




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 [www.BenefitsAccess.org](http://www.BenefitsAccess.org). 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 <https://www.healthcare.gov/sbc-glossary> or call 1-833-762-0876 to request a copy. The plan sponsor provides a health reimbursement account (HRA) that you can use to pay for eligible unreimbursed expenses, e.g., your deductible, co-payments and coinsurance described below. This year your HRA will be funded with \$250 for an individual or \$500 for an individual with at least one covered dependent. If you do not use your entire HRA during a calendar year, the remaining amount will roll over to the following year, with no cap on accumulated funds.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p><b>Health Check Completed:</b>  <a href="#">In-Network</a>: \$3,000 individual/\$6,000 family  <a href="#">Out-of-Network</a><sup>1</sup>: \$6,000 individual/\$12,000 family</p> <p><b>Health Check Not Completed:</b>  <a href="#">In-Network</a>: \$3,250 individual/\$6,500 family  <a href="#">Out-of-Network</a><sup>1</sup>: \$6,250 individual/\$12,500 family</p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. <a href="#">Preventive care</a></p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>Yes. \$50/individual or \$150/family <a href="#">deductible</a> for dental benefits, if elected.</p>	<p>You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p><a href="#">In-Network</a>: \$5,000 individual/\$10,000 family  <a href="#">Out-of-Network</a><sup>1</sup>: \$10,000 individual /\$20,000 family</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p><a href="#">Copayments</a> for certain services, <a href="#">premiums</a>, <a href="#">balance-billing</a> charges, vision expenses, dental expenses, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes. See <a href="http://myWespathHealth.com">myWespathHealth.com</a> or call 1-833-762-0876 for a list of <a href="#">network providers</a>.</p>	<p>This <a href="#">plan</a> uses a <a href="#">provider network</a>. You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a>. You will pay the most if you use an <a href="#">out-of-network provider</a><sup>1</sup>, and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (<a href="#">balance billing</a>). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a><sup>1</sup> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</p>
<p>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</p>	<p>No.</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</p>

 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider <sup>1</sup> (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	MD Live virtual visits: No member cost share.
	<a href="#">Specialist</a> visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
	<a href="#">Preventive care/screening/immunization</a>	No charge ( <a href="#">deductible</a> does not apply)	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
	Imaging (CT/PET scans, MRIs)	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required for MRI, MRA and PET scans.

<sup>1</sup> Starting January 1, 2022, as required by applicable law, in-network cost sharing rules may apply for certain out-of-network services, including certain emergency services, air ambulance services, and services from an out-of-network provider at an in-network facility. This means the amount you pay for these services may be lower than provided in this SBC.

For more information about limitations and exceptions, see the [plan](#) or policy document at [www.BenefitsAccess.org](http://www.BenefitsAccess.org).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider <sup>1</sup> (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.OptumRx.com">www.OptumRx.com</a></p>	Generic drugs	Retail (30-day) \$10 <a href="#">copayment</a>	Retail (30-day) <a href="#">Copayment</a> plus amount exceeding allowed amount	<p>* To maximize <a href="#">plan</a> benefits, <b>refills for most maintenance medications require use of the OptumRx Home Delivery (mail-order) service or a local Walgreens pharmacy.</b></p> <p>Non-sedating allergy drugs are covered as non-preferred. <a href="#">Specialty drugs</a> may require <a href="#">preauthorization</a> by contacting OptumRx at 1-855-239-8471</p>
		* Walgreens or OptumRx Home Delivery (up to 90-day supply) \$25 <a href="#">copayment</a>		
	Preferred brand drugs	Retail (30-day) 30% <a href="#">coinsurance</a> (\$30 minimum; \$65 maximum)	Retail (30-day) <a href="#">Coinsurance</a> plus amount exceeding allowed amount	
		* Walgreens or OptumRx Home Delivery (up to 90-day supply) 30% <a href="#">coinsurance</a> (\$75 minimum; \$165 maximum)		
Non-preferred brand drugs	Retail (30-day) 40% <a href="#">coinsurance</a> (\$50 minimum; \$120 maximum)	Retail (30-day) Coinsurance plus amount exceeding allowed amount		
	* Walgreens or OptumRx Home Delivery (up to 90-day supply) 40% <a href="#">coinsurance</a> (\$125 minimum; \$300 maximum)			
<a href="#">Specialty drugs</a>	Coinsurance after <a href="#">deductible</a> , dependent on classification of drug (e.g., preferred, non-preferred)	Coinsurance dependent on classification of drug (e.g., preferred, non-preferred)		
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.

