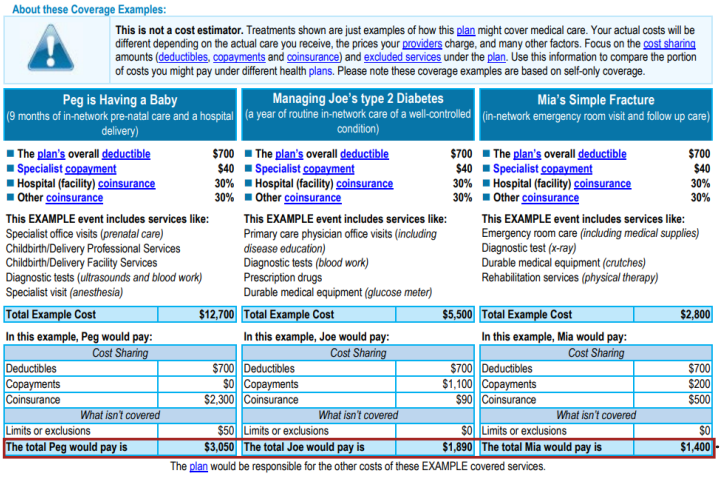
**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments 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) | | Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition) | | Mia's Simple Fracture (in-network emergency room visit and follow up care) | |
|---|---|---|---|---|---|
| The plan's overall deductible | $6,500 | The plan's overall deductible | $6,500 | The plan's overall deductible | $6,500 |
| Specialist coinsurance | 50% | Specialist coinsurance | 50% | Specialist coinsurance | 50% |
| Hospital (facility) coinsurance | 50% | Hospital (facility) coinsurance | 50% | Hospital (facility) coinsurance | 50% |
| Other coinsurance | 50% | Other coinsurance | 50% | Other coinsurance | 50% |
| **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*) | | **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*) | | **This EXAMPLE event includes services like:** Emergency room care (*including medical supplies*) Diagnostic test (*x-ray*) Durable medical equipment (*crutches*) Rehabilitation services (*physical therapy*) | |
| **Total Example Cost** | **$12,700** | **Total Example Cost** | **$5,500** | **Total Example Cost** | **$2,800** |
| **In this example, Peg would pay:** | | **In this example, Joe would pay:** | | **In this example, Mia would pay:** | |
| *Cost Sharing* | | *Cost Sharing* | | *Cost Sharing* | |
| Deductibles | $6,500 | Deductibles | $4,700 | Deductibles | $2,500 |
| Copayments | $0 | Copayments | $300 | Copayments | $10 |
| Coinsurance | $2,000 | Coinsurance | $0 | Coinsurance | $100 |
| *What isn't covered* | | *What isn't covered* | | *What isn't covered* | |
| Limits or exclusions | $50 | Limits or exclusions | $0 | Limits or exclusions | $0 |
| **The total Peg would pay is** | **$8,550** | **The total Joe would pay is** | **$5,000** | **The total Mia would pay is** | **$2,610** |

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

*PHP HMO Exclusive Bronze, Michigan 2024*

### Sample Coverage Example: Silver Plan with Cost-Sharing Reductions



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) | | Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition) | | Mia's Simple Fracture (in-network emergency room visit and follow up care) | |
|---|---|---|---|---|---|
| The plan's overall deductible | $700 | The plan's overall deductible | $700 | The plan's overall deductible | $700 |
| Specialist copayment | $40 | Specialist copayment | $40 | Specialist copayment | $40 |
| Hospital (facility) coinsurance | 30% | Hospital (facility) coinsurance | 30% | Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% | Other 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*) | | **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*) | | **This EXAMPLE event includes services like:** Emergency room care (*including medical supplies*) Diagnostic test (*x-ray*) Durable medical equipment (*crutches*) Rehabilitation services (*physical therapy*) | |
| **Total Example Cost** | **$12,700** | **Total Example Cost** | **$5,500** | **Total Example Cost** | **$2,800** |
| **In this example, Peg would pay:** | | **In this example, Joe would pay:** | | **In this example, Mia would pay:** | |
| *Cost Sharing* | | *Cost Sharing* | | *Cost Sharing* | |
| Deductibles | $700 | Deductibles | $700 | Deductibles | $700 |
| Copayments | $0 | Copayments | $1,100 | Copayments | $200 |
| Coinsurance | $2,300 | Coinsurance | $90 | Coinsurance | $500 |
| *What isn't covered* | | *What isn't covered* | | *What isn't covered* | |
| Limits or exclusions | $50 | Limits or exclusions | $0 | Limits or exclusions | $0 |
| **The total Peg would pay is** | **$3,050** | **The total Joe would pay is** | **$1,890** | **The total Mia would pay is** | **$1,400** |

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

*PHP HMO Exclusive Silver Standard CSR87, Michigan 2024*

| | Pregnancy and delivery | Managing Type-2 diabetes | Broken bone |
|---|---|---|---|
| Bronze Plan | $8,550 | $5,000 | $2,610 |
| Silver CSR Plan | $3,050 | $1,890 | $1,400 |

For more resources, visit www.healthreformbeyondthebasics.org



Beyond the Basics