2019 ASSOCIATE BENEFITS
OPEN ENROLLMENT
NOW IS YOUR CHANCE TO ENROLL...

YOUR COVERAGE CHOICES

We value the contributions of our associates and strive to provide quality benefits to our workforce. In appreciation of your dedicated service we are pleased to offer a variety of affordable coverage options through The American Worker. We encourage you to review this guide so you understand your benefit options and can make the right choices for you and your family.

MEDICAL OPTIONS: Choose 1 of 5 Plans

Med Enhanced
- Copays for Dr. Visits, Labs, X-rays and Generic Drugs
- 100% in-network coverage for ACA required preventive services

Med Enhanced Plus
- Includes all the Med Enhanced benefits ***PLUS***
- Coverage for Accidents, Hospital Stays, Surgeries and more

Med Advantage
- 100% in-network coverage for ACA required preventive services

Med Advantage Plus
- Includes all the Med Advantage benefits ***PLUS***
- Coverage for Dr. Visits, Labs, X-rays, Prescription discounts and more

Med Basic
- Coverage for Dr. Visits, Labs, X-rays, Prescription discounts and more

EXCITING NEWS FOR 2019...

Med Enhanced: *Better benefits for the same cost*
- Lower Copays for Dr. Visits, Labs, and X-rays
- Added Copay for Specialist Visits

Med Enhanced Plus: *Better benefits for the same cost*
- All of the Med Enhanced upgrades *PLUS*
- Increased Surgery and Admission benefits
- Added coverage for Advanced Studies

Med Advantage and Med Advantage Plus
- Lower cost for the same great benefits

Med Basic and Additional Coverage Options
- Same great benefits at the same low cost

ADDITIONAL COVERAGE OPTIONS

You can elect any of these benefit plans on a freestanding basis or in addition to medical coverage.

- **Dental:** Pays up to $500 per year
- **Vision:** Coverage for eye exams and corrective eyewear
- **Short-term Disability:** Pays $200 per week for up to 26 weeks
- **Life and AD&D Insurance:** $20,000 of coverage for associates

2019 OPEN ENROLLMENT: Monday, October 1 - Wednesday, October 31, 2018

COVERAGE EFFECTIVE DATE: Monday, December 31, 2018

If you are currently enrolled your coverage will continue for 2019 unless you make a change during Open Enrollment.

Deductions for 2019 coverage begin the week of December 24, 2018.

ENROLL NOW

Online: www.TheAmericanWorker.com
Available anytime

Phone: (877) 220-1862
Monday - Friday, 8 AM to 8 PM ET

Mobile Device: Text Staff2019 to 24587
Available anytime

Enrolling Online...

Click "**Register and Enroll**" at the top of the page
Select "**Returning User?**" or "**New User?**"
- **Returning Users**: Login using your username and password
- **New Users**: Select "**Employee ID**" and in the fields below enter
  - Employee ID #: **Your Social Security Number**
  - Group #: **98418**
  - Date of Birth: **Your Date of Birth**

Click "**Continue**" to enroll yourself and your dependents
Note: New users will need to create an account before enrolling

Para información o ayuda en Español llame al (877) 220-1862

EmployBridge Benefits Department: (877) 785-5125

MEDICAL COVERAGE OPTIONS OVERVIEW

You can choose ***ONE*** of the five medical options below. The benefits vary by plan, so an overview of each plan has been included to help you better understand and compare your options. Review the following chart so you can make the right choice for you and your family.

Coverage Overview	Basic	Advantage	Advantage Plus	Enhanced	Enhanced Plus
First Health Network	✓	✓	✓	✓	✓
Primary Care Office Visit Specialist Office Visit	Pays $100/Day		Pays $100/Day	You Pay $10* You Pay $75*	You Pay $10* You Pay $75*
Teladoc	✓		✓		✓
Outpatient Diagnostic Lab Outpatient Diagnostic X-ray	Pays $75/Day Pays $200/Day		Pays $75/Day Pays $200/Day	You Pay $20*	You Pay $20*
Outpatient Diagnostic Advanced Studies	Pays $300/Day		Pays $300/Day		Pays $300/Day
Preventive Care		Plan Pays 100%*	Plan Pays 100%*	Plan Pays 100%*	Plan Pays 100%*
Accident (per occurrence)	Pays up to $300		Pays up to $300		Pays up to $1,000
Emergency Room Sickness					Pays $150/Day
Inpatient Surgery	Pays $1,000/Day		Pays $1,000/Day		Pays $2,000/Day
Hospital Admission (lump sum)	Pays $500/ Confinement		Pays $500/ Confinement		Pays $1,000/ Confinement
Inpatient Hospital Indemnity	Pays $100/Day		Pays $100/Day		Pays $600/Day
Inpatient Intensive Care Unit	Pays $200/Day		Pays $200/Day		Pays $1,200/Day
Prescription Drug	Generic & Brand Discounts		Generic & Brand Discounts	Generic Copays Brand Discounts	Generic Copays Brand Discounts

