



# FOX VALLEY & VICINITY LABORERS

## HEALTH AND WELFARE AND PENSION FUNDS

DATE: May 1, 2025  
TO: Plan Participants  
FROM: Board of Trustees

### **BOARDS OF TRUSTEES**

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SUBJECT: Fox Valley Laborers Health and Welfare Fund  
Summary of Benefits and Coverage

Enclosed is the Fox Valley Laborers Health and Welfare Fund Summary of Benefits and Coverage (SBC). This document is being provided to you as part of the Affordable Care Act to help participants and their families understand your health coverage, as well as to understand common terms used by the health plan. Receipt of this document does not guarantee eligibility for benefits.

The SBC is provided in a standard format and can only differ regarding specific plan benefits. We hope the document will be a helpful resource by identifying the key provisions of the Fund's health and welfare plan. Due to space considerations, the document does not identify all of the rules governing benefits and coverage. Please continue to refer to the January 2019 Edition of the Summary Plan Description booklet and subsequent Summary of Material Modifications for a complete statement of the Fund's rules governing the benefits and coverage.

The SBC provides three examples of services covered under the plan. These examples help illustrate how deductibles, copays and coinsurance work under the plan. There are three examples provided: having a baby, managing Type 2 diabetes, and treatment of a simple fracture. Because each person's care will be different, these examples are not intended to show exact costs. Instead, the sample costs are based on national averages supplied by the U.S. Department of Health and Human Services and they are not specific to a certain geographic area or health plan.

If you are not clear about any of the underlined terms used in the SBC, you can view the Uniform Glossary. The Uniform Glossary is a separate document from the SBC and is available at <https://www.healthcare.gov/sbc-glossary/> or you can call the Fund Office toll free at (866) 828-0900 to request a copy.

If you have any questions, please do not hesitate to contact the Fund Office.





# FOX VALLEY & VICINITY LABORERS

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-696-6775.
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-696-6775
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-696-6775。
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-696-6775.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-696-6775.
Greek	ΠΡΟΣΟΧΗ: Εάν μιλάτε αγγλικά, οι υπηρεσίες γραμματείας, δωρεάν, είναι διαθέσιμες σε εσάς. Καλέστε 1-877-696-6775.
Gujarati	સાવધાન: જો તમે ઇંગલિશ બોલતા હો, ભાષા સહાય સેવાઓ, નિ:શુલ્ક, તમારા માટે ઉપલબ્ધ છે. 1-877-696-6775 પર કોલ કરો
Hindi	सावधानी: यदि आप अंग्रेजी बोलते हैं, तो भाषा सहायता सेवाएं नि:शुल्क, आपके लिए उपलब्ध हैं। 1-877-696-6775 पर कॉल करें।
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-696-6775.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-696-6775 번으로 전화해 주십시오.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-696-6775.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-696-6775.
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-696-6775.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-696-6775.
Urdu	لئے آپ، چارج مفت، خدمات یک مدد یک زبان، تو یہ بولتے انگلش آپ اگر: انتباه یہ ابی دست 1-877-696-6775 کو یکر کال
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-696-6775.

2371 Bowes Road, Suite 500, Elgin, Illinois 60123-5523

OFFICE (847) 742-0900

FAX (847) 742-4430


TOLL FREE (866) 828-0900

www.fvlab.com



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 1-866-828-0900 or visit us at [www.fvlab.com](http://www.fvlab.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 <https://www.healthcare.gov/sbc-glossary/> or call 1-866-828-0900 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$150</b> person / <b>\$400</b> family Carry forward of October, November and/or December expenses satisfying the <a href="#">deductible</a> to the next calendar year	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Certain <a href="#">preventive care</a> , accidental injury and <a href="#">prescription drugs</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive care</a> services without cost sharing and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive care</a> services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <a href="#">deductibles</a> for specific services?	Yes. Dental: <b>\$50</b> person. Doesn't apply to <a href="#">preventive dental care</a> . There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Medical: <b>\$1,500</b> person, plus \$150 <a href="#">deductible</a> (\$400 family) Prescription Drug: <b>\$3,000</b> person	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-800-810-2583 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	For accidental injury, <a href="#">Plan</a> pays 100% of covered expenses for office visits, physician services, and hospital charges incurred within 48 hours of the injury, up to \$750 per person per calendar year ( <a href="#">deductible</a> waived).
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Acupuncture is covered for individuals over age five for treatment of the back, neck, spine, and vertebra, for conditions due to subluxation, strains, sprains, and nerve root problems. The care must be provided by a physician. Chiropractic care rendered by a licensed chiropractor for individuals over age five for treatment of dysfunction in joints and muscles that may be associated with neurological or mechanical dysfunction of the spinal joint and surrounding tissue and appendicular skeleton for up to 26 visits per calendar year with an extension of up to an additional 26 medically necessary visits after medical review is covered.
	<a href="#">Preventive care/screening/immunization</a>	No charge ( <a href="#">deductible</a> does not apply)	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None

