Heding

Truck Service, Inc.

Union Center, WI

Health, Dental & Vision

Benefits are available to all employees 30 days after onboarding. Below are some highlights and we invite you to scroll down to view details of our excellent insurance package. All for only $50/week!

Highlights

Annual Deductible – $100 (Employee) & $200 for Family

Annual MAX out of pocket costs – $1,500 per Family

Weekly Accident & Sickness Benefit – $175/week

Life Insurance – $20,000

Michigan Conference of Teamsters Welfare Fund (MCTWF)
Benefit Package 820
SCHEDULE OF BENEFITS

New Key 2 Medical Benefit	BCBS PPO Network	Non-BCBS PPO Network
Annual Deductible	$100 per individual $200 per family	$300 per individual $600 per family
Annual Out of Pocket Maximum includes medical copay and coinsurance amounts. MCTWF complies with the Affordable Care Act out-of-pocket cost limits*	$1,500 per family in excess of deductible	$2,500 per family in excess of deductible
In-Patient Hospital Expenses	Covered 85%** of CC subject to deductible for up to 365 days semi-private room or private room if medically necessary	Covered 75%** of MAB subject to deductible for up to 365 days semi-private room or private room if medically necessary
Hospital Emergency Expenses (must meet criteria)	Covered 100% of CC after $100** copay (waived if admitted)	Covered 100% of MAB after $100** copay (waived if admitted)
Mental Health & Substance Use Disorder Benefits (must receive prior authorization for inpatient services by calling BCBS at 800-762-2382)	**Inpatient Hospital:**Covered 85%** of CC subject to deductible **Inpatient Physician:**Covered 85%** of CC subject to deductible **Outpatient Physician:**$20** copay	**Inpatient Hospital:**Covered 75%** of MAB subject to deductible **Inpatient Physician:**Covered 75%** of MAB subject to deductible **Outpatient Physician:**Covered 70%** of MAB subject to deductible
Surgical Expenses	Covered 85%** of CC subject to deductible	Covered 75%** of MAB subject to deductible
Specified Organ Transplant Program Expenses	Covered 100% of CC. Must use a designated facility.	Covered 100% of CC. Must use a designated facility.
Maternity Expenses Pre/Post Natal Delivery	Covered 85%** of CC subject to deductible	Covered 75%** of MAB subject to deductible
Anesthesia Expenses	Covered 85%** of CC subject to deductible	Covered 75%** of MAB subject to deductible
Ambulance Expenses Ground/Air/Water	Covered 85%** of CC subject to deductible	Covered 85%** of MAB subject to deductible
X-ray and Diagnostic Testing Expenses	Covered 85%** of CC subject to deductible	Covered 75%** of MAB subject to deductible
Laboratory Expenses Fluids/Pathology/Diagnostic Tests	Covered 85%** of CC subject to deductible	Covered 75%** of MAB subject to deductible
Physician Charges Inpatient Outpatient Primary Care Visit Outpatient Specialist Visit Outpatient Urgent Care Visit MDLIVE Telehealth Consultation	Covered 85%** of CC subject to deductible $20** copay $40** copay $45** copay $10** copay	Covered 75%** of MAB subject to deductible Covered 70%** of MAB subject to deductible Covered 70%** of MAB subject to deductible Covered 70%** of MAB subject to deductible Not Covered
Wellness Benefit Physical / GYN Exam / Well Child Exam	Covered 100% of CC Deductible & coinsurance waived	Covered 75%** of MAB subject to deductible
Wellness Benefit Pap Smear Screening & Mammogram Screening	Covered 100% of CC Deductible & coinsurance waived	Covered 75%** of MAB subject to deductible
Wellness Benefit Child Immunization / Adult Flu Vaccination	Covered 100% of CC Deductible & coinsurance waived	Covered 75%** of MAB subject to deductible
Injection Expenses	Covered 85%** of CC subject to deductible	Covered 75%** of MAB subject to deductible
Chiropractic Expenses	24 spinal manipulations per person annually covered 80% of CC. One mechanical traction per day only with spinal manipulation covered under *Physical, Speech & Occupational Therapy Expenses*. One "new patient" office visit every 36 months and one "established patient" office visit annually, per chiropractor, covered under *Physician Charges - Outpatient/Office Visit*.	24 spinal manipulations per person annually covered 70% of MAB. One mechanical traction per day only with spinal manipulation covered under *Physical, Speech & Occupational Therapy Expenses*. One "new patient" office visit every 36 months and one "established patient" office visit annually, per chiropractor, covered under *Physician Charges - Outpatient/Office Visit.*
Hearing Aid Expenses	Covered 85%** of CC subject to deductible, up to $1,500 per person, per ear every 2 years	Covered 85%** of MAB subject to deductible, up to $1,500 per person, per ear every 2 years
Outpatient Cancer Treatment (e.g. chemotherapy & radiation therapy)	Covered 85%** of CC subject to deductible	Covered 75%** of MAB subject to deductible
Physical, Speech & Occupational Therapy Expenses	Covered 85%** of CC subject to deductible	Covered 75%** of MAB subject to deductible