You MUST visit a First Health Network provider for services to be covered. Services from out-of-network providers are NOT covered.

Weekly Rates *(Note: Biweekly rates are twice the weekly rates. Monthly rates are slightly more than 4 times the weekly rates.)*	Basic	Advantage	Advantage Plus	Enhanced	Enhanced Plus
Associate Only	$18.59**	$3.23	$21.82**	$17.00	$32.08**
Associate & Spouse	$31.24**	$5.10	$36.34**	$42.14	$77.74**
Associate & Child(ren)	$31.37**	$5.29	$36.66**	$51.00	$77.02**
Associate & Family	$47.30**	$5.97	$53.27**	$68.72	$108.23**

*****Rates include a $0.25 weekly administrative fee***

First Health Network*

Members have access to one of the nations largest networks providing savings on Physician and Hospital services

- Over 490,000 provider locations across the country
- To locate a provider, visit **www.FirstHealthLBP.com**

Tip... When making an appointment, make sure to tell your provider your coverage includes the First Health network and confirm they participate in the network.

Teladoc: Talk to a Doctor Anytime for *FREE****

Quality care in minutes from U.S. board-certified doctors 24 hours a day, 365 days a year by phone, online video or mobile app

- Convenient and effective care at no cost to you
- Doctors diagnose, treat and, if needed, prescribe medication
- Avoid expensive urgent care or ER visits for non-emergencies

Registration required prior to use

BENEFIT DEDUCTIONS & CHANGES DURING THE YEAR

The cost of coverage is deducted from your paycheck before taxes are taken out, which saves you money. Since deductions are processed pretax, IRS regulations determine when you can enroll, change or cancel coverage during the year.

You must enroll when initially eligible or during Open Enrollment and the coverage you elect will remain in place for the entire year. If you don't, you must wait until the next Open Enrollment to enroll. However, if you experience a Qualifying Life Event (QLE) during the year, you may be eligible to enroll in new coverage, make changes to existing coverage or cancel your current coverage.

Qualifying Life Events include, but are not limited to: birth, adoption or legal guardianship of a child; marriage, divorce, or legal separation; death of a spouse or child; spousal change of employment affecting insurance coverage.

You have 30 days from the date of the QLE to call The American Worker to make a change. If you do not, you will not be able to make a change until the next Open Enrollment. Coverage changes must be consistent with the QLE and documentation may be required.

*******Teladoc state requirements: AR and DE require initial consultations to be done via video. ID requires all consultations are done via video.****

MED BASIC - PLAN HIGHLIGHTS

The Med Basic Plan provides coverage for basic healthcare services due to an accident or illness. The plan pays a fixed amount per day for covered services. The plan pays in addition to other coverage, which can help offset out-of-pocket costs when receiving treatment.

The Med Basic Plan gives you coverage both in and out of the First Health Network. Visiting a First Health Network provider can reduce your costs. The plan also includes Teladoc and prescription drug discounts to help you save on medical expenses.