<sup>1</sup> Starting January 1, 2022, as required by applicable law, in-network cost sharing rules may apply for certain out-of-network services, including certain emergency services, air ambulance services, and services from an out-of-network provider at an in-network facility. This means the amount you pay for these services may be lower than provided in this SBC.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider <sup>1</sup> (You will pay the most)	
If you need immediate medical attention <sup>1</sup>	<a href="#">Emergency room care</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Costs assume true emergency.
	<a href="#">Emergency medical transportation</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Costs assume true emergency.
	<a href="#">Urgent care</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	\$200 <a href="#">copayment</a> then 70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% <a href="#">coinsurance</a> ( <a href="#">deductible</a> does not apply)	50% <a href="#">coinsurance</a> ( <a href="#">deductible</a> does not apply for office visits)	MD Live virtual visits: No member cost share.  Eligible out-of-pocket expenses for the behavioral health, pharmacy and medical plans count toward the out-of-pocket limit. <a href="#">Preauthorization</a> is required for intensive outpatient services.
	Inpatient services	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	\$200 <a href="#">copayment</a> then 70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required, including for partial hospitalization.

<sup>1</sup> Starting January 1, 2022, as required by applicable law, in-network cost sharing rules may apply for certain out-of-network services, including certain emergency services, air ambulance services, and services from an out-of-network provider at an in-network facility. This means the amount you pay for these services may be lower than provided in this SBC.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider <sup>1</sup> (You will pay the most)	
If you are pregnant	Office visits	No charge ( <a href="#">deductible</a> does not apply) for prenatal care except ultrasounds 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> for ultrasounds and subsequent eligible physician charges	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you are pregnant	Childbirth/delivery facility services	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	\$200 <a href="#">copayment</a> then 70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required.
	<a href="#">Home health care</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Limited to 60 visits per calendar year. <a href="#">Preauthorization</a> is required.
If you need help recovering or have other special health needs	<a href="#">Rehabilitation services</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Benefits reflect outpatient services. Inpatient <a href="#">rehabilitation</a> will be considered under the inpatient hospitalization benefit and require <a href="#">preauthorization</a> .
	<a href="#">Habilitation services</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
	<a href="#">Skilled nursing care</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Limited to 120 days per calendar year. <a href="#">Preauthorization</a> is required.
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Coverage for wigs is limited to 5 per lifetime. <a href="#">Preauthorization</a> is required for all rentals and any purchase over \$1,500.
	<a href="#">Hospice services</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required. \$200 <a href="#">copayment</a> then 70% <a href="#">coinsurance</a> after <a href="#">deductible</a> for out-of-network, inpatient hospice.

