Washington Teamsters Welfare Trust: Plan B

Coverage Period: 01/01/2020 – 12/31/2020

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

Coverage for: Family | Plan Type: PPO

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.wateamsters.com or call 1-800-458-3053. 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 1-800-458-3053 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300 individual / $900 family. Goes to $200 individual / $600 family if you complete the Health Assessment, $400 individual / $1,200 family if you don't.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes. The deductible does not apply to in-network preventive care, office visits, prescription drugs, obesity programs.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	Yes. $75 for outpatient emergency room visits.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$2,500 individual / $5,000 family shared in and out-of-network medical coinsurance limit. In addition, an ACA mandated limit for in-network prescription drugs of $3,150 individual / $6,300 family and in-network medical of $5,000 individual / $10,000 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Not included in the medical $2,500 individual / $5,000 family coinsurance limit are premiums, deductibles, co-pays, non-covered charges and obesity care. Not included in the ACA mandated limit for in-network prescriptions and in-network medical are premiums, out-of-network and non-covered charges and obesity care.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.wateamsters.com and select Premera BlueCard Network Directory or call 1-800-810-2583 for a list of participating providers. Be sure to reference the alpha prefix TMP. For prescription drugs see www.medimpact.com or call 1-800-788-2949.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 3 for how this plan pays different kinds of providers.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-pay/visit	$25 co-pay/visit	Applies to charge for the office visit only not other professional fees.
	Specialist visit	$25 co-pay/visit	$25 co-pay/visit	Applies to charge for the office visit only not other professional fees.
	Preventive care/screening/ immunization	No charge	40% co-insurance after deductible and $25 co-pay	None
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	None
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medimpact.com	Generic drugs	Retail: 10% or 15% co-pay/prescription; Mail order: 10% co-pay/prescription to maximum $15	Not covered except for a medical emergency	Covers up to a 34-day supply (retail prescription); up to 100 day supply (mail order prescription). Lower retail co-pay % applies to recommended retail pharmacies.
	Preferred brand drugs	Retail: 30% or 35% co-pay/prescription; Mail order: 30% co-pay/prescription to maximum $90	Not covered except for a medical emergency	Covers up to a 34-day supply (retail prescription); up to 100 day supply (mail order prescription). Lower retail co-pay % applies to recommended retail pharmacies.
	Non-preferred brand drugs	Retail: 40% or 45% co-pay/prescription; Mail order: 40% co-pay/prescription to maximum $130	Not covered except for a medical emergency	Covers up to a 34-day supply (retail prescription); up to 100 day supply (mail order prescription). Lower retail co-pay % applies to recommended retail pharmacies.
	Specialty drugs	Mail Order only: 30% co-pay/prescription to maximum $90	Not covered except for a medical emergency	Mail Order only. Covers up to 100-day supply for mail order.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	None
	Physician/surgeon fees	20% co-insurance	40% co-insurance	None
If you need immediate medical attention	Emergency room care	After $75 deductible, 20% co-insurance	After $75 deductible, 20% co-insurance	Notify Plan within 24 hours of admission
	Emergency medical transportation	20% co-insurance	40% co-insurance	None
	Urgent care	20% co-insurance	40% co-insurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Prior Authorization Required
	Physician/surgeon fees	20% co-insurance	40% co-insurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 co-pay/session	$10 co-pay/session	None
	Inpatient services	20% co-insurance	40% co-insurance	Prior Authorization Required
If you are pregnant	Office visits	20% co-insurance	40% co-insurance	Child's pregnancy is not covered.
	Childbirth/delivery professional services	20% co-insurance	40% co-insurance	Child's pregnancy is not covered.
	Childbirth/delivery facility services	20% co-insurance	40% co-insurance	Child's pregnancy is not covered.
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Limited to 130 visits per year
	Rehabilitation services	20% co-insurance inpatient $25 co-pay/visit outpatient	40% co-insurance inpatient $25 co-pay/visit outpatient	None - inpatient Limited to 24-48 visits per year for outpatient
	Habilitation services	20% co-insurance inpatient $25 co-pay/visit outpatient	40% co-insurance inpatient $25 co-pay/visit outpatient	None - inpatient Limited to 24-48 visits per year for outpatient
	Skilled nursing care	20% co-insurance	40% co-insurance	Limited to 180 days per condition
	Durable medical equipment	20% co-insurance	40% co-insurance	None
	Hospice services	20% co-insurance	40% co-insurance	Limited to 60 visits

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 your child needs dental or eye care	Children's eye exam	20% co-insurance	40% co-insurance	Medical conditions of eye only. See vision plan for routine exam for visual acuity or eyewear.
	Children's glasses	Not Covered	Not Covered	Covered by separate vision plan.
	Children's dental check-up	Not Covered	Not Covered	Covered by separate dental plan.

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
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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

- Acupuncture (limited benefit)
- Bariatric surgery (if meeting plan criteria)
- Chiropractic care (limited benefit)
- Hearing aids (limited benefit)
- Weight loss programs (if meeting plan criteria)

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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov 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: Northwest Administrators at 1-800-458-3053 or www.nwadmin.com. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-458-3053.]