Coverage Overview	Med Basic
First Health Network	Included - *See page 2 for details*
Primary Care Office Visit Specialist Office Visit	Plan Pays $100 per Day, 6 Days per Person per Year
Teladoc	Access to Doctors by Phone or Online Anytime for ***Free*** Registration required prior to use - *See page 2 for details*
Outpatient Diagnostic Lab	Plan Pays $75 per Testing Day, 3 Days per Person per Year
Outpatient Diagnostic X-ray	Plan Pays $200 per Testing Day, 3 Days per Person per Year
Outpatient Diagnostic Advanced Studies	Plan Pays $300 per Testing Day, 3 Days per Person per Year
Accidental Injury Care	Plan Pays $300 Maximum per Occurrence
Surgical Indemnity	
Daily Inpatient	Plan Pays $1,000 per Day, 1 Day per Person Per Year
Daily Outpatient / Daily Outpatient Minor	Plan Pays $500 / $100 per Day
Outpatient Benefit Maximum	1 Day per Person per Year
Anesthesia	Plan Pays 30% of the Surgical Benefit
Daily In-Hospital Indemnity	Plan Pays $100 per Day, 500 Days Lifetime Maximum
Hospital Admission *(Lump Sum)*	Plan Pays $500 per Confinement
Intensive Care Unit	Plan Pays $200 per Day; 30 Days per Person per Year
Substance Abuse	Plan Pays $50 per Day; 30 Days per Person per Year
Mental Illness	Plan Pays $50 per Day; 30 Days per Person per Year
Skilled Nursing	Plan Pays $50 per Day; 60 Days per Person per Stay
Prescription Drug Coverage	AWP Value Rx - *See below for details*

Weekly Rates	
Associate Only	$18.59*
Associate & Spouse	$31.24*
Associate & Child(ren)	$31.37*
Associate & Family	$47.30*

Rates include a $0.25 weekly administrative fee

The Med Basic Plan is underwritten by Nationwide Life Insurance Company but includes other benefits such as First Health, Teladoc and AWP Value Rx which are provided by separate vendors.

AWP Value Rx - Provided by Phoenix Benefit Management

This program is designed to provide substantial prescription drug savings by helping you identify affordable options.

- Select Generic and Brand drugs available for $10, $20, $50 or less
- Non-Select Generic and Brand drugs are available at a discount
- Over 56,000 participating pharmacies nationwide. To locate a pharmacy visit www.AWPValueRx.com.

AWP Value Rx is a non-insurance prescription drug discount program

Notes: The Med Basic Plan (a) is not a substitute for minimum essential health coverage under the Affordable Care Act (ACA), and (b) does not qualify as minimum essential coverage under the ACA.
The Med Basic Plan is not available to New Hampshire or Vermont residents.

MED ADVANTAGE & MED ADVANTAGE PLUS - PLAN HIGHLIGHTS

Both plans provide 100% in-network coverage for all ACA required preventive services.

The Med Advantage Plan only covers preventive services. It does not provide any coverage for illness or accidents.

The Med Advantage Plus Plan adds coverage for the treatment of illnesses and accidents such as Doctor Visits, Labs, X-rays, Surgeries, Hospital Stays, and more. It also includes Teladoc and Prescription Drug discounts.

Coverage Overview	Med Advantage
First Health Network	Required - *See page 2 for details*
Preventive Care*	Plan Pays 100% for all ACA required Preventive Care Services See page 6 for a list of Covered Preventive Care Services

You MUST visit a First Health Network provider for services to be covered. Services from out-of-network providers are NOT covered.

Coverage Overview	Med Advantage Plus
First Health Network	Required - *See page 2 for details*
Preventive Care*	Plan Pays 100% for all ACA required Preventive Care Services See page 6 for a list of Covered Preventive Care Services
Primary Care Office Visit Specialist Office Visit	Plan Pays $100 per Day, 6 Days per Person per Year
Teladoc	Access to Doctors by Phone or Online Anytime for ***Free*** Registration required prior to use - *See page 2 for details*
Outpatient Diagnostic Lab	Plan Pays $75 per Testing Day, 3 Days per Person per Year
Outpatient Diagnostic X-ray	Plan Pays $200 per Testing Day, 3 Days per Person per Year
Outpatient Diagnostic Advanced Studies	Plan Pays $300 per Testing Day, 3 Days per Person per Year
Accidental Injury Care	Plan Pays $300 Maximum per Occurrence
Surgical Indemnity Daily Inpatient Daily Outpatient / Daily Outpatient Minor Outpatient Benefit Maximum	 Plan Pays $1,000 per Day, 1 Day per Person Per Year Plan Pays $500 / $100 per Day 1 Day per Person per Year
Anesthesia	Plan Pays 30% of the Surgical Benefit
Daily In-Hospital Indemnity	Plan Pays $100 per Day, 500 Days Lifetime Maximum
Hospital Admission *(Lump Sum)*	Plan Pays $500 per Confinement
Intensive Care Unit	Plan Pays $200 per Day; 30 Days per Person per Year
Substance Abuse	Plan Pays $50 per Day; 30 Days per Person per Year
Mental Illness	Plan Pays $50 per Day; 30 Days per Person per Year
Skilled Nursing	Plan Pays $50 per Day; 60 Days per Person per Stay
Prescription Drug Coverage	AWP Value Rx - *See below for details*

You MUST visit a First Health Network provider for services to be covered. Services from out-of-network providers are NOT covered.

Weekly Rates	Med Advantage	Med Advantage Plus
Associate Only	$3.23	$21.82**
Associate & Spouse	$5.10	$36.34**
Associate & Child(ren)	$5.29	$36.66**
Associate & Family	$5.97	$53.27**

****Rates include a $0.25 weekly administrative fee***

AWP Value Rx - Provided by Phoenix Benefit Management

This program is designed to provide substantial prescription drug savings by helping you identify affordable options.

- Select Generic and Brand drugs available for $10, $20, $50 or less
- Non-Select Generic and Brand drugs are available at a discount
- Over 56,000 participating pharmacies nationwide. To locate a pharmacy visit www.AWPValueRx.com.

The AWP Value Rx is a non-insurance discount program

Notes: The Med Advantage Plus Plan is not available to New Hampshire or Vermont residents.
The Med Advantage and Med Advantage Plus Plans do not satisfy state coverage requirements in Massachusetts.

MED ENHANCED & MED ENHANCED PLUS - PLAN HIGHLIGHTS

Both plans provide in-network coverage for Doctor Visits, Labs, X-rays, ACA required Preventive Services, and Generic Prescription Drugs. The Med Enhanced Plus Plan adds coverage for Accidents, Surgeries, Hospital Stays, and more.

Coverage Overview	Med Enhanced Plan
First Health Network	Required - *See page 2 for details*
Preventive Care*	Plan Pays 100% for all ACA required Preventive Care Services See page 6 for a list of Covered Preventive Care Services
Primary Care Office Visit*	You pay $10 per Visit, 4 Visits per Person per Year
Specialist Office Visit*	You pay $75 per Visit, 1 Visit per Person per Year
Outpatient Diagnostic Lab & X-ray*	You pay $20 per Visit, 4 Visits per Person per Year
Prescription Drug Coverage	FBG Rx - *See below for details*

You MUST visit a First Health Network provider for services to be covered. Services from out-of-network providers are NOT covered.

Coverage Overview	Med Enhanced Plus Plan
First Health Network	Required - *See page 2 for details*
Preventive Care*	Plan Pays 100% for all ACA required Preventive Care Services See page 6 for a list of Covered Preventive Care Services
Primary Care Office Visit*	You pay $10 per Visit, 4 Visits per Person per Year
Specialist Office Visit*	You pay $75 per Visit, 1 Visit per Person per Year
Teladoc	Access to Doctors by Phone or Online Anytime for *Free* Registration required prior to use - *See page 2 for details*
Outpatient Diagnostic Lab & X-ray*	You pay $20 per Visit, 4 Visits per Person per Year
Outpatient Diagnostic Advanced Studies	Plan Pays $300 per Testing Day, 3 Days per Person per Year
Emergency Room Sickness	Plan Pays $150 per Day, 2 Days per Person per Year
Accidental Injury Care	Plan Pays $1,000 Maximum per Occurrence
Surgical Indemnity Daily Inpatient Daily Outpatient / Daily Outpatient Minor Outpatient Benefit Maximum	 Plan Pays $2,000 per Day, 1 Day per Person Per Year Plan Pays $1,000 / $200 per Day 1 Day per Person per Year
Anesthesia	Plan Pays 30% of the Surgical Benefit
Daily In-Hospital Indemnity	Plan Pays $600 per Day, 500 Days Lifetime Maximum
Hospital Admission *(Lump Sum)*	Plan Pays $1,000 per Confinement
Intensive Care Unit	Plan Pays $1,200 per Day; 30 Days per Person per Year
Substance Abuse	Plan Pays $300 per Day; 30 Days per Person per Year
Mental Illness	Plan Pays $300 per Day; 30 Days per Person per Year
Skilled Nursing	Plan Pays $300 per Day; 60 Days per Person per Stay
Prescription Drug Coverage	FBG Rx - *See below for details*

You MUST visit a First Health Network provider for services to be covered. Services from out-of-network providers are NOT covered.

Weekly Rates	Med Enhanced	Med Enhanced Plus
Associate Only	$17.00	$32.08**
Associate & Spouse	$42.14	$77.74**
Associate & Child(ren)	$51.00	$77.02**
Associate & Family	$68.72	$108.23**

****Rates include a $0.25 weekly administrative fee***

FBG Rx

Effective and reliable prescription drug coverage with a broad network of over 63,000 participating pharmacies nationwide.

- Generic drugs: $15 Copay
- Brand drugs: Discounts
- To locate a pharmacy visit www.FBG-Rx.com.

***Notes:** The Med Enhanced Plus Plan is not available to New Hampshire or Vermont residents.*
The Med Enhanced and Med Enhanced Plus Plans do not satisfy state coverage requirements in Massachusetts.

PREVENTIVE CARE BENEFIT - COVERED SERVICES OVERVIEW

Benefit included in the Med Advantage, Med Advantage Plus, Med Enhanced, and Med Enhanced Plus Plans.

To promote health and wellness the Affordable Care Act (ACA) requires most plans cover a variety of preventive care services performed by network providers at 100%. The lists below provide an overview of the preventive care services covered at 100% in-network.

Please note, the U.S. Preventive Services Task Force periodically updates these lists and sets the requirements such as age, gender or health conditions for services to be covered. For a current list including all requirements visit www.healthcare.gov/preventive-care-benefits.

First Health Network

One of the nations largest networks with over 490,000 locations across the country. To find a provider visit www.FirstHealthLBP.com

You MUST visit a First Health Network provider for services to be covered. Services from out-of-network providers are NOT covered.

Adults

Screenings: Abdominal Aortic Aneurysm, Alcohol Misuse, Blood Pressure, Cholesterol, Colorectal Cancer, Depression, Diabetes (Type 2), Hepatitis B, Hepatitis C, HIV, Lung Cancer, Obesity, Syphilis, Tobacco Use, Tuberculosis

Counseling: Alcohol Misuse, Diet, Obesity, Sexually Transmitted Infection Prevention

Immunizations: Diphtheria, Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus (HPV), Influenza (Flu Shot), Measles, Meningococcal, Mumps, Pertussis, Pneumococcal, Rubella, Tetanus, Varicella (Chickenpox)

Other: Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer, Falls Prevention, Statin Preventive Medication, Tobacco Use Cessation Interventions

Women including Pregnant Women or Women who may become Pregnant

Screenings: Anemia, Breast Cancer Mammography, Cervical Cancer, Chlamydia, Diabetes, Domestic and Interpersonal Violence, Gestational Diabetes, Gonorrhea, Hepatitis B, HIV, Human Papillomavirus (HPV), Maternal Depression, Osteoporosis, Preeclampsia, Rh Incompatibility, Syphilis, Tobacco Use, Urinary Incontinence, Urinary Tract or Other Infection

Counseling: Breast Cancer Chemoprevention, Breast Cancer Genetic Testing (BRCA), Breastfeeding, Contraception, Domestic and Interpersonal Violence, HIV, Sexually Transmitted Infection

Other: Breastfeeding Supplies for Pregnant and Nursing Women, FDA Approved Contraceptive Methods, Folic Acid Supplements, Tobacco Use Cessation Interventions, Well-woman Visits

Children

Screenings: Autism, Bilirubin Concentration, Blood, Blood Pressure, Cervical Dysplasia, Depression, Developmental, Dyslipidemia, Hearing, Hematocrit or Hemoglobin, Hemoglobinopathies or Sickle Cell, Hepatitis B, HIV, Hypothyroidism, Lead, Obesity, Phenylketonuria (PKU), Sexually Transmitted Infection, Tuberculin, Vision

Assessments: Alcohol Use, Behavioral, Drug Use, Oral Health Risk, Tobacco Use

Counseling: Obesity, Sexually Transmitted Infection Prevention

Immunizations: Diphtheria, Haemophilus Influenzae Type B, Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Inactivated Poliovirus, Influenza (Flu Shot), Measles, Meningococcal, Pertussis, Pneumococcal, Rotavirus, Tetanus, Varicella (Chickenpox)

Other: Fluoride Chemoprevention Supplements, Fluoride Varnish, Gonorrhea Preventive Medication, Height, Weight and Body Mass Index (BMI) Measurements, Iron Supplements, Medical History

DENTAL (Provided by Ameritas Life Insurance Corporation)

Keep a bright, healthy smile while supporting your overall well-being with affordