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 1-866-692-0860 or visit www.ncilhwf.com. 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 1-866-692-0860 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$750** person/**$1,500** family; Out-of-Network: **$1,500** person/**$4,500** family.	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. Outpatient surgical procedures, second surgical opinion, in-network preventive care, vision, hearing benefits, and dental are covered before you meet your deductible.	This plan covers some items and services even if you have not 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. **$50** person/**$100** family for dental. There are no other specific deductibles.	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?	In-Network Medical: **$2,500** person/**$7,500** family; In-Network Prescription Drugs: **$4,100** person/**$5,700** 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, dental benefits administered separately by Delta Dental, vision and hearing benefits administered separately by Professional Benefit Administrators, Inc., prescription drug copayments, and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com or call 1-800-810-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 copay/visit	50% coinsurance	-- None --
	Specialist visit	$50 copay/visit	50% coinsurance	-- None --
	Preventive care/screening/ Immunization	No charge. Deductible does not apply.	Not covered	You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	-- None --
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com.	Generic drugs	10% coinsurance, minimum $10 copay/ maximum $20 copay/fill retail, 10% coinsurance minimum $20 copay/maximum $40 copay/fill mail order. Deductible does not apply.	Not covered	Covers up to a 34-day supply (retail); up to 90-day supply (mail order). If your Physician has not indicated Dispense as Written on your prescription and you choose to receive the brand name medication rather than the available generic medication, you will have to pay the difference in cost between the generic and the brand name medication in addition to the copayment.
	Preferred Brand drugs	20% coinsurance, minimum $20 copay/ maximum $50 copay/fill retail, 20% coinsurance minimum $50 copay/maximum $100 copay/fill mail order. Deductible does not apply.		
	Non-Preferred drugs	30% coinsurance, minimum $35 copay/ maximum $125 copay/fill retail, 30% coinsurance minimum $100 copay/maximum $250 copay/fill mail order. Deductible does not apply.		

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)	
	Specialty Drugs	20% coinsurance, minimum $20 copay/ maximum $50 copay/fill retail, 20% coinsurance minimum $50 copay/maximum $100 copay/fill mail order. Deductible does not apply.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance. Deductible does not apply.	50% coinsurance. Deductible does not apply.	Preauthorization is required, call 800-367-9938. Failure to preauthorize will result in $250 penalty.
	Physician/surgeon fees	20% coinsurance. Deductible does not apply.	50% coinsurance. Deductible does not apply.	
If you need immediate medical attention	Emergency room care	$200 copay/visit	$200 copay/visit	-- None --
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required, call 800-367-9938. Failure to preauthorize will result in $250 penalty. Charges limited to semi-private room rates.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit for office visits; 20% coinsurance for day treatment and partial hospitalization	50% coinsurance	-- None-
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization is required, call 800-367-9938. Failure to preauthorize will result in $250 penalty. Charges limited to semi-private room rates.

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 are pregnant	Office visits	20% coinsurance	50% coinsurance	Cost sharing does not apply for preventive screenings. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Charges limited to semi-private room rates.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Up to 40 visits/calendar year (combined maximum for in-network and out-of-network).
	Rehabilitation services	20% coinsurance	50% coinsurance	Maximum of 60 inpatient days per year. Maximum of 60 outpatient visits per year (combined maximum for in-network and out-of-network). Out-of-network inpatient services are not covered. Preauthorization is required, call 800-367-9938. Failure to preauthorize will result in $250 penalty.
	Habilitation services	20% coinsurance (speech therapy for developmental disorders only)	50% coinsurance (speech therapy for developmental disorders only)	Maximum of 32 visits per lifetime.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Skilled nursing care	20% coinsurance	50% coinsurance	Maximum of 60 inpatient days per year. Maximum of 60 outpatient visits per year (combined maximum for in-network and out-of-network). Failure to preauthorize results in $250 penalty. Out-of-network inpatient services are not covered. Preauthorization is required, call 800-367-9938. Failure to preauthorize will result in $250 penalty.
	Durable medical equipment	20% coinsurance	50% coinsurance	Rental benefit not to exceed the purchase price. For medical purpose, not for comfort or convenience.
	Hospice services	20% coinsurance	50% coinsurance	Covered if terminally ill.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	$250 annual maximum; administered separately by Professional Benefit Administrators, Inc.
	Children's glasses	No charge	No charge	
	Children's dental check-up	No charge for children under 19; No charge after $50 deductible for children 19 and over.	20% coinsurance after $50 deductible; Deductible does not apply for children under 19.	Coverage is limited to 2 exams/year. Administered separately by Delta Dental of Illinois.

