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, call 1-866-417-4240. 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 or call 1-866-417-4240 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300** person / **$900** family. If 2 or more family members are in a common accident, only one deductible will apply.	Generally, you must pay all of the costs from provider 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.** Covered preventive care services provided by a Preferred Provider. Teladoc services.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**Yes. $100**/ preferred hospital and **$300**/non-preferred hospital per admission. Dental: **$25** person / **$50** family	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?	Tier I Medical: **$1,000** person. Tier II Medical: **$2,000** person / **$4,000** family (includes deductibles and in network coinsurance) Prescription Drugs: **$5,150** person / **$10,300** 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-billed charges, deductibles (Tier 1 only), Prescription Drugs (Tier 1 only) durable medical equipment (Tier 1 only), artificial limbs and implanted devices (Tier 1 only), 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.premera.com/sharedadmin or call (800) 810-BLUE (2583) for a list of network providers (BlueCard PPO). For Teladoc visit www.teladoc.com/premera or call (855) 332-4059.	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	**No.**	You can see the specialist you choose without a referral.

Important Questions	Answers	Why This Matters:
see a 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
		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	20% coinsurance	20% coinsurance of Allowed Amount	Deductible and coinsurance waived for Teladoc visits. Chiropractic care limited to 25 visits annually. Nutritionist, 4 visit and only with diagnosis of pulmonary or cardiac disease. Massage and Acupuncturist limited to 10 visits per year. Diabetes Education limited to once per lifetime.
	Specialist visit			
	Preventive care/screening/ immunization	No Charge Deductible does not apply.	20% coinsurance of Allowed Amount	Preventive care is defined in accordance with Federal Regulations. 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	20% coinsurance of Allowed Amount	None.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com.	Generic drugs	Retail: 20% coinsurance/prescription Mail: $10 copay/prescription.		Covers up to a 34-day supply for a retail prescription and up to a 90-day supply for a mail order prescription. For brand drugs, when a generic is available, the plan pays cost of generic equivalent. Specialty drugs are limited to one fill (30-day supply) per month. New to market Specialty drugs will receive clinical review and require preauthorization. No coverage for drugs available without physician's prescription (except insulin). Non-formulary drugs may not be covered without approval through the preauthorization process. To review preferred prescription drugs,
	Preferred brand drugs	Retail: 20% coinsurance/prescription Mail: $30 copay/prescription		
	Non-preferred brand drugs	Retail: 30% coinsurance/prescription Mail: $50 copay/prescription		
	Specialty drugs	Same as generic/brand benefit		

* For more information about limitations and exceptions, see the plan or policy document at www.nwplumberstrust.com

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)	
				see the formulary at www.caremark.com.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance of Allowed Amount	Preauthorization is required, the Plan may disallow charges if preauthorization is not obtained. Orthognathic surgery only covered for dependent children.
	Physician/surgeon fees			None.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance of Allowed Amount	Emergency services provided in response to an emergent condition will be covered the same at in-network or out-of-network facilities.
	Emergency medical transportation	20% coinsurance	20% coinsurance of Allowed Amount	Must show medical necessity. Transportation to nearest facility.
	Urgent care	20% coinsurance	20% coinsurance of Allowed Amount	Emergency services provided at an out-of-network Urgent Care facility will be covered as though in-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance of Allowed Amount	Preauthorization is required, the Plan may disallow charges if preauthorization is not obtained.
	Physician/surgeon fees	20% coinsurance	20% coinsurance of Allowed Amount	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance of Allowed Amount	None.
	Inpatient services	20% coinsurance	20% coinsurance of Allowed Amount	Care must be provided at an approved treatment facility. Inpatient stays require preauthorization, the Plan may disallow charges if preauthorization is not obtained.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance of Allowed Amount	Cost sharing does not apply to certain preventive services. Depending on the type of services a coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance of Allowed Amount	No coverage for dependent child except for ACA preventive services.
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance of Allowed Amount	Licensed birthing facility charges only to extent charges would have been incurred at hospital. No

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)	
				coverage for dependent child except for ACA preventive services.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance of Allowed Amount	Physician certification required.
	Rehabilitation services	20% coinsurance	20% coinsurance of Allowed Amount	To correct the effect of illness or injury. ECG-monitored exercise limited to 12 weeks.
	Habilitation services	20% coinsurance	20% coinsurance of Allowed Amount	Coverage limited to the care rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and normal motor development. The Plan also covers habilitative therapy services for autism spectrum and other disorders classified in the current International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) as mental disorders.
	Skilled nursing care	20% coinsurance	20% coinsurance of Allowed Amount	Maximum of 70 days, provided hospitalized at least 5 days and admitted to skilled nursing care within 14 days.
	Durable medical equipment	20% coinsurance	20% coinsurance of Allowed Amount	None.
	Hospice services	20% coinsurance	20% coinsurance of Allowed Amount	Certified fewer than 6 months to live.
If your child needs dental or eye care	Children's eye exam	No charge		Once every year
	Children's glasses	No charge for children under age 19.		Once every 2 years
	Children's dental check-up	Costs in excess of the Dental Schedule (between $35 and $47)		The annual maximum of $1,500 does not apply to dependent children under age 19.

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.)		
• Bariatric surgery • Benefits when Medicare is or could be primary (This exclusion applies if you are eligible to enroll in Medicare, but fail to do so.)	• Cosmetic Surgery (except to repair injury or congenital defect) • Expenses resulting from work related conditions	• Infertility treatment • Long-term care • Routine foot care • Weight Loss Programs • Work related injury or illness

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Chiropractic Care • Dental Care (Adult)	• Hearing Aids • Non-emergency care when traveling outside the U.S.	• Private-Duty Nursing (if medically necessary) • 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Trust Administration Office at 1-866-417-4240.

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 1-866-417-4240.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-417-4240.

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	**$300**
Specialist *coinsurance*	**20%**
Hospital (facility) *coinsurance*	**20%**
Other *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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,360**

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

The plan's overall deductible	**$300**
Specialist *coinsurance*	**20%**
Hospital (facility) *coinsurance*	**20%**
Other *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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	**$300**
Specialist *coinsurance*	**20%**
Hospital (facility) *coinsurance*	**20%**
Other *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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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

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, call 1-866-417-4240. 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 or call 1-866-417-4240 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300** person / **$900** family. If 2 or more family members are in a common accident, only one deductible will apply.	Generally, you must pay all of the costs from provider 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.** Covered preventive care services provided by a Preferred Provider. Teladoc services.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**Yes. $100**/ preferred hospital and **$300**/non-preferred hospital per admission.	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?	Tier I Medical: **$1,000** person. Tier II Medical: **$2,000** person / **$4,000** family (includes deductibles and in network coinsurance) Prescription Drugs: **$5,150** person / **$10,300** 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-billed charges, deductibles (Tier 1 only), Prescription Drugs (Tier 1 only) durable medical equipment (Tier 1 only), artificial limbs and implanted devices (Tier 1 only), 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.premera.com/sharedadmin or call (800) 810-BLUE (2583) for a list of network providers (BlueCard PPO). For Teladoc visit www.teladoc.com/premera or call (855) 332-4059.	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	**No.**	You can see the specialist you choose without a referral.

Important Questions	Answers	Why This Matters:
see a 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
		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	20% coinsurance	20% coinsurance of Allowed Amount	Deductible and coinsurance waived for Teladoc visits. Chiropractic care limited to 25 visits annually. Nutritionist, 4 visit and only with diagnosis of pulmonary or cardiac disease. Massage and Acupuncturist limited to 10 visits per year. Diabetes Education limited to once per lifetime.
	Specialist visit			
	Preventive care/screening/ immunization	No Charge Deductible does not apply.	20% coinsurance of Allowed Amount	Preventive care is defined in accordance with Federal Regulations. 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	20% coinsurance of Allowed Amount	None.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com.	Generic drugs	Retail: 20% coinsurance/prescription Mail: $10 copay/prescription.		Covers up to a 34-day supply for a retail prescription and up to a 90-day supply for a mail order prescription. For brand drugs, when a generic is available, the plan pays cost of generic equivalent. Specialty drugs are limited to one fill (30-day supply) per month. New to market Specialty drugs will receive clinical review and require preauthorization. No coverage for drugs available without physician's prescription (except insulin). Non-formulary drugs may not be covered without approval through the preauthorization process. To review preferred prescription drugs,
	Preferred brand drugs	Retail: 20% coinsurance/prescription Mail: $30 copay/prescription		
	Non-preferred brand drugs	Retail: 30% coinsurance/prescription Mail: $50 copay/prescription		
	Specialty drugs	Same as generic/brand benefit		

* For more information about limitations and exceptions, see the plan or policy document at www.nwplumberstrust.com

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)	
				see the formulary at www.caremark.com.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance of Allowed Amount	Preauthorization is required, the Plan may disallow charges if preauthorization is not obtained. Orthognathic surgery only covered for dependent children.
	Physician/surgeon fees			None.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance of Allowed Amount	Emergency services provided in response to an emergent condition will be covered the same at in-network or out-of-network facilities.
	Emergency medical transportation	20% coinsurance	20% coinsurance of Allowed Amount	Must show medical necessity. Transportation to nearest facility.
	Urgent care	20% coinsurance	20% coinsurance of Allowed Amount	Emergency services provided at an out-of-network Urgent Care facility will be covered as though in-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance of Allowed Amount	Preauthorization is required, the Plan may disallow charges if preauthorization is not obtained.
	Physician/surgeon fees	20% coinsurance	20% coinsurance of Allowed Amount	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance of Allowed Amount	None.
	Inpatient services	20% coinsurance	20% coinsurance of Allowed Amount	Care must be provided at an approved treatment facility. Inpatient stays require preauthorization, the Plan may disallow charges if preauthorization is not obtained.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance of Allowed Amount	Cost sharing does not apply to certain preventive services. Depending on the type of services a coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance of Allowed Amount	No coverage for dependent child except for ACA preventive services.
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance of Allowed Amount	Licensed birthing facility charges only to extent charges would have been incurred at hospital. No

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)	
				coverage for dependent child except for ACA preventive services.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance of Allowed Amount	Physician certification required.
	Rehabilitation services	20% coinsurance	20% coinsurance of Allowed Amount	To correct the effect of illness or injury. ECG-monitored exercise limited to 12 weeks.
	Habilitation services	20% coinsurance	20% coinsurance of Allowed Amount	Coverage limited to the care rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and normal motor development. The Plan also covers habilitative therapy services for autism spectrum and other disorders classified in the current International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) as mental disorders.
	Skilled nursing care	20% coinsurance	20% coinsurance of Allowed Amount	Maximum of 70 days, provided hospitalized at least 5 days and admitted to skilled nursing care within 14 days.
	Durable medical equipment	20% coinsurance	20% coinsurance of Allowed Amount	None.
	Hospice services	20% coinsurance	20% coinsurance of Allowed Amount	Certified fewer than 6 months to live.
If your child needs dental or eye care	**Active**			
	Children's eye exam	No charge		Once every year (Active/Retiree Plan only)
	Children's glasses	No charge for children under age 19.		Once every 2 years (Active/Retiree only)
	Children's dental check-up	Not covered		Not covered

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.)		
• Bariatric surgery • Benefits when Medicare is or could be primary (This exclusion applies if you are eligible to enroll in Medicare, but fail to do so.)	• Cosmetic Surgery (except to repair injury or congenital defect) • Dental Care • Expenses resulting from work related conditions	• Infertility treatment • Long-term care • Routine foot care • Weight Loss Programs • Work related injury or illness

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Chiropractic Care	• Hearing Aids • Non-emergency care when traveling outside the U.S.	• Private-Duty Nursing (if medically necessary) • Routine Eye Care (Adult)

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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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Trust Administration Office at 1-866-417-4240.

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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:

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

About these Coverage Examples:

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Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$300**
Specialist *coinsurance*	**20%**
Hospital (facility) *coinsurance*	**20%**
Other *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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,360**

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

The plan's overall deductible	**$300**
Specialist *coinsurance*	**20%**
Hospital (facility) *coinsurance*	**20%**
Other *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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	**$300**
Specialist *coinsurance*	**20%**
Hospital (facility) *coinsurance*	**20%**
Other *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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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