AUTOMOBILE MECHANICS' LOCAL 701 WELFARE FUND

361 S. FRONTAGE ROAD, SUITE 100 | BURR RIDGE, IL 60527

TELEPHONE: (708) 482-0110 | TOLL FREE: (800) 704-6270 | FAX: (708) 482-9140

IMPORTANT BENEFIT PLAN CHANGES

The Trustees of the Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund (the "Trustees") have made certain changes to the Pre-Medicare Retirees plan (the "Plan") as documented in the applicable combination Summary Plan Description and Plan Document ("SPD/Plan") that was previously provided to you. The changes are summarized below and are effective as of September 1, 2023.

1. The Standard Option under the Plan will be eliminated effective as of September 1, 2023.

2. The Enhanced Option under the Plan is the only option available after September 1, 2023, therefore, if you are currently enrolled in the Standard Option, you will be automatically moved to the Enhanced Option on that date. Because the Enhanced Option allows you to cover your eligible dependent children in addition to your spouse (under age 65 and not enrolled in Medicare), you will have the option to add any eligible dependent children or your spouse (if under age 65 and not enrolled in Medicare) to your coverage under the Plan when you are moved to the Enhanced Option.

SUMMARY OF MATERIAL MODIFICATIONS

This document, referred to as a "summary of material modifications," is intended to supplement the SPD/Plan. Full details are contained in the SPD/Plan. You should retain this summary of material modifications with your copy of the SPD/Plan. The Trustees reserve the right to amend, modify, or terminate the Plan at any time and from time to time. Receipt of this document does not confer or guarantee eligibility for benefits. If you have any questions, you may contact the Fund Office at (708) 482-0110 ~ Toll Free (800) 704-6270.

1. Elimination of the Plan's Standard Option

The SPD/Plan was amended to eliminate the Plan's Standard Option. Therefore, all references and provisions related to the Standard Option will be removed effective as of September 1, 2023.

2. Transfer from Standard Option to Enhanced Option

As a result of the SPD/Plan being amended to eliminate the Plan's Standard Option, if you were covered under the Standard Option prior to September 1, 2023, you will be automatically transferred to the Enhanced Option as of September 1, 2023. You will have the ability to enroll your spouse (if your spouse is under age 65 and not enrolled in Medicare and was not previously covered under the Standard Option) and any eligible dependent children since they are both eligible to be covered under the Enhanced Option. If you need help enrolling your spouse and/or eligible dependent children, please contact the Fund Office at (708) 482-0110 ~ Toll Free (800) 704-6270.

Please refer to the Monthly Contribution Rate Sheet for the applicable rates as of September 1, 2023 based on whether you are enrolled in single or family coverage that is attached to this summary of material modifications. Please also refer to the attached Schedule of Benefits and the Summary of Benefits and Coverage ("SBC") for the Enhanced Plan, which provides a list of the benefits available and the potential out-of-pocket costs and any coverage limitations associated with receiving such benefits under the Plan.

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PRE-MEDICARE RETIREES PLAN-ENHANCED OPTION
MONTHLY CONTRIBUTION RATE
EFFECTIVE SEPTEMBER 1, 2023
Single Rate $633.00
Family Rate $1,268.00

The Board of Trustees is pleased to announce that effective September 1, 2023, the Pre-Medicare Retirees Plan-Enhanced Option will be the only Pre-Medicare Retirees Plan offered. The Standard Option will be eliminated effective September 1, 2023. The Trustees are subsidizing the cost of your premium by 30% effective September 1, 2023. If you are currently enrolled in the Enhanced Plan, your monthly premium will be substantially lower for family coverage, and you now have the option to pay for single coverage. *Please note the retiree must be covered under the Local #701 Pre-Medicare Retirees Plan or the Local #701 HRA for Medicare Eligible Retirees Plan for any spouse and/or dependent(s) to remain covered under this Plan.*

Attached is the Summary of Material Modifications ("SMM") that explains the benefit enhancements. Also attached are the Schedule of Benefits and the Summary of Benefits and Coverage ("SBC") for the Enhanced Plan. If you are currently enrolled in the Standard Option, you will see your benefits have been substantially increased to include: a lower medical deductible, no prescription deductible, lower copayments, and you now have dental and vision benefits.