New Key 2 Medical Benefit	BCBS PPO Network	Non-BCBS PPO Network
Home Health Care Expenses	Covered 85%** of CC subject to deductible	Covered 85%** of MAB subject to deductible
Skilled Nursing Facility Expenses	85%** eligible expenses subject to deductible for room and board and other medical services up to 730 days reduced by 2 times the number of days in hospital.	85%** eligible expenses subject to deductible for room and board and other medical services up to 730 days reduced by 2 times the number of days in hospital.
Hospice Care Expenses	Covered 85%** of CC subject to deductible	Covered 85%** of MAB subject to deductible
Durable Medical Equipment and Medical Supplies Expenses	Covered 85%** of CC subject to deductible	Covered 85%** of scheduled amount subject to deductible
Prosthetic Devices and Orthotics Expenses	Covered 85%** of CC subject to deductible	Covered 85%** of MAB subject to deductible
Survivor Health Benefits	Provides up to 36 months of free medical and prescription drug coverage for eligible spouses and dependent children of participants who die while actively covered under a MCTWF medical benefits package. Coverage will mirror the benefits provided to the deceased participant's MCTWF participating group.	Provides up to 36 months of free medical and prescription drug coverage for eligible spouses and dependent children of participants who die while actively covered under a MCTWF medical benefits package. Coverage will mirror the benefits provided to the deceased participant's MCTWF participating group.

New Rx1 Prescription Drug Benefit	Caremark Pharmacy Network			
	Covered in full after the below applicable copay at a participating retail or mail order pharmacy.			
	Retail & Mail Up to 34 days	Retail 90 & Mail 35 - 60 days	Retail 90 61 - 90 days	Mail 61 - 90 days
Generic	$5 copay	$10 copay	$15 copay	$10 copay
Preferred Brand	$15 copay	$30 copay	$45 copay	$35 copay
Non-Preferred Brand	$30 copay	$60 copay	$90 copay	$70 copay

Dental Benefit	Delta Dental PPO Network	Delta Dental Premier Network	Non-Delta Dental Network
Dental Package 1	**Dental:** Class I & II covered in full; Class III 90% of CC. Annual maximum $2,100 per person. **Orthodontic:** 85% of CC up to $3,500 lifetime per adult/child.	**Dental:** Class I & II covered in full; Class III 85% of CC. Annual maximum $2,000 per person. **Orthodontic:** 85% of CC up to $3,500 lifetime per adult/child.	**Dental:** Class I & II 100% of MAB; Class III 85% of MAB. Annual maximum $2,000 per person. **Orthodontic:** 50% of MAB up to $2,000 lifetime per child.

