




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 the Trust Fund Office at 1-800-251-5014. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.dol.gov/ebsa/healthreform.com](http://www.dol.gov/ebsa/healthreform.com) or call 1-800-251-5014 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$250/individual, \$750/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Contract <u>Provider</u> (and certain Non-Contract <u>Provider</u> ) <u>preventive care</u> , hearing aid benefit, outpatient <u>prescription drugs</u> (some subject to separate <u>deductible</u> outlined below), chemical dependency, dental, and vision 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 deductibles for specific services?</b>	Yes. \$100/individual for retail brand name <u>prescription drugs</u> (except for brand name PPI drugs). There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	Medical Limit: Contract <u>Providers</u> : \$2,500/individual, \$5,000/family; Non-Contract <u>Providers</u> : \$5,000/individual, \$15,000/family. Overall ACA Limit (in- <u>network</u> only, applicable only to Reduced Comprehensive Medical Benefit): \$6,300/individual, \$13,600/family. <u>Prescription drugs</u> (in- <u>network</u> ): \$1,600/individual, \$2,200/family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	Medical: <u>Out-of-Pocket Limit</u> does not include <u>premiums</u> , <u>balance-billing</u> charges, dental & vision <u>plan</u> expenses, <u>prescription drugs</u> , penalties for failure to obtain <u>preauthorization</u> , amounts over the reference-based price for certain surgeries, certain treatment at a Non-Center of Medical Excellence facility, health care this <u>plan</u> doesn't cover and Non-Contract <u>copayments</u> and <u>coinsurance</u> . <u>Prescription Drug: Out-of-Pocket Limit</u> does not include Medical expenses, <u>premiums</u> , <u>balance-billing</u> charges, dental and vision <u>plan</u> expenses, penalties for failure to obtain <u>preauthorization</u> , amounts over the max for PPI drugs, health care this <u>plan</u> doesn't cover, and Non-Participating Pharmacy expenses.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> for a list of Contract <u>Providers</u> in California or call the Trust Fund Office. For a list of Contract <u>Providers</u> outside of California, see <a href="http://www.bluecares.com">www.bluecares.com</a> or call 1-800-810-2583. For Contract chemical dependency <u>providers</u> , call Assistance Recovery Program (ARP) at (800) 562-3277. For hearing aids, call (888) 432-7464 or (800) 442-8231.	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
		Contract Provider (You will pay the least)	Out-of-Area Provider	Non-Contract Provider (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	10% <u>coinsurance</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	20% <u>coinsurance</u> plus <u>balance billing</u>	None
	<u>Specialist</u> visit	10% <u>coinsurance</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	20% <u>coinsurance</u> plus <u>balance billing</u>	None
	<u>Preventive care/screening/Immunization</u>	No charge. <u>Deductible</u> does not apply.	Mammogram, Pap smear, colorectal cancer <u>screening</u> , adult immunizations: 10% <u>coinsurance</u> plus <u>balance billing</u> . <u>Deductible</u> does not apply. All other preventive services: Not covered.	Mammogram, Pap smear, colorectal cancer <u>screening</u> , adult immunizations: 20% <u>coinsurance</u> plus <u>balance billing</u> . <u>Deductible</u> does not apply. All other preventive services: Not covered.	<ul style="list-style-type: none"> <li>No charge for physical exam (employee and spouse, once per person per calendar year) and well-child care (except <u>balance billing</u> for out-of-area and Non-Contract <u>providers</u>.) <u>Deductible</u> does not apply.</li> <li>You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.</li> <li>Well-child care with an Out-of-Area or Non-Contract <u>Provider</u> does not count toward the Non-Contract <u>Provider</u> <u>out-of-pocket limit</u>.</li> </ul>
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	20% <u>coinsurance</u> plus <u>balance billing</u>	Professional/physician charges may be billed separately.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Out-of-Area Provider	Non-Contract Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	20% <u>coinsurance</u> plus <u>balance billing</u>	<p><u>Preauthorization</u> by <b>Carelon Medical Benefits Management (CMBM)</b> is required to avoid non-payment. Professional/physician can request prior authorization online or by phone.</p> <p>Online</p> <ol style="list-style-type: none"> <li>1. Register with Carelon</li> <li>2. Go to the ProviderPortalSM</li> <li>3. Submit your request</li> </ol> <p>By phone</p> <ol style="list-style-type: none"> <li>1. Call 866-666-0776</li> <li>2. Submit your request</li> </ol> <p>When to request</p> <ul style="list-style-type: none"> <li>• You should request prior authorization before the start of services</li> <li>• You can request retrospective authorization up to 2 business days after the treatment start date</li> </ul> <p>What to include</p> <ul style="list-style-type: none"> <li>• Clinical information, such as what the physician is suspecting or ruling out, and if the patient has received treatment for the symptoms</li> </ul> <p>What Carelon will do</p> <ul style="list-style-type: none"> <li>• Review the requested imaging scan for clinical appropriateness</li> <li>• Review the site of care against health plan clinical criteria</li> <li>• Identify alternate imaging locations</li> </ul> <p>What you should know</p> <ul style="list-style-type: none"> <li>• Failure to contact Carelon for prior authorization may result in claim denial</li> <li>• Prior authorization isn't required for emergency room services, inpatient hospitalization, or observation stays</li> </ul>