Single rate includes a retiree or spouse (under age 65 without Medicare) or an eligible dependent

$633.00 per month

Family rate includes a retiree and/or spouse (under age 65 without Medicare) and/or eligible dependent(s)

$1,268.00 per month

Reminder: Monthly payments are due on the 1st of each month and coverage will terminate if not paid timely.

Automobile Mechanics' Local #701 Welfare Fund
Pre-Medicare Retirees Plan- Enhanced Option Schedule of Benefits (2023 Edition)

Comprehensive Medical Benefit (Pre-Medicare Retirees and their Dependents)	
Deductibles	
• Calendar Year Deductible	$250 per person; $500 per family
• Non-PPO Hospital Deductible	$500 per person for each non-Emergency admission to a Non-PPO Hospital (in addition to the calendar year deductible)
Calendar Year Out-of-Pocket Maximums[1]	
• PPO – Major Medical – Prescription Drug[2]	 $2,500 per person; $5,000 per family $6,600 per person; $13,200 per family
• Additional Non-PPO Maximum	$1,000 per person; $2,000 per family
Calendar Year Plan Maximums	
• Chiropractic/Spinal Care	12 visits per person
• Rehabilitative Speech Therapy (to restore normal speech)	30 visits per person
• Rehabilitative Physical Therapy	20 visits per person[3]
• Habilitative outpatient Physical and Speech Therapy	30 visits for Speech Therapy or a combined 70 visits for Speech and Physical Therapy
Special Benefit Maximums	
• Hospital Daily Room and Board	Single room rate
• Non-PPO Hospital Intensive Care	Full Reasonable and Customary Rate
• Hearing Aid Program	$2,500 per person every three years
• Infertility Treatment[4]	$10,000 per person per lifetime

Comprehensive Medical Benefit (Pre-Medicare Retirees and their Dependents)		
Type of Service	**PPO Provider**	**Non-PPO Provider**
• Outpatient Pre-Admission Tests	Plan pays 100%; no deductible	Plan pays 100%; no deductible
• Hospital Inpatient and Outpatient Surgeries & Hospital Inpatient Services	Plan pays 90% (including surgeries during office visits)	Plan pays 70%
• Emergency Room or Emergency Services for an Emergency Medical Condition	Plan pays 80%	Plan pays 80% of the lesser of the amount billed or the Qualifying Payment Amount ("QPA") Plan pays 70% if not Emergency
• Ground Ambulance	Plan pays 80%	Plan pays 80%
• Air Ambulance	Play pays 80%	Plan pays 80% of the lesser of the amount billed or the QPA
• Preventive Services	Plan pays 100%; no deductible	Not covered
• Non-Hospital Services (e.g., Office Visits, Lab Tests)	Plan pays 80%	Plan pays 70%
• Chiropractic/Spinal Care[5]	Plan pays 80% for up to 12 visits per person per calendar year	Plan pays 70% for up to 12 visits per person per calendar year
• Substance Abuse Treatment[6] – Inpatient – Outpatient	 Plan pays 90% Plan pays 90%	 Plan pays 70% Plan pays 70%
• Mental Health Treatment – Inpatient – Outpatient	 Plan pays 90% Plan pays 90%	 Plan pays 70% Plan pays 70%
• Hearing Aid Program	Plan pays 100% up to $2,500 per person every three years	Plan pays 100% up to $2,500 per person every three years
• Ambulatory Surgical Center	Plan pays 90%	Not covered
• Other Covered Medical Expenses	Plan pays 80%	Plan pays 70%

[1] Excludes amounts paid for non-covered expenses.

[2] The prescription drug calendar year out-of-pocket maximum will be adjusted annually so that the combined out-of-pocket maximums for prescription drugs and major medical equal the maximum permitted under the Affordable Care Act ("ACA").