Standard Vision Benefit	EyeMed Vision Network	Non-EyeMed Vision Network
Vision	One exam and one vision correction option[1] per person per calendar year. Exam 100% of CC. Frames covered up to retail value of $150, you are responsible for any charges in excess after a 20% discount. 100% of CC for pair of clear plastic single, bifocal, trifocal or lenticular lenses. 100% of CC for progressive lenses after a copay of $42 for Standard lenses, $72 for Premium Tier 1 lenses, $82 for Premium Tier 2 lenses, $107 for Premium Tier 3 lenses, or $42 plus 80% of charges less $120 allowance for Premium Tier 4 lenses. 100% of CC per pair of polycarbonate lenses under age 19. Up to $120 for contact lenses; you are responsible for any charges in excess after a 15% discount for conventional contact lenses (no discount for disposable contact lenses,). $20 additional contact lens allowance when lenses are purchased through contactsdirect.com. 100% of CC for contact lens fitting; you are responsible up to $40 for standard contact lens fitting and follow-up, or for the retail price less 10% for premium contacts lens fitting and follow-up. Up to $250 per eye per lifetime for laser vision correction (Lasik or PRK) from U.S. Laser Network; you are responsible for any charges in excess after a 15% discount of CC or 5% off the promotional price (whichever is lower). [1] A vision correction option is defined as either (a) one pair of lenses and frames, whether purchased together or separately, (b) contact lenses and fitting, or (c) laser vision correction for one or both eyes. Note: Coverage for one such annual vision option cannot be later replaced with coverage for another vision option.	One exam and one vision correction option[1] per person per calendar year. Exam up to $50. Frames up to $75. Up to $50 for pair of clear plastic single lenses, up to $60 for pair of bifocal lenses, up to $70 for pair of trifocal lenses, and up to $70 for pair of lenticular lenses. No coverage for progressive lenses. Up to $80 for contact lenses. No coverage for contact lens fitting. Up to $250 per eye per lifetime for laser vision correction. [1] A vision correction option is defined as either (a) one pair of lenses and frames, whether purchased together or separately, (b) contact lenses and fitting, or (c) laser vision correction for one or both eyes. Note: Coverage for one such annual vision option cannot be later replaced with coverage for another vision option.

Other Benefit(s)	Coverage
Weekly Accident & Sickness Benefit (participant only)	$175 per week for a maximum of 26 weeks. Payable on the first day for an accident or the 8th day for illness after the last day worked. Family coverage continues while collecting weekly benefit.
Total & Permanent Disability (TPD) Benefit (participant only)	$250 per month. $20,000 maximum benefit over an 80-month period.

Other Benefit(s)	Coverage
Death Benefit Participant Spouse Children (Birth up to age 26)	 $20,000 $3,000 $1,500
Accidental Death and Dismemberment (AD&D) Benefit (participant only)	$20,000 Maximum
Benefit Bank Weeks	Receive 6 benefit bank weeks for the period of 04/01/2021 through 3/31/2024.***

CC (Contracted Charges) means the agreed upon fees between MCTWF and in-network providers.

MAB (Maximum Allowable Benefit) means the portion of the amount billed by an out-of-network provider that has been established as the benefit package maximum payable amount, subject to deductible, coinsurance and co-payments.

* In accordance with the Affordable Care Act, effective January 1, 2017, all MCTWF Actives Plan medical and prescription drug benefits combined in-network out-of-pocket costs are subject to calendar year limits. Out-of-pocket costs refer to deductibles, copay and coinsurance amounts (but not contribution payments, or out-of-network cost-sharing or balance bill payments). Once a calendar year limit is reached, coverage must be provided for the balance of the year without further out-of-pocket costs for in-network medical and prescription drug benefits. The limits for 2021 are $8,550 per individual and $17,100 per family member accumulations toward these statutory out-of-pocket cost limits are tracked on each MCTWF Explanation of Benefits (EOB) form and in each MCTWF Participant Portal account.