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Out-of-Area Provider	Non-Contract Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>	Generic drugs	Retail Pharmacy (34-day supply): \$5 <u>copayment/script</u> . Mail Order (90-day supply): \$10 <u>copayment/script</u> .	You pay the full cost at the time of purchase, and submit a claim for reimbursement. You will be reimbursed the allowed amount less the applicable participating pharmacy <u>copayments</u> . You are responsible for any amount the pharmacy charges above the contract amount the participating pharmacy would have charged.		<ul style="list-style-type: none"> <li>• A 90-day supply available at contract retail pharmacy for three <u>copayments/script</u>.</li> <li>• Retail brand name drugs (except for PPI drugs used for acid reflux) are subject to a separate \$100 <u>deductible</u>. Medical <u>plan deductible</u> does not apply to <u>prescription drugs</u>.</li> <li>• PPI drugs maximum <u>Plan</u> payment of \$30/script for retail, \$90/script for mail order. Charges over <u>plan</u> limits do not count toward the <u>prescription drug out-of-pocket limit</u>.</li> <li>• If you obtain a brand drug at a Retail Pharmacy when a generic drug is available, you pay the brand <u>copayment</u> + the cost difference between the brand and generic drug (unless <u>Provider</u> specifies no generic substitution).</li> <li>• If the cost of the drug is less than the <u>copayment</u>, you pay just the drug cost.</li> <li>• Some drugs are subject to step therapy, quantity limits and <u>preauthorization</u>.</li> <li>• No charge for ACA-required generic preventive drugs (such as FDA-approved generic contraceptives) or brand name contraceptives if a generic is medically inappropriate.</li> </ul>
	Preferred brand drugs	Retail Pharmacy (34-day supply): \$25 <u>copayment/script</u> . Mail Order (90-day supply): \$50 <u>copayment/script</u> .			
	Non-preferred brand drugs	Retail Pharmacy (34-day supply): \$40 <u>copayment/script</u> . Mail Order (90-day supply): \$80 <u>copayment/script</u> .			
	<u>Specialty drugs</u>	20% <u>coinsurance</u> up to the <u>copayment</u> max (Generic: \$50/script, Preferred brand: \$100/ script, Non-Preferred \$200/script)	Not covered		Available only through OptumRx Specialty Drug Program at (866) 218-5445.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Out-of-Area Provider	Non-Contract Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	<ul style="list-style-type: none"> <li>Outpatient surgery requires <u>preauthorization</u> to avoid a \$300 penalty.</li> <li>Max of \$6,000 is payable for an arthroscopy, \$2,000 for cataract surgery, \$1,500 for colonoscopy (facility fee) if you have your surgery at an outpatient hospital rather than an ambulatory surgical center; max of \$35,000 for facility charges for a single hip or knee joint replacement surgery. Charges over <u>plan</u> limits do not count toward the <u>out-of-pocket limit</u>.</li> <li>Per-surgery max of \$500 for services at a Non-Contract Ambulatory Surgery Facility.</li> <li>Charges over <u>plan</u> limits do not count toward the <u>out-of-pocket limit</u>.</li> </ul>
	Physician/surgeon fees	10% <u>coinsurance</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	20% <u>coinsurance</u> plus <u>balance billing</u>	None.
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copayment</u> /visit, then 10% <u>coinsurance</u>	\$100 <u>copayment</u> /visit, then 10% <u>coinsurance</u> *	\$100 <u>copayment</u> /visit, then 10% <u>coinsurance</u> *	<ul style="list-style-type: none"> <li><u>Copayment</u> waived if you are admitted directly to the hospital. Professional/physician charges may be billed separately</li> <li>*The emergency room care coinsurance for an Out-of-Area Provider and Non-Contract Provider is calculated as 10% of the Recognized Amount under the No Surprises Act.</li> </ul>
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	10% <u>coinsurance</u> (20% <u>coinsurance</u> if not an <u>emergency medical condition</u> ) plus <u>balance billing</u>	<ul style="list-style-type: none"> <li>Professional/physician charges may be billed separately</li> <li>Balance billing will not apply to covered air ambulance services.</li> </ul>
	<u>Urgent care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	Professional/physician charges may be billed separately