[3] Rehabilitative Physical Therapy will be approved in excess of the Calendar Year Plan Maximum if approved in advance by pre-certification, case management, and utilization review. To ensure you receive the maximum benefits available under the Plan, you should ask your Physician to contact MCM/Valenz Care prior to receiving treatment.

[4] Expenses to determine Infertility are not included under the lifetime maximum.

[5] Chiropractic/spinal care includes all services and supplies for care of the back, neck, spine, and vertebrae.

[6] Inpatient treatment is covered if it is provided by a Hospital or approved Residential Treatment Facility.

Automobile Mechanics' Local #701 Welfare Fund
Pre-Medicare Retirees Plan- Enhanced Option Schedule of Benefits (2023 Edition)

• Overweight or Obesity Condition-Related Expenses	Plan pays 50%[7]	Not covered
• Telemedicine Services	Plan pays 100% for specifically contracted services with Plan's selected vendor; no deductible	Not covered
• Imaging Procedures (CT/PET scans, MRIs)	Plan pays 100% with no deductible if the Plan's designated imaging provider is used; Plan pays 80% for non-contracted providers	Plan pays 70%
Prescription Drug Benefits (Pre-Medicare Retirees and Dependents)		
Calendar Year Out-of-Pocket Maximum for Prescription Drugs[8]	$6,600 per person; $13,200 per family	
Network Retail Pharmacies	**For up to a 30-day supply, you pay the lesser of the actual drug cost or:**	
• Generic Medication	$6 copayment	
• Preferred Brand Drug	$25 copayment	
• Non-Preferred Brand Drug	$40 copayment	
Mail Order Service or Network Retail Pharmacies	**For up to a 90-day supply, you pay the lesser of the actual drug cost or:**	
• Generic Medication	$15 copayment	
• Preferred Brand Drug	$65 copayment	
• Non-Preferred Brand Drug	$100 copayment	
• Specialty Drugs	100% co-insurance. If co-insurance assistance is unavailable for a drug, the co-insurance defaults to the tiered structure shown above	
• Immunizations administered through the Fund's pharmacy benefits manager	Plan pays 100% (please see SPD for a list of specific covered immunizations)	
• Diabetic Testing Supplies and Syringes	Plan pays 100%	

Dental Benefits (Pre-Medicare Retirees and Dependents)	
Calendar Year Maximum (not applicable to preventive oral care for eligible Dependent children under age 19)	$2,000 per person
Lifetime Orthodontia Maximum	$4,000 per person
Calendar Year Deductible	
• Routine Dental Services	$25 per person
• All Other Covered Dental Services	None
Copayment Percentages	
• Routine Dental Services	Plan pays 100% after deductible
• Basic Dental Services, Major Dental Services & Orthodontia	Plan pays 50%

Vision Benefits (Pre-Medicare Retirees and Dependents)		
	Network Provider	**Non-Network Provider**
Complete Eye Exam (One per calendar year)	$10 copayment	Plan pays up to $35 per person
Single Vision Lenses	$20 copayment every calendar year for lenses and/or frame	Plan pays up to $40 per person every year
Scratch Resistant Coating, Anti-Reflective Coating, Progressives	25%- 30% savings	N/A
Frames	$20 copayment for lenses and/or frame. Plan pays up to $175 every calendar year	Plan pays up to $50 per person every calendar year
Contact Lenses	In place of frames and lenses, Plan pays up to $175 every calendar year for contacts and contact lens exam	Plan pays up to $90 per person every calendar year
Lasik Surgery	Plan pays up to $250 per eye for $500 total allowance after 15% discount if surgery performed at network provider	Plan pays up to $250 per eye for $500 total allowance

[7] Expenses for treatment rendered in connection with overweight or obesity conditions are covered in limited circumstances. Please see the full Summary Plan Description for further information about the circumstances in which such expenses are covered under the Plan.