** The co-payments and/or coinsurance payments for these services apply toward the annual out-of-pocket maximum.

*** Participant receives the noted 6 weeks except in cases where a different arrangement was approved by MCTWF, or the participant is contributed on under a MCTWF benefit package with seasonal eligibility requirements, in which case they do not receive benefit bank weeks.

Eligibility for auto-related accidental injuries or illnesses under your MCTWF benefit package will be available only to the extent that claims resulting from the accident are in excess of the greater of (1) the required insurance coverage or other financial protection required under applicable state law, or (2) the benefit limits of any other insurance under which the individual is entitled to coverage. MCTWF will provide benefits pursuant to a signed *MCTWF Assignment, Subrogation and Reimbursement Agreement*, contingent upon the submission of proof that benefits have been exhausted through the auto carrier and/or other insurance available. MCTWF does not provide Qualified Health Coverage.

If you are the operator or occupant of a rental vehicle and other medical coverage is available, no MCTWF benefits will be paid for auto-related accidental injuries or illnesses.

This Schedule of Benefits is not a full statement of covered services under your benefit package. As a general rule, all procedures or services not deemed experimental by the medical community are covered. Contact MCTWF's Member Services Call Center for any benefit questions you may have.

Michigan Conference of Teamsters Welfare Fund
2700 Trumbull Avenue, Detroit, Michigan 48216
(313) 964-2400 or (800) 572-7687
Alternative Outage Number (800) 482-2219
www.mctwf.org

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, contact our Member Services Department at 1-800-572-7687. 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.mctwf.org or call 1-800-572-7687 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$100 Individual/$200 family network providers. $300 Individual/$600 family non-network providers.	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care/screening and primary, specialist, emergency room, or urgent care provider services as long as you use a network provider.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers, $1,500/family for most medical services. For non-network providers, $2,500 /family for most medical services.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, non-network coinsurance expenses.	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.mctwf.org or call 1-800-572-7687	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)	Non-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	30% coinsurance	None
	Specialist visit	$40 copay/visit	30% coinsurance	
	Preventive care	No charge	25% 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.
	Screening	No charge	25% coinsurance	
	Immunization	No charge	25% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	25% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	25% coinsurance	Preauthorization required, otherwise not covered
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Generic drugs	$5 copay/prescription for up to 34 days supply (retail & mail order), $10 copay for 35-60 days' supply (retail & mail order), $15 copay for 61-90 days' supply (retail) and $10 copay 61-90 days' supply (mail order).	Difference between the charges and the allowed amount plus the applicable network copay.	Preauthorization required as follows, otherwise not covered: Coverage of non-formulary brand drugs, compound drugs exceeding a specified dollar limit, and drugs within the following therapeutic categories: Acne, Anti-Obesity, ADHD/Narcolepsy (age 20 and above), Anabolic Steroids, Oral Anti-fungal, SSRI (brand name only), Proton Pump Inhibitors (brand or generic treatment greater than 90 days per one year period). Erectile dysfunction tablets, influenza treatment and preventions, smoking cessation and other limitations *see section 6.8 in SPD.
	Preferred brand drugs	$15 copay/prescription for up to 34 days supply (retail & mail order), $30 copay for 35-60 days' supply (retail & mail order), $45 copay for 61-90 days' supply (retail) and $35 copay 61-90 days' supply (mail order).		
	Non-preferred brand drugs	$30 copay/prescription for up to 34 days supply (retail & mail order), $60 copay for 35-60 days' supply (retail & mail order), $90 copay for 61-90 days' supply (retail) and $70 copay 61-90 days' supply (mail order).		
	Specialty drugs	$15 copay/prescription for up to 34 days supply (retail & mail order), $30 copay for 35-60 days' supply (retail & mail order), $45 copay for 61-90 days' supply (retail) and $35 copay 61-90 days' supply (mail order)		Prior authorization required, other-wise not covered. Certain specialty drugs may be deemed as non-preferred brand drugs and may be subject to the corresponding copay structure
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	25% coinsurance	None
	Physician fees	15% coinsurance	25% coinsurance	
	Surgeon fees	15% coinsurance	25% coinsurance	

* For more information about limitations and exceptions, see your Summary Plan Description (SPD) or Schedule of Benefits (SOB) at www.mctwf.org

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Copay waived if admitted. *see section 6.8 in SPD for limitations.
	Emergency medical transportation	15% coinsurance	15% coinsurance	*see section 3.15 in SPD for limitations.
	Urgent care	$45 copay/visit	30% coinsurance	None
If you have a hospital stay	Facility fee(e.g. hospital room)	15% coinsurance	25% coinsurance	None
	Physician fees	15% coinsurance	25% coinsurance	
	Surgeon fees	15% coinsurance	25% coinsurance	
If you need mental health, behavioral health, or substance abuse services.	Outpatient services	$20 copay/visit	30% coinsurance	None
	Inpatient services	15% coinsurance	25% coinsurance	Prior authorization required, otherwise not covered.
If you are pregnant	Office visits	15% coinsurance	25% coinsurance	None
	Childbirth/delivery professional services	15% coinsurance	25% coinsurance	
	Childbirth/delivery facility services	15% coinsurance	25% coinsurance	
If you need help re-covering or have other special health needs	Home health care	15% coinsurance	15% coinsurance	Prior authorization required, otherwise not covered.
	Rehabilitation services	15% coinsurance	25% coinsurance	None
	Habilitation services	15% coinsurance	25% coinsurance	
	Skilled nursing care	15% coinsurance	15% coinsurance	Prior authorization required, otherwise not covered. *see your SOB for limitations.
	Durable medical equipment	15% coinsurance	15% coinsurance	Prior authorization generally required for purchases and repairs only, otherwise not covered.
	Hospice services	15% coinsurance	15% coinsurance	Prior authorization required, otherwise not covered.

* For more information about limitations and exceptions, see your Summary Plan Description (SPD) or Schedule of Benefits (SOB) at www.mctwf.org

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	Any Charge over $50	Limited to one exam year.
	Children's glasses	Basic Lenses - No charge	Lenses - any charge over $50 for single, $60 for bifocal, $70 for trifocal and $70 for lenticular.	Limited to one vision correction option/year.
		Frames - any charge over $150	Frames - any charge over $75	
	Children's dental check-up	No charge	Any charge over the allowed amount	Limited to 2 oral examinations and cleanings/ year.

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.)

- Acupuncture
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Routine foot care (except in presence of certain systemic conditions)

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

- Bariatric surgery
- Chiropractic care up to 24 spinal manipulations per person annually. One mechanical traction per day only with spinal manipulation expenses. One "new patient" office visit every 36 months and one "established patient" office visit annually, per chiropractor.
- Dental care (Adult) up to annual per person maximum of $2,100 PPO or $2,000 Premier.
- Hearing aids up to $1,500 per person, per ear every 2 years.
- Non-emergency care when traveling outside the U.S. Contact 1-800-810-2583.
- Private-duty nursing limited to 24 hrs. per day for 5 days lifetime, 16 hrs. per day for 45 days lifetime and 8 hrs. per day for 900 days lifetime.
- Routine eye care (Adult) limited to one exam and one vision correction option 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). 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 plan at 1-800-572-7687. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Michigan Office of Financial and Insurance Regulations at 1-877-999-6442.

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 1-800-572-7687.

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** **$100**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment** **15%**
- **Other copayment/coinsurance** **$20/15%**

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	$100
Copayments	$20
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,580**

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

- **The plan's overall deductible** **$100**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment** **15%**
- **Other copayment/coinsurance** **$20/15%**

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	$590
Coinsurance	$279
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,024**

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

- **The plan's overall deductible** **$100**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment** **15%**
- **Other copayment/coinsurance** **$20/$100/15%**

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	$100
Copayments	$220
Coinsurance	$150
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$470**

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