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Out-of-Area Provider	Non-Contract Provider (You will pay the most)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	<ul style="list-style-type: none"> <li>• <u>Preauthorization</u> is required to avoid a \$300 penalty.</li> <li>• A \$35,000 maximum for facility charges for a single hip or knee joint replacement surgery. Charges over <u>plan</u> limits do not count toward the <u>out-of-pocket limit</u>.</li> <li>• No benefits for transplants or bariatric surgery performed at a facility that is not an Anthem Center of Medical Excellence (CME) or a Blue Distinction Center. Your expenses at a facility that is not a CME or Blue Distinction Center do not count toward the <u>out-of-pocket limit</u>.</li> <li>• It is encouraged that an Anthem Blue Cross CME or Blue Distinction Center be considered for cardiac care, spinal surgery and treatment for complex and rare cancers.</li> <li>• Coverage provided for semi-private room, intensive care unit, or cardiac care unit.</li> </ul>
	Physician/surgeon fees	10% <u>coinsurance</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	20% <u>coinsurance</u> plus <u>balance billing</u>	None.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office visits and other outpatient: 10% <u>coinsurance</u>	Office visits and other outpatient: 10% <u>coinsurance</u> plus <u>balance billing</u>	Office visits and other outpatient: 20% <u>coinsurance</u> plus <u>balance billing</u>	<ul style="list-style-type: none"> <li>• Chemical dependency services are not covered for dependent children.</li> <li>• <u>Deductible</u> does not apply to covered substance abuse treatment.</li> </ul>
	Inpatient services	10% <u>coinsurance</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	<ul style="list-style-type: none"> <li>• <u>Preauthorization</u> is required to avoid a \$300 penalty.</li> <li>• Chemical dependency services are not covered for dependent children.</li> <li>• <u>Deductible</u> does not apply to covered substance abuse treatment.</li> </ul>
<b>If you are pregnant</b>	Office visits	No charge. <u>Deductible</u> does not apply.	10% <u>coinsurance</u> plus <u>balance billing</u>	20% <u>coinsurance</u> plus <u>balance billing</u>	<ul style="list-style-type: none"> <li>• <u>Cost sharing</u> does not apply for <u>preventive services</u>.</li> <li>• Depending on the type of services, <u>coinsurance</u> may apply.</li> <li>• Maternity care may include tests and services described somewhere else in the SBC (see row "If you have a test" for coverage of an ultrasound).</li> </ul>