\*For more information about limitations and exceptions, call 1-866-828-0900. Balance billing does not apply to out-of-network emergency room care, air ambulance or treatment from ancillary providers at certain in-network facilities. A Family Supplemental Benefit based on years of service is available to reimburse certain medically necessary expenses that are not covered under the [plan](#), other than [deductible](#) or [out-of-pocket limit](#) expenses.



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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs	<b>Retail</b> - \$8 <a href="#">copayment</a> /prescription; <b>Mail Order or Contracted Retail Pharmacy</b> - \$15 <a href="#">copayment</a> /prescription	<b>Retail</b> – 50% <a href="#">coinsurance</a> after \$8 <a href="#">copayment</a> /prescription; if no in-network pharmacy available within zip code, 20% <a href="#">coinsurance</a> after \$8 <a href="#">copayment</a> /prescription	Covers up to 30-day supply (retail); 90-day supply (mail order or contracted retail pharmacy). 90-day supply is required for maintenance medications after two 30-day retail pharmacy fills. <a href="#">Copayments</a> and <a href="#">coinsurance</a> do not count towards the medical <a href="#">out-of-pocket limit</a> . Certain preventive medications including certain contraceptives and immunizations are covered at no charge at a network pharmacy. Certain prescriptions are not covered, including prescriptions that are not on the pharmacy network <a href="#">formulary</a> list. Certain drugs require <a href="#">prior authorization</a> . If you don't get <a href="#">preauthorization</a> , benefits could be reduced where <a href="#">plan</a> pays nothing. Clinical management programs apply to certain prescription drugs, including <a href="#">specialty medications</a> . <a href="#">Specialty drugs</a> must be dispensed by the CVS/Caremark specialty pharmacy.
	Preferred brand drugs	<b>Retail</b> - \$15 <a href="#">copayment</a> /prescription; <b>Mail Order or Contracted Retail Pharmacy</b> - \$30 <a href="#">copayment</a> /prescription; And, if generic is available <a href="#">copayment</a> is \$15 or \$30 plus the cost differential between the brand name and generic.	<b>Retail</b> – 50% <a href="#">coinsurance</a> after \$15 <a href="#">copayment</a> /prescription; if no in-network pharmacy available within zip code, 20% <a href="#">coinsurance</a> after \$15 <a href="#">copayment</a> /prescription	
	Non-preferred brand drugs	Same as preferred	Same as preferred	
	<a href="#">Specialty drugs</a>	Same as preferred	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Out-of-network ancillary services at in-network facility are covered at in-network cost sharing.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	If accidental injury care received within 48 hours of the injury, <a href="#">deductible</a> does not apply and <a href="#">coinsurance</a> does not apply to the first \$750 of charges.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Air transportation is covered only if due to inaccessibility by ground transport or ground transport would be detrimental to the patient's health status. Out-of-network air ambulance is at 10% coinsurance.

\*For more information about limitations and exceptions, call 1-866-828-0900. Balance billing does not apply to out-of-network emergency room care, air ambulance or treatment from ancillary providers at certain in-network facilities. A Family Supplemental Benefit based on years of service is available to reimburse certain medically necessary expenses that are not covered under the [plan](#), other than [deductible](#) or [out-of-pocket limit](#) expenses.