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
- Habilitation services (speech therapy for developmental disorders only)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs (except as required by the ACA)

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

- Acupuncture (Covered under spinal manipulation benefit and smoking cessation benefit if prescribed by a physician)
- Bariatric surgery (Based on meeting criteria for life-threatening obesity)
- Chiropractic care (Up to 60 treatments or $1,000 per year)
- Dental care (Adult) (Up to $1,500 per year under separately administered plan)
- Hearing aids (Up to $5,000 lifetime; limit does not apply to exams)
- Private-duty nursing (Only if medically necessary)
- Routine eye care (Adult) (Up to $250 for all vision benefits combined under separately administered plan)
- Routine foot care (Up to $500 per year for orthotics)

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-EBSA (3272) or 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 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 Fund Office at 1-866-692-0860 or at www.ncilhwf.com. 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.

Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance, 320 W. Washington Street, 4th Floor, Springfield, Illinois 62767, 1-866-445-5364, http://www.insurance.illinois.gov, DOL.Director@illinois.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 1-866-692-0860.

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	$750
Specialist cost sharing	$50
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$1,750
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

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

The plan's overall deductible	$750
Specialist cost sharing	$50
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$70
Copayments	$260
Coinsurance	$1,360
What isn't covered	
Limits or exclusions	$70
The total Joe would pay is	**$1,760**

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

The plan's overall deductible	$750
Specialist cost sharing	$50
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$390
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,160**

Your costs may be less if you participate in the Disease Management Program and qualify for the Sav-Rx vouchers.

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 1-866-692-0860 or visit www.ncilhwf.com. 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 1-866-692-0860 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$750** person/**$1,500** family; Out-of-Network: **$1,500** person/**$4,500** family.	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. Outpatient surgical procedures, second surgical opinion, in-network preventive care, vision, hearing benefits, and dental are covered before you meet your deductible.	This plan covers some items and services even if you have not 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. **$50** person/**$100** family for dental. There are no other specific deductibles.	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?	In-Network Medical: **$2,500** person/**$7,500** family; In-Network Prescription Drugs: **$4,100** person/**$5,700** 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, dental benefits administered separately by Delta Dental, vision and hearing benefits administered separately by Professional Benefit Administrators, Inc., prescription drug copayments, and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.mycigna.com or call 1-800-435-5694 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 copay/visit	50% coinsurance	-- None --
	Specialist visit	$50 copay/visit	50% coinsurance	-- None --
	Preventive care/screening/ Immunization	No charge. Deductible does not apply.	Not covered	You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	-- None --
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com.	Generic drugs	10% coinsurance, minimum $10 copay/ maximum $20 copay/fill retail, 10% coinsurance minimum $20 copay/maximum $40 copay/fill mail order. Deductible does not apply.	Not covered	Covers up to a 34-day supply (retail); up to 90-day supply (mail order). If your Physician has not indicated Dispense as Written on your prescription and you choose to receive the brand name medication rather than the available generic medication, you will have to pay the difference in cost between the generic and the brand name medication in addition to the copayment.
	Preferred Brand drugs	20% coinsurance, minimum $20 copay/ maximum $50 copay/fill retail, 20% coinsurance minimum $50 copay/maximum $100 copay/fill mail order. Deductible does not apply.		
	Non-Preferred drugs	30% coinsurance, minimum $35 copay/ maximum $125 copay/fill retail, 30% coinsurance minimum $100 copay/maximum $250 copay/fill mail order. Deductible does not apply.		