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Out-of-Area Provider	Non-Contract Provider (You will pay the most)	
	Childbirth/delivery professional services	10% <u>coinsurance</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	20% <u>coinsurance</u> plus <u>balance billing</u>	<ul style="list-style-type: none"><li>• <u>Preauthorization</u> by Anthem is required only if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section.</li><li>• Delivery expenses are not covered for dependent children.</li></ul>
	Childbirth/delivery facility services	10% <u>coinsurance</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	20% <u>coinsurance</u> plus <u>balance billing</u>	None.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	20% <u>coinsurance</u> plus <u>balance billing</u>	Outpatient physical & occupational therapy max is 20 visits/year (40 visits if 24 months before/after related surgery or stroke).
	<u>Habilitation services</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	20% <u>coinsurance</u> plus <u>balance billing</u>	Coverage limited to <u>habilitation services</u> for mental health conditions. Other <u>habilitation services</u> are not covered.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	20% <u>coinsurance</u> plus <u>balance billing</u>	<u>Preauthorization</u> is required to avoid non-payment. Coverage provided for semi-private room.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	20% <u>coinsurance</u> plus <u>balance billing</u>	<u>Preauthorization</u> is recommended for equipment costing more than \$500 before renting or buying.
	<u>Hospice services</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u> plus <u>balance billing</u>	20% <u>coinsurance</u> plus <u>balance billing</u>	Covered if terminally ill.
If your child needs dental or eye care	Children’s eye exam	\$7.50 <u>copayment</u> /visit	\$7.50 <u>copayment</u> /visit plus amounts over \$45		Your vision coverage is available under a separate vision <u>plan</u> . <u>Cost sharing</u> for vision services does not count toward the medical <u>plan’s out-of-pocket limit</u> . Medical <u>plan deductible</u> does not apply.
	Children’s glasses	No charge	Amounts over \$34		
	Children’s dental check-up	No charge	No charge except <u>balance billing</u>		Your dental coverage is available under a separate dental <u>plan</u> . Your <u>cost sharing</u> for dental services does not count toward the medical <u>plan’s out-of-pocket limit</u> . Medical plan deductible does not apply.

#### 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 <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• <u>Habilitation services</u> (except for mental health condition)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs (except as required under health reform)</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		

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|---|--|--|
| <ul style="list-style-type: none"> <li>• Acupuncture (16 visits/treatment series)</li> <li>• Bariatric Surgery (if <u>preauthorization</u> is received and surgery is performed at a Center of Medical Excellence)</li> <li>• Chiropractic care (up to 20 visits/year)</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care (Adult) (available only through a separate benefit administered by Delta Dental, up to \$2,500/calendar year)</li> <li>• Hearing aids (\$2,025/ear every 4 years)</li> <li>• Infertility treatment (only services to diagnose)</li> </ul> | <ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private duty nursing (when determined to be Medically Necessary)</li> <li>• Routine eye care (Adult) (available only through separate benefit administered by VSP)</li> </ul> |
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**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Zenith at 1-800-251-5014. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-251-5014.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-251-5014.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-251-5014.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-251-5014.

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



## About these Coverage Examples:



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

### Peg is Having a Baby

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

■ The plan's overall <u>deductible</u>	\$250
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

#### 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:

Cost Sharing	
Deductibles	\$260
Copayments	\$0
Coinsurance	\$1,090
What isn't covered	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$1,370</b>

### Managing Joe's type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$250
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

#### 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:

Cost Sharing	
Deductibles	\$350
Copayments	\$810
Coinsurance	\$90
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,250</b>

### Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$250
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital ER (facility)</u>	\$100 <u>copayment</u> + 10% <u>coinsurance</u>
■ <u>Other coinsurance</u>	10%

#### 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:

Cost Sharing	
Deductibles	\$260
Copayments	\$100
Coinsurance	\$240
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$600</b>