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)	
	<a href="#">Urgent care</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Private rooms are only covered if it is determined to be <a href="#">medically necessary</a> ; weekend admission (Friday or Saturday) is covered only if treatment or surgery is provided within 24 hours of hospital admission. Post stabilization services provided at an out-of-network facility after an emergency admission are covered at 10% coinsurance.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Post stabilization services provided at an out-of-network facility after an emergency admission are covered at 10% coinsurance.
	Inpatient services	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Covered for care within seven days following an inpatient hospital stay for the same or related condition
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Physical, speech and occupational therapy for short-term therapy for physical treatment to improve the status of a physical disability and ordered by a physician is covered for a continuous course of treatment for up to 26 weeks (short-term) for a specific condition/diagnosis when performed by a registered physical therapist or chiropractor, registered speech therapist, or registered or licensed occupational therapist. An extension

\*For more information about limitations and exceptions, call 1-866-828-0900. Balance billing does not apply to out-of-network emergency room care, air ambulance or treatment from ancillary providers at certain in-network facilities. A Family Supplemental Benefit based on years of service is available to reimburse certain medically necessary expenses that are not covered under the [plan](#), other than [deductible](#) or [out-of-pocket limit](#) expenses.

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)	
				of benefits recommended by the physician may be approved after medical review in four week increments with an overall maximum benefit of no more than 52 weeks.
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Physical, speech and occupational therapy is covered for dependents with congenital disability.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Must be provided by a licensed registered or practical nurse and prescribed by a physician.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a> . Covers the rental of durable medical equipment not to exceed a reasonable purchase price	20% <a href="#">coinsurance</a> . Covers the rental of durable medical equipment not to exceed a reasonable purchase price.	Purchase of <a href="#">medically necessary</a> equipment and cost of maintenance agreements are covered only when the <a href="#">plan</a> determines that it is cost effective. One pair of medically necessary custom orthotic devices prescribed by a physician or podiatrist is covered in a 12-month period.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Coverage limited to an individual who is diagnosed as terminally ill with 6 months or less to live by a certified physician.
If your child needs dental or eye care	Children's eye exam	No charge ( <a href="#">deductible</a> does not apply)	No charge ( <a href="#">deductible</a> does not apply)	Once every calendar year
	Children's glasses	No charge	No charge	\$300 calendar year limit.
	Children's dental check-up	Preventive Care - No charge ( <a href="#">deductible</a> does not apply) General Care – 15% <a href="#">coinsurance</a> (dental <a href="#">deductible</a> applies)	Preventive Care - No charge ( <a href="#">deductible</a> does not apply) General Care – 15% <a href="#">coinsurance</a> (dental <a href="#">deductible</a> applies)	Dental x-rays fall under General Care. Annual limit for children: up to age 18 – no annual limit age 18 and over – \$2,500 limit

#### 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 (limited exceptions)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs and weight loss drugs

\*For more information about limitations and exceptions, call 1-866-828-0900. Balance billing does not apply to out-of-network emergency room care, air ambulance or treatment from ancillary providers at certain in-network facilities. A Family Supplemental Benefit based on years of service is available to reimburse certain medically necessary expenses that are not covered under the [plan](#), other than [deductible](#) or [out-of-pocket limit](#) expenses.

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

- |  |  |  |
|--|--|--|
| • Acupuncture                                | • Dental care (Adult)                        | • Non-emergency care when traveling outside the U.S. |
| • Bariatric surgery (authorization required) | • Hearing aids                               | • Private-duty nursing (transplant care)             |
| • Chiropractic care                          | • Infertility treatment (excluding children) | • 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 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://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](http://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, you can contact: the Fund Administrative Office at 1-866-828-0900 or contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>.

**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 1-866-828-0900.

————— *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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$150
■ <a href="#">Specialist</a> <a href="#">coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*pre-natal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$150
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,200
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,420</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$150
■ <a href="#">Specialist</a> <a href="#">coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other (Rx) <a href="#">copayments</a>	\$8/\$15/Rx

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$150
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$200
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$670</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$150
■ <a href="#">Specialist</a> <a href="#">coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
[Diagnostic tests](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$150
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$460</b>

A Family Supplemental Benefit based on years of service is available to reimburse certain medically necessary expenses that are not covered under the [plan](#), other than [deductible](#) or [out-of-pocket limit](#) expenses

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.