



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.meritain.com](http://www.meritain.com) or call (941) 951-2916. 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.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call Meritain Health, Inc. at (800) 925-2272 to request a copy.

| Important Questions                                                       | Answers                                                                                                                                                                                                                                                                                                                                                            | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <u>deductible</u>?</b>                             | For participating <u>providers</u> :<br>\$5,000 person / \$10,000 family                                                                                                                                                                                                                                                                                           | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                                                               |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. For participating <u>providers</u> :<br><u>Preventive care</u> , office visit services, <u>emergency room care</u> (all <u>providers</u> – <u>emergency services</u> ), <u>urgent care</u> , maternity care (professional fees), outpatient mental health/substance abuse services and routine eye exams are covered before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                     |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No.                                                                                                                                                                                                                                                                                                                                                                | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | For participating providers:<br>\$7,900 person / \$15,800 family                                                                                                                                                                                                                                                                                                   | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <u>Premiums</u> , <u>preauthorization</u> penalty amounts, <u>balance billing</u> charges and health care this <u>plan</u> doesn't cover.                                                                                                                                                                                                                          | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. See <a href="http://www.aetna.com/docfind/custom/myme ritain">www.aetna.com/docfind/custom/myme ritain</a> or call (800) 343-3140 for a list of <u>network providers</u> .                                                                                                                                                                                    | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>          | No.                                                                                                                                                                                                                                                                                                                                                                | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

 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                                                                                                                                                                                                                                                                                                                                                                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                  |                                                                | Participating Provider<br>(You will pay the least)                                    | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                    | Primary care visit to treat an injury or illness               | \$50 <u>copay</u> /visit                                                              | Not Covered                                           | <u>Copay</u> applies per visit regardless of what services are rendered (includes telemedicine other than Teladoc). You will pay a \$25 <u>copay</u> ( <u>deductible</u> does not apply) if you receive consultation services through Teladoc.                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                  | <u>Specialist</u> visit                                        | \$75 <u>copay</u> /visit                                                              | Not Covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                  | <u>Preventive care</u> /<br><u>screening</u> /<br>immunization | No Charge                                                                             | Not Covered                                           | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Routine adult physical limited to 1 per year. Routine hearing exam limited to 1 per year. Routine mammograms (ages 35-39) limited to 1 baseline mammogram and all other routine mammograms (ages 40 & older) limited to 1 per year. Routine gynecological exam limited to 1 per year. |
| <b>If you have a test</b>                                                                                                                                                                        | <u>Diagnostic test</u> (x-ray, blood work)                     | No Charge                                                                             | Not Covered                                           | -----none-----                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                  | Imaging (CT/PET scans, MRIs)                                   | 30% <u>coinsurance</u>                                                                | Not Covered                                           | <u>Preauthorization</u> required for PET scans and non-orthopedic CT/MRI's. If you don't get <u>preauthorization</u> , benefits could be reduced by \$100 of the total cost of the service.                                                                                                                                                                                                                                                                                     |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.medone-rx.com">www.medone-rx.com</a> | Generic drugs                                                  | \$15 <u>copay</u> (30-day retail)/<br>\$30 <u>copay</u> (90-day retail & mail order)  | Not Covered                                           | <u>Deductible</u> does not apply. Covers up to a 30-day supply (retail prescription); 90-day supply (retail maintenance drugs & mail order prescription). The <u>copay</u> applies per prescription. There is no charge for preventive drugs. Dispense as Written (DAW) provision applies. Step therapy provision applies. *Contact the Prescription Drug Card Program Administrator for <u>specialty drug</u> assistance.                                                      |
|                                                                                                                                                                                                  | <u>Formulary</u> brand drugs                                   | \$35 <u>copay</u> (30-day retail)/<br>\$70 <u>copay</u> (90-day retail & mail order)  | Not Covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                  | Non- <u>Formulary</u> brand drugs                              | \$65 <u>copay</u> (30-day retail)/<br>\$130 <u>copay</u> (90-day retail & mail order) | Not Covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                  | <u>Specialty drugs</u>                                         | Not Covered*                                                                          | Not Covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If you have outpatient surgery</b>                                                                                                                                                            | Facility fee (e.g., ambulatory surgery center)                 | 30% <u>coinsurance</u>                                                                | Not Covered                                           | <u>Preauthorization</u> required for certain surgeries. If you don't get <u>preauthorization</u> , benefits could be                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                  | Physician/surgeon fees                                         | 30% <u>coinsurance</u>                                                                | Not Covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay                                                                       |                                                                                         | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|----------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                           | Participating Provider<br>(You will pay the least)                                      | Non-Participating Provider<br>(You will pay the most)                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                  |                                           |                                                                                         |                                                                                         | reduced by \$100 of the total cost of the service. See your <u>plan</u> document for a detailed listing.                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>If you need immediate medical attention</b>                                   | <u>Emergency room care</u>                | \$500 <u>copay</u> /visit (emergency services)/<br>Not Covered (non-emergency services) | \$500 <u>copay</u> /visit (emergency services)/<br>Not Covered (non-emergency services) | Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for <u>emergency services</u> . <u>Copay</u> waived if admitted to the hospital.                                                                                                                                                                                                                                                                                                               |
|                                                                                  | <u>Emergency medical transportation</u>   | 30% <u>coinsurance</u> (emergency services)/<br>Not Covered (non-emergency services)    | Not Covered                                                                             | Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for air ambulance.                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                  | <u>Urgent care</u>                        | \$100 <u>copay</u> /visit                                                               | Not Covered                                                                             | <u>Copay</u> applies per visit regardless of what services are rendered.                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)        | 30% <u>coinsurance</u>                                                                  | Not Covered                                                                             | <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$100 of the total cost of the service.                                                                                                                                                                                                                                                                                                                                             |
|                                                                                  | Physician/surgeon fees                    | 30% <u>coinsurance</u>                                                                  | Not Covered                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$50 <u>copay</u> /visit                                                                | Not Covered                                                                             | Includes telemedicine other than Teladoc.                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                  | Inpatient services                        | 30% <u>coinsurance</u>                                                                  | Not Covered                                                                             | <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$100 of the total cost of the service.                                                                                                                                                                                                                                                                                                                                             |
| <b>If you are pregnant</b>                                                       | Office visits                             | \$50 <u>copay</u> /visit                                                                | Not Covered                                                                             | <u>Preauthorization</u> required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get <u>preauthorization</u> , benefits could be reduced by \$100 of the total cost of the service. <u>Cost sharing</u> does not apply to <u>preventive services</u> from a participating <u>provider</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby counts towards the mother's expense. |
|                                                                                  | Childbirth/delivery professional services | \$50 <u>copay</u> /visit                                                                | Not Covered                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                  | Childbirth/delivery facility services     | 30% <u>coinsurance</u>                                                                  | Not Covered                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>If you need help recovering or have other special health needs</b>            | <u>Home health care</u>                   | No Charge                                                                               | Not Covered                                                                             | Limited to 60 visits per year (3 intermittent visits per day). <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$100 of the total cost of the service.                                                                                                                                                                                                                                                                              |

| Common Medical Event                          | Services You May Need            | What You Will Pay                                                                                                                      |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                              |
|-----------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                               |                                  | Participating Provider (You will pay the least)                                                                                        | Non-Participating Provider (You will pay the most) |                                                                                                                                                                                                                                     |
|                                               | <u>Rehabilitation services</u>   | \$75 <u>copay</u> /visit (physical, speech/hearing & occupational therapy)/ 30% <u>coinsurance</u> (cardiac rehab & pulmonary therapy) | Not Covered                                        | Physical, speech/hearing & occupational therapy limited to a combined maximum of 60 visits per year. Cardiac rehab and pulmonary therapy limited to 36 visits per year per therapy type.                                            |
|                                               | <u>Habilitation services</u>     | Not Covered                                                                                                                            | Not Covered                                        | This exclusion will not apply to expenses that are considered mental health or substance abuse services, or congenital anomalies amenable to surgical repair (such as cleft lip/palate).                                            |
|                                               | <u>Skilled nursing care</u>      | 30% <u>coinsurance</u>                                                                                                                 | Not Covered                                        | Limited to 60 days per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$100 of the total cost of the service.                                                      |
|                                               | <u>Durable medical equipment</u> | 30% <u>coinsurance</u>                                                                                                                 | Not Covered                                        | <u>Preauthorization</u> required for electric/ motorized scooters or wheelchairs and pneumatic compression devices. If you don't get <u>preauthorization</u> , benefits could be reduced by \$100 of the total cost of the service. |
|                                               | <u>Hospice services</u>          | 30% <u>coinsurance</u> (inpatient)/ No Charge (outpatient)                                                                             | Not Covered                                        | Bereavement counseling is not covered.                                                                                                                                                                                              |
| <b>If your child needs dental or eye care</b> | Children's eye exam              | No Charge                                                                                                                              | Not Covered                                        | Limited to 1 exam per 24 month period.                                                                                                                                                                                              |
|                                               | Children's glasses               | Not Covered                                                                                                                            | Not Covered                                        | Not Covered                                                                                                                                                                                                                         |
|                                               | Children's dental check-up       | Not Covered                                                                                                                            | Not Covered                                        | Not Covered                                                                                                                                                                                                                         |

#### Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)                                                                                                                          |                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <ul style="list-style-type: none"> <li>Ambulance transportation for non-emergency services</li> <li>Bariatric surgery</li> <li>Bereavement counseling</li> <li>Cosmetic surgery</li> <li>Dental care (Adult &amp; Child)</li> <li>Emergency room services for non-emergency services</li> </ul> | <ul style="list-style-type: none"> <li>Glasses (Adult &amp; Child)</li> <li>Habilitation services</li> <li>Hearing aids</li> <li>Infertility treatment (except diagnosis, testing and services to surgically treat the underlying cause)</li> <li>Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing (except for home health care &amp; hospice)</li> <li>Routine foot care (except for metabolic or peripheral vascular disease)</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 plan document.)**

- Acupuncture (as a form of anesthesia in connection with surgery)
- Chiropractic care (20 visits per year)
- Routine eye care (Adult & Child – 1 exam per 24-month period)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or Safe Children Coalition, Inc at (941) 951-2916. 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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or Safe Children Coalition, Inc at (941) 951-2916.

**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 1-800-378-1179.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-378-1179.

*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 <u>plan's</u> overall <u>deductible</u> | \$5,000 |
| ■ <u>Primary care physician copayment</u>     | \$50    |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%     |
| ■ Other <u>coinsurance</u>                    | 30%     |

This EXAMPLE event includes services like:

Primary care physician 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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$5,000        |
| Copayments                        | \$60           |
| Coinsurance                       | \$1,500        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$6,620</b> |

### Managing Joe's Type 2 Diabetes

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

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$5,000 |
| ■ <u>Specialist copayment</u>                 | \$75    |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%     |
| ■ Other <u>coinsurance</u>                    | 30%     |

This EXAMPLE event includes services like:

Specialist 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> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$900          |
| Copayments                        | \$1,100        |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,020</b> |

### Mia's Simple Fracture

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

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$5,000 |
| ■ <u>Specialist copayment</u>                 | \$75    |
| ■ Hospital (facility) <u>copayment</u>        | \$500   |
| ■ Other <u>coinsurance</u>                    | 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> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,700        |
| Copayments                        | \$600          |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,300</b> |

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