<sup>1</sup> Starting January 1, 2022, as required by applicable law, in-network cost sharing rules may apply for certain out-of-network services, including certain emergency services, air ambulance services, and services from an out-of-network provider at an in-network facility. This means the amount you pay for these services may be lower than provided in this SBC.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider <sup>1</sup> (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	<b>Exam Core:</b> \$20 <a href="#">copayment</a> <b>Full Vision:</b> \$20 <a href="#">copayment</a> <b>Premier Vision:</b> \$20 <a href="#">copayment</a>	<b>Exam Core:</b> Exam fee exceeding \$45 <b>Full Vision:</b> Exam fee exceeding \$45 <b>Premier Vision:</b> Exam fee exceeding \$45	<b>Exam Core:</b> Includes one exam every year <b>Full Vision:</b> Includes one exam every year <b>Premier Vision:</b> Includes one exam every year
	Children's glasses	<b>Exam Core:</b> Not Covered <b>Full Vision:</b> \$20 <a href="#">copayment</a> for frames and/or lenses; for frames, 80% of cost in excess of \$160 <b>Premier Vision:</b> \$20 <a href="#">copayment</a> for frames and/or lenses; for frames, 80% of cost in excess of \$200	<b>Exam Core:</b> Not Covered <b>Full Vision:</b> Cost of frames in excess of \$70. Cost of single vision lenses over \$30; line bifocal lenses over \$50; lined trifocal lenses over \$65 <b>Premier Vision:</b> Cost of frames in excess of \$70. Cost of single vision lenses over \$30; line bifocal lenses over \$50; lined trifocal lenses over \$65	<b>Exam Core:</b> None <b>Full Vision:</b> Includes one pair of frames and lenses every year <b>Premier Vision:</b> Includes one pair of frames and lenses and contact lenses or two pair of frames and lenses every year
	Children's dental check-up	<b>Dental PPO:</b> No charge unless <a href="#">plan</a> maximum has been met <b>Dental HMO*:</b> No charge unless <a href="#">plan</a> maximum has been met <b>Passive PPO 2000:</b> No charge unless <a href="#">plan</a> maximum has been met	<b>Dental PPO:</b> No charge unless <a href="#">plan</a> maximum has been met <b>Dental HMO*:</b> No charge unless <a href="#">plan</a> maximum has been met <b>Passive PPO 2000:</b> No charge unless <a href="#">plan</a> maximum has been met	<b>Dental PPO:</b> Annual coverage is limited to \$2,000 maximum ( <a href="#">in-network</a> ) and \$1,000 ( <a href="#">out-of-network</a> ) for all covered services <b>Dental HMO*:</b> Please refer to Dental HMO Patient Charge Schedule for additional services. <b>Passive PPO 2000:</b> Coverage is limited to \$2,000 annual maximum for all covered services

\*Not available in all areas.

<sup>1</sup> Starting January 1, 2022, as required by applicable law, in-network cost sharing rules may apply for certain out-of-network services, including certain emergency services, air ambulance services, and services from an out-of-network provider at an in-network facility. This means the amount you pay for these services may be lower than provided in this SBC.

## 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](#).)

- Cosmetic surgery
- Long-term care
- Non-emergency care when traveling outside the U.S.

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

- Acupuncture
- Dental care (Adult), if elected
- Private-duty nursing
- Weight loss programs
- Bariatric surgery (if meet eligibility)
- Hearing aids
- Routine eye care (Adult)
- Chiropractic care
- Infertility treatment
- Routine foot care

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor'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: your Wespeth Care Coordinator at 1-833-762-0876 or visit us at [www.myWespethHealth.com](http://www.myWespethHealth.com).

### 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 1-833-762-0876.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-762-0876.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-762-0876.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-833-762-0876.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-762-0876.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-833-762-0876.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-833-762-0876.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-833-762-0876.

*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.

<sup>1</sup> Starting January 1, 2022, as required by applicable law, in-network cost sharing rules may apply for certain out-of-network services, including certain emergency services, air ambulance services, and services from an out-of-network provider at an in-network facility. This means the amount you pay for these services may be lower than provided in this SBC.

## About these Coverage Examples:



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

### Peg is Having a Baby

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

- The [plan's](#) overall [deductible](#) \$3,250
- [Specialist coinsurance](#) 50%
- Hospital (facility) [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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
---------------------	--

<a href="#">Deductibles</a>	\$3,250
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,800

<i>What isn't covered</i>	
---------------------------	--

Limits or exclusions	\$60
----------------------	------

<b>The total Peg would pay is</b>	<b>\$5,060</b>
-----------------------------------	----------------

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$3,250
- [Specialist coinsurance](#) 50%
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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:

<i>Cost Sharing</i>	
---------------------	--

<a href="#">Deductibles</a>	\$3,250
<a href="#">Copayments</a>	\$70
<a href="#">Coinsurance</a>	\$900

<i>What isn't covered</i>	
---------------------------	--

Limits or exclusions	\$20
----------------------	------

<b>The total Joe would pay is</b>	<b>\$4,240</b>
-----------------------------------	----------------

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$3,250
- [Specialist coinsurance](#) 50%
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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:

<i>Cost Sharing</i>	
---------------------	--

<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0

<i>What isn't covered</i>	
---------------------------	--

Limits or exclusions	\$0
----------------------	-----

<b>The total Mia would pay is</b>	<b>\$2,800</b>
-----------------------------------	----------------

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: **1-800-851-2201**.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.