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

Washington Teamsters Welfare Trust: Plan B

About these Coverage Examples:

Coverage Period: 01/01/2020 – 12/31/2020

Coverage for: Family | Plan Type: PPO

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	$400*
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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*)

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,810

*Assumes the Health Assessment is not taken

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	$400*
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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*)

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,260

Mia's Simple Fracture

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

The plan's overall deductible	$400*
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$800

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, see www.kp.org/plandocuments or call 1-888-901-4636 (TTY: 711). 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 http://www.healthcare.gov/sbc-glossary or call 1-888-901-4636 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 individual/$750 family. Goes to $150 individual/$450 family if you complete the Health assessment, $350 individual/$1,050 family if you don't. Shared in and out-of-network.	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 and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits.
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?	$3,000 individual/$9,000 family shared in and out-of-network limit. There is also an ACA in-network limit of $8,150 individual/$16,300 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, health care this plan doesn't cover and services indicated in chart starting on page 2.	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.kp.org/wa or call 1-888-901-4636 (TTY: 711) 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?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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 (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 / visit Deductible does not apply	$25 / visit Deductible does not apply	None
	Specialist visit	$25 / visit Deductible does not apply	$25 / visit Deductible does not apply	None
	Preventive care/screening/ immunization	No charge Deductible does not apply	$25 / visit, 40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization required or will not be covered.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/wa.	Value based drugs Preferred generic drugs (Tier 1)	Retail: $4 / prescription Retail: $8 / prescription; Mail Order: $5 discount from retail cost share / prescription Deductible does not apply	Retail: $13 / prescription Deductible does not apply	Up to a 30-day supply (retail) or a 90-day supply (mail order). Subject to formulary guidelines.
	Preferred brand drugs (Tier 2)	Retail: $25 / prescription; Mail Order: $5 discount from retail cost share / prescription Deductible does not apply	Retail: $30 / prescription Deductible does not apply	Up to a 30-day supply (retail) or a 90-day supply (mail order). Subject to formulary guidelines.
	Non-preferred generic/brand drugs (Tier 3)	Retail: $50 / prescription Mail Order: $5 discount from retail cost share / prescription Deductible does not apply	Retail: $55 / prescription Deductible does not apply	Up to a 30-day supply (retail) or a 90-day supply (mail order). Subject to formulary guidelines.
	Specialty drugs	Applicable preferred generic, preferred brand, or non-preferred generic/brand cost shares may apply. Deductible does not apply	Applicable preferred generic, preferred brand, or non-preferred generic/brand cost shares may apply. Deductible does not apply	Up to a 30-day supply (retail). Subject to formulary guidelines.

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 (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$25 / visit, 20% coinsurance	$25 / visit, 40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$75 / visit, 20% coinsurance	$75 / visit, 20% coinsurance	You must notify Kaiser Permanente within 24 hours if admitted to an out-of-network provider; limited to initial emergency only; Copayment waived if admitted directly to the hospital as an inpatient.
	Emergency medical transportation	20% coinsurance Deductible does not apply	20% coinsurance Deductible does not apply	None
	Urgent care	$25 / visit Deductible does not apply	$25 / visit Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required or will not be covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization required or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 / visit Deductible does not apply	$25 / visit Deductible does not apply	None
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required or will not be covered.
If you are pregnant	Office visits	20% coinsurance	$25 / visit Deductible does not apply	Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services cost shares are separate from that of the mother.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services cost shares are separate from that of the mother.

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 (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge Deductible does not apply	40% coinsurance	130 visit limit / year. Preauthorization required or will not be covered.
	Rehabilitation services	Outpatient: $25 / visit Deductible does not apply Inpatient: 20% coinsurance	Outpatient: $25 / visit Deductible does not apply Inpatient: 40% coinsurance	Outpatient: 60 visit limit / year. Inpatient: 60 day limit / year (combined with Habilitation services). Inpatient: Preauthorization required or will not be covered.
	Habilitation services	Outpatient: $25 / visit Deductible does not apply Inpatient: 20% coinsurance	Outpatient: $25 / visit Deductible does not apply Inpatient: 40% coinsurance	Outpatient: 60 visit limit / year. Inpatient: 60 day limit / year (combined with Rehabilitation services). Inpatient: Preauthorization required or will not be covered.
	Skilled nursing care	20% coinsurance	40% coinsurance	180 day limit / year. Limits are combined with in and out-of-network provider networks. Preauthorization required or will not be covered.
	Durable medical equipment	20% coinsurance Deductible does not apply	20% coinsurance	Subject to formulary guidelines. Preauthorization required or will not be covered.
	Hospice services	No charge Deductible does not apply	40% coinsurance	Preauthorization required or will not be covered.
If your child needs dental or eye care	Children's eye exam	$25 / visit Deductible does not apply	Not covered	Limited to one exam / 12 months
	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's glasses
- Cosmetic surgery
- Dental care (Adult & Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Acupuncture (8 visit limit / year)
- Bariatric surgery
- Chiropractic care (20 visit limit / year)
- Hearing aids ($1,000 / ear / 36 months)
- Routine eye care (Adult)

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 shown in the chart below. 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 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 the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-888-901-4636 (TTY: 711) or www.kp.org/wa
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov.
Washington Department of Insurance	1-800-562-6900 or www.insurance.wa.gov

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-888-901-4636 (TTY: 711).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4636 (TTY: 711).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-901-4636 (TTY: 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-901-4636 (TTY: 711).

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 deductible	$350
Specialist copayment	$25
Hospital (facility) coinsurance	20%
Other (blood work) coinsurance	20%

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)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$350
Copayments	$30
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,340

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

The plan's overall deductible	$350
Specialist copayment	$25
Hospital (facility) coinsurance	20%
Other (blood work) coinsurance	20%

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)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$350
Copayments	$1,000
Coinsurance	$10
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,420

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

The plan's overall deductible	$350
Specialist copayment	$25
Hospital (facility) coinsurance	20%
Other (x-ray) coinsurance	20%

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$350
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$750

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