[8] The prescription drug calendar year out-of-pocket maximum will be adjusted annually so that the combined out-of-pocket maximums for prescription drugs and major medical equal the maximum permitted under the Affordable Care Act ("ACA").

Automobile Mechanics' Local #701 Welfare Fund: Pre-Medicare Retirees Plan- Enhanced Option

Coverage Period: 01/01/2023 – 12/31/2023

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** Individual, 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, go to www.mech701-benefits.org or call 1-800-704-6270. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-704-6270 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** individual **$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. **Preventive care**, outpatient pre-admission tests, and certain diabetic supplies under the Plan's **prescription drug** benefit are covered before you meet your **deductible**.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **co-insurance** 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. **$500** per non-Emergency admission to **out-of-network providers**. 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?	For major medical **network providers**: **$2,500** individual**; $5,000** family; For **prescription drug coverage**: **$6,600** individual; **$13,200** family; For **out-of-network providers**, an additional **$1,000** individual; **$2,000** 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.	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.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 **co-insurance** 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, and 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% **co-insurance**	30% **co-insurance**	None.
	Specialist visit	20% **co-insurance**	30% **co-insurance**	None.
	Preventive care/ screening/ immunization	No charge; **deductible** does not apply	Not covered	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% **co-insurance**	30% **co-insurance**	Outpatient pre-admission tests covered at no cost with no **deductible**. Genetic tests that are not required by law are covered if deemed **medically necessary**.
	Imaging (CT/PET scans, MRIs)	20% **co-insurance** (0% **co-insurance** and no **deductible** if you use a **provider** contracted with the **Plan**'s designated imaging provider network)	30% **co-insurance**	Outpatient pre-admission tests covered at no cost with no **deductible**. If you use a provider contracted with the **Plan**'s designated imaging provider network (Absolute Solutions), then imaging services are covered at no cost to you.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.empirxhealth.com		**Network Pharmacies – 30 You pay the lesser of the actual drug cost or:**	**Mail or Network Pharmacies – 90 You pay the lesser of the actual drug cost or:**	
	Generic drugs	$6 for up to a 30-day supply	$15 for a 90-day supply	Not Covered	None.


All **copayment** and **co-insurance** 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, and Other Important Information
		Network Provider (You will pay the least)		Out-of-Network Provider (You will pay the most)	
	Preferred brand drugs	$25 for up to a 30-day supply	$65 for a 90-day supply	Not Covered	None.
	Non-preferred brand drugs	$40 for up to a 30-day supply	$100 for a 90-day supply	Not Covered	None.
	Specialty drugs	100% **co-insurance**. If **co-insurance** assistance is unavailable for a drug, the **co-insurance** defaults to the tiered structure shown above.		Not Covered	The Fund's contracted specialty drug case manager will work with drug manufacturers so that the cost to you does not exceed the tiered structure shown above.
If you have outpatient surgery	Facility fee	10% **co-insurance**		30% **co-insurance**	**Out-of-network** ambulatory surgery centers not covered.
	Physician/surgeon fees	10% **co-insurance**		30% **co-insurance**	None.
If you need immediate medical attention	**Emergency room services**	20% **co-insurance**		20% **co-insurance** (30% if non-emergency)	None.
	Emergency medical transportation	20% **co-insurance**		20% **co-insurance**	None.
	Urgent care	20% **co-insurance**		30% **co-insurance**	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% **co-insurance**		30% **co-insurance**	**Preauthorization** is required. Coverage limited to single private room rate. Coverage at **out-of-network** Hospital Intensive Care limited to Full Reasonable and Customary Rate. **Out-of-network providers** subject to $500 **deductible** for non-emergency admission.
	Physician/surgeon fee	10% **co-insurance**		30% **co-insurance**	None.


