




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 800-241-2136. 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://healthcare.gov/sbc-glossary> or call 1-800-241-2136 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<p><a href="#">In-Network</a>: \$1,150/individual; \$2,300/family  <a href="#">Non-Network</a>: \$3,000/individual; \$6,000/family</p> <p>If you qualify for the Standard Enhancements by participating in the <a href="#">plan's</a> wellness program:  <a href="#">In-Network</a>: \$900/individual; \$1,800/family  <a href="#">Non-Network</a>: \$2,500/individual; \$4,500/family</p>	<p>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>.</p>
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	<p>Yes. <a href="#">Prescription drugs</a>, dental benefits, vision benefits, <a href="#">In-Network provider</a> office visits and <a href="#">preventive services</a>.</p>	<p>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 services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	<p>Yes. \$150 for <a href="#">hospitalization</a>; \$200 for <a href="#">emergency room care</a>; \$50 for dental services. There are no other specific <a href="#">deductibles</a>.</p>	<p>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.</p>
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<p><a href="#">In-Network</a>: \$7,500/individual; \$15,000/family  <a href="#">Non-Network</a>: unlimited</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<p>Amounts applied toward <a href="#">non-network</a> charges; <a href="#">premiums</a>; <a href="#">balance-billing</a> charges; vision benefits; dental benefits for individuals age 19 and older; and healthcare this <a href="#">plan</a> doesn't cover (except <a href="#">prescription drugs</a> covered under The Kroger Company Plan)</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	<p>Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-810-BLUE (2583) for a list of <a href="#">network providers</a>.</p>	<p>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</p>

Important Questions	Answers	Why This Matters:
		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> , except that the <a href="#">plan</a> will not cover tests or examinations performed by an Audiologist unless ordered by your doctor.