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)	
	Specialty Drugs	20% coinsurance, minimum $20 copay/ maximum $50 copay/fill retail, 20% coinsurance minimum $50 copay/maximum $100 copay/fill mail order. Deductible does not apply.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance. Deductible does not apply.	50% coinsurance. Deductible does not apply.	Preauthorization is required. Call in c/o Professional Benefit Administrators, Inc., 800-436-5694. Failure to preauthorize will result in $250 penalty.
	Physician/surgeon fees	20% coinsurance. Deductible does not apply.	50% coinsurance. Deductible does not apply.	
If you need immediate medical attention	Emergency room care	$200 copay/visit	$200 copay/visit	-- None --
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required. Call in c/o Professional Benefit Administrators, Inc., 800-436-5694. Failure to preauthorize will result in $250 penalty. Charges limited to semi-private room rates.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit for office visits; 20% coinsurance for day treatment and partial hospitalization	50% coinsurance	-- None-
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization is required. Call in c/o Professional Benefit Administrators, Inc., 800-436-5694. Failure to preauthorize will result in $250 penalty. Charges limited to semi-private room rates.

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 are pregnant	Office visits	20% coinsurance	50% coinsurance	Cost sharing does not apply for preventive screenings. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Charges limited to semi-private room rates.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Up to 40 visits/calendar year (combined maximum for in-network and out-of-network).
	Rehabilitation services	20% coinsurance	50% coinsurance	Maximum of 60 inpatient days per year. Maximum of 60 outpatient visits per year (combined maximum for in-network and out-of-network). Out-of-network inpatient services are not covered. Preauthorization is required. Call in c/o Professional Benefit Administrators, Inc., 800-436-5694. Failure to preauthorize will result in $250 penalty.
	Habilitation services	20% coinsurance (speech therapy for developmental disorders only)	50% coinsurance (speech therapy for developmental disorders only)	Maximum of 32 visits per lifetime.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Skilled nursing care	20% coinsurance	50% coinsurance	Maximum of 60 inpatient days per year. Maximum of 60 outpatient visits per year (combined maximum for in-network and out-of-network). Failure to preauthorize will result in $250 penalty. Out-of-network inpatient services are not covered. Preauthorization is required. Call in c/o Professional Benefit Administrators, Inc., 800-436-5694. Failure to preauthorize will result in $250 penalty.
	Durable medical equipment	20% coinsurance	50% coinsurance	Rental benefit not to exceed the purchase price. For medical purpose, not for comfort or convenience.
	Hospice services	20% coinsurance	50% coinsurance	Covered if terminally ill.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	$250 annual maximum; administered separately by Professional Benefit Administrators, Inc.
	Children's glasses	No charge	No charge	
	Children's dental check-up	No charge for children under 19; No charge after $50 deductible for children 19 and over.	20% coinsurance after $50 deductible; Deductible does not apply for children under 19.	Coverage is limited to 2 exams/year. Administered separately by Delta Dental of Illinois.

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

- Acupuncture (Covered under spinal manipulation benefit and smoking cessation benefit if prescribed by a physician)
- Bariatric surgery (Based on meeting criteria for life-threatening obesity)
- Chiropractic care (Up to 60 treatments or $1,000 per year)
- Dental care (Adult) (Up to $1,500 per year under separately administered plan)
- Hearing aids (Up to $5,000 lifetime; limit does not apply to exams)
- Private-duty nursing (Only if medically necessary)
- Routine eye care (Adult) (Up to $250 for all vision benefits combined under separately administered plan)
- Routine foot care (Up to $500 per year for orthotics)

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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 1-866-692-0860.

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	$750
Specialist cost sharing	$50
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$1,750
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

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

The plan's overall deductible	$750
Specialist cost sharing	$50
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$70
Copayments	$260
Coinsurance	$1,360
What isn't covered	
Limits or exclusions	$70
The total Joe would pay is	**$1,760**

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

The plan's overall deductible	$750
Specialist cost sharing	$50
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$390
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,160**

Your costs may be less if you participate in the Disease Management Program and qualify for the Sav-Rx vouchers.

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