All **copayment** and **co-insurance** 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, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	10% **co-insurance**	30% **co-insurance**	None.
	Inpatient services	10% **co-insurance**	30% **co-insurance**	**Preauthorization** is required. Inpatient substance abuse services are covered if provided by a Hospital or approved Residential Treatment Facility.
If you are pregnant	Office visits	20% **co-insurance**	30% **co-insurance**	**Preventive care** services covered at no cost at PPO providers. Expenses for a dependent child's pregnancy not covered, except as required under applicable law.
	Childbirth/delivery professional services	10% **co-insurance**	30% **co-insurance**	
	Childbirth/delivery facility services	10% **co-insurance**	30% **co-insurance**	
If you need help recovering or have other special health needs	**Home health care**	20% **co-insurance**	30% **co-insurance**	Physician should contact MCM/Valenz Care for **preauthorization**.
	Rehabilitation services	20% **co-insurance**	30% **co-insurance**	30 rehabilitative speech therapy visits/year per person; 20 rehabilitative physical therapy visits/year per person. Physician should contact MCM/Valenz Care for **preauthorization**.
	Habilitation services	20% **co-insurance**	30% **co-insurance**	Habilitative services to develop a function are limited to 30 visits/year per person for speech therapy or a combined 70 visits/year per person for speech and physical therapy. Speech therapy of an idiopathic developmental delay nature, educational or provided by school is not covered.

All **copayment** and **co-insurance** 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, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	20% **co-insurance**	30% **co-insurance**	Physician should contact MCM/Valenz Care for **preauthorization**.
	Durable medical equipment	20% **co-insurance**	30% **co-insurance**	Physician should contact MCM/Valenz Care for **preauthorization**.
	Hospice service	20% **co-insurance**	30% **co-insurance**	Coverage limited to Hospice Care program covered expenses. Physician should contact MCM/Valenz Care for **preauthorization**.
If your child needs dental or eye care	Children's eye exam	$10 **co-pay**	All costs over $35	Coverage limited to one exam per calendar year.
	Children's glasses	$20 **co-pay**	All costs over $40 (single vision), $56 (lined bifocal), or $68 (lined trifocal)	Coverage limited to $175 every calendar year at **network providers** or $50 every year at **out-of-network providers**.
	Children's dental check-up	No charge after $25 **deductible** for routine services	Fees and costs above what is allowed and agreed as Reasonable and Customary	Basic, Major and Orthodontia services covered at 50% **co-insurance**; $2,000 calendar year maximum for dental benefits (except for preventive oral care for children under 19); $4,000 per person lifetime orthodontia maximum.

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
- Genetic Testing (unless approved by the Trustees)
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Pregnancy coverage for dependent children

- Private-duty nursing
- Routine foot care (except for limited orthotics coverage)
- Speech therapy for an idiopathic developmental delay nature, educational, or provided by school
- Weight loss programs (except as required under the ACA preventive services mandate)

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

- Acupuncture
- Bariatric Surgery (subject to certain conditions)
- Chiropractor care (up to 12 visits per person per calendar year; includes services for care of the back, neck, spine, and vertebrae)
- Dental care (Adult)
- Hearing aids (up to $2,500 per person every three years)
- Infertility treatment (up to $10,000 per person per lifetime)
- Routine eye care (Adult) (once per calendar year)

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. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage 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 Coverage Meet the Minimum Value Standard? 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 1-800-704-6270.

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

Automobile Mechanics' Local #701 Welfare Fund: Pre-Medicare Retirees Plan- Enhanced Option

Coverage Period: 01/01/2023 – 12/31/2023

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** Individual, Family

Plan Type: PPO

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 co-insurance) 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	$250
Specialist co-insurance	20%
Hospital (facility) co-insurance	10%
Other co-insurance	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	$250
Copayments	$10
Co-insurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,720**

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

The plan's overall deductible	$250
Specialist co-insurance	20%
Hospital (facility) co-insurance	10%
Other co-insurance	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	$250
Copayments	$100
Co-insurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$770**

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

The plan's overall deductible	$250
Specialist co-insurance	20%
Hospital (facility) co-insurance	10%
Other co-insurance	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	$250
Copayments	$10
Co-insurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$760**

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