 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
		In-Network Provider Standard Enhancements (You will pay the least)	In-Network Provider Basic Level if No Wellness Participation	Non-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	\$30 <a href="#">copay</a> /office visit; 20% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to office visit	\$30 <a href="#">copay</a> /office visit; 30% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to office visit	50% <a href="#">coinsurance</a>	<a href="#">Copay</a> applies only to professional service charge. Other charges incurred during visit are subject to <a href="#">deductible</a> and <a href="#">coinsurance</a> .
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /office visit; 20% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to office visit	\$40 <a href="#">copay</a> /office visit; 30% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to office visit	50% <a href="#">coinsurance</a>	No charge for visits completed through LiveHealth Online ( <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> )
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for. No charge for Cologuard® for colorectal cancer screening up to \$700; amounts over \$700 subject to <a href="#">deductible</a> and 20% <a href="#">coinsurance</a> if you participate in the <a href="#">plan's</a> wellness program or 30% <a href="#">coinsurance</a> if no wellness participation.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Provider Standard Enhancements (You will pay the least)	In-Network Provider Basic Level if No Wellness Participation	Non-Network Provider (You will pay the most)	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for genetic testing. No coverage if you fail to obtain <a href="#">preauthorization</a> .
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. No coverage if you fail to obtain <a href="#">preauthorization</a> .
<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.kpp-rx.com">www.kpp-rx.com</a> or by calling 1-800-482-1285.	Generic drugs	Retail: Greater of 10% <a href="#">coinsurance</a> or \$10 <a href="#">copay</a> per prescription, not to exceed \$40 per prescription; <a href="#">deductible</a> does not apply Mail Order: Greater of 10% <a href="#">coinsurance</a> or \$25 <a href="#">copay</a> per prescription, not to exceed \$80 per prescription; <a href="#">deductible</a> does not apply		Not covered	<p><a href="#">Prescription Drugs</a> are provided under The Kroger Company Plan and are not covered under this Plan. Benefits are shown here to provide information on all of your benefits in a single document. While covered through two separate <a href="#">plans</a>, there is a single <a href="#">out-of-pocket limit</a>.</p> <p>Coverage is limited to 30-day supply for retail and specialty drugs. Maintenance medications may be available for up to a 90-day supply at retail. Coverage is limited to 90-day supply for mail order.</p> <p>If you receive a brand name drug when a generic drug is available, you will also pay the difference in cost between the generic and brand name drug.</p> <p>Coverage is excluded for medications not on the <a href="#">plan's</a> chosen prescription drug list. Certain medications may be subject to quantity limits, step therapy, reference based pricing, <a href="#">preauthorization</a> or other utilization management programs. Failure to obtain <a href="#">preauthorization</a> will result in the drug not being covered.</p> <p><a href="#">Specialty drugs</a> must be filled through Axium Healthcare Pharmacy.</p>
	Preferred brand drugs	Retail: Greater of 20% <a href="#">coinsurance</a> or \$20 <a href="#">copay</a> per prescription, not to exceed \$70 per prescription; <a href="#">deductible</a> does not apply Mail Order: Greater of 30% <a href="#">coinsurance</a> or \$50 <a href="#">copay</a> per prescription, not to exceed \$140 per prescription; <a href="#">deductible</a> does not apply		Not covered	
	Non-preferred brand drugs	Retail: Greater of 30% <a href="#">coinsurance</a> or \$35 <a href="#">copay</a> per prescription, not to exceed \$125 per prescription; <a href="#">deductible</a> does not apply Mail Order: Greater of 30% <a href="#">coinsurance</a> or \$75 <a href="#">copay</a> per prescription, not to exceed \$250 per prescription; <a href="#">deductible</a> does not apply		Not covered	
	<a href="#">Specialty drugs</a> – Generic/ Bio-Similar	8% <a href="#">coinsurance</a> not to exceed \$100 per prescription; <a href="#">deductible</a> does not apply		Not covered	
	<a href="#">Specialty drugs</a> – Preferred brand drugs	15% <a href="#">coinsurance</a> not to exceed \$250 per prescription; <a href="#">deductible</a> does not apply		Not covered	
	<a href="#">Specialty drugs</a> – Non-preferred brand drugs	25% <a href="#">coinsurance</a> not to exceed \$400 per prescription; <a href="#">deductible</a> does not apply		Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Provider Standard Enhancements (You will pay the least)	In-Network Provider Basic Level if No Wellness Participation	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. No coverage if you fail to obtain <a href="#">preauthorization</a> .
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$200 <a href="#">deductible</a> /visit and 20% <a href="#">coinsurance</a>	\$200 <a href="#">deductible</a> /visit and 30% <a href="#">coinsurance</a>	\$200 <a href="#">deductible</a> /visit and 30% <a href="#">coinsurance</a>	Separate emergency room <a href="#">deductible</a> is waived if admitted to the hospital.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
	<a href="#">Urgent care</a>	\$75 <a href="#">copay</a> /visit; 20% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to office visit	\$75 <a href="#">copay</a> /visit; 30% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to office visit	50% <a href="#">coinsurance</a>	<a href="#">Copay</a> applies only to professional service charge. Other charges are subject to <a href="#">deductible</a> and <a href="#">coinsurance</a> .
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 <a href="#">deductible</a> /confinement, then 20% <a href="#">coinsurance</a>	\$150 <a href="#">deductible</a> /confinement, then 30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Admissions must be <a href="#">preauthorized or certified</a> . No coverage for stays/days if you fail to obtain <a href="#">preauthorization or certification</a> .
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <a href="#">copay</a> /office visit; 20% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to office visit	\$30 <a href="#">copay</a> /office visit; 30% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to office visit	50% <a href="#">coinsurance</a>	<a href="#">Copay</a> applies only to professional service charge. Other charges are subject to <a href="#">deductible</a> and <a href="#">coinsurance</a> . Coverage is excluded for substance abuse services.
	Inpatient services	\$150 <a href="#">deductible</a> /confinement, then 20% <a href="#">coinsurance</a>	\$150 <a href="#">deductible</a> /confinement, then 30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Admissions must be <a href="#">preauthorized</a> or certified. No coverage for stays/days if you fail to obtain <a href="#">preauthorization</a> or certification. Coverage is excluded for substance abuse services.
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Provider Standard Enhancements (You will pay the least)	In-Network Provider Basic Level if No Wellness Participation	Non-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	\$150 <a href="#">deductible</a> /confinement, then 20% <a href="#">coinsurance</a>	\$150 <a href="#">deductible</a> /confinement, then 30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Dependent child pregnancy charges excluded, except for mandated <a href="#">preventive services</a> .
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Coverage is limited to 40 visits per year and must receive <a href="#">preauthorization</a> . No coverage if you fail to obtain <a href="#">preauthorization</a> .
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. No coverage if you fail to obtain <a href="#">preauthorization</a> .
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. No coverage if you fail to obtain <a href="#">preauthorization</a> .
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. No coverage if you fail to obtain <a href="#">preauthorization</a> .
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
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	All charges in excess of \$30; <a href="#">deductible</a> does not apply	Coverage limited to one exam every 12 months.
	Children's glasses	No charge; <a href="#">deductible</a> does not apply	No charge; <a href="#">deductible</a> does not apply	All charges in excess of \$35-\$75 (depending on lens type) and \$50 for frames; <a href="#">deductible</a> does not apply	Coverage limited to one set of prescribed glasses every 12 months. Additional charges will apply for frames purchased from a <a href="#">network provider</a> over \$100 retail value
	Children's dental check-up	25% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	Not covered	Coverage limited to one exam every 6 months and \$500 maximum (\$1,500 if qualify for Standard Enhancements)



## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Cosmetic surgery, except to repair disfigurement caused by an accident, abnormal congenital conditions of a child or where required by law</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids</li><li>• Infertility treatment</li><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Pregnancy related charges for dependent children, except those covered under <a href="#">preventive care</a></li><li>• <a href="#">Prescription drugs</a> (<a href="#">prescription drugs</a> are provided by your employer)</li><li>• Substance abuse services</li><li>• Weight loss programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Chiropractic care, limited to 24 visits/year</li><li>• Dental care (adult), limited to \$500 annual max (\$1,500 if qualify for Standard Enhancements)</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine eye care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Routine foot care</li></ul>

**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](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 on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the Plan at 1-800-241-2136 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](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 1-800-241-2136.

*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>	\$1,150
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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*)

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

<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$1,300
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$3,380
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,750</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>	\$1,150
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$350
<a href="#">Copayments</a>	\$760
<a href="#">Coinsurance</a>	\$650
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,760</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>	\$1,150
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*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:

<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$1,350
<a href="#">Copayments</a>	\$90
<a href="#">Coinsurance</a>	\$370
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,810</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact the Plan at: 1-800-678-4656.

\* This [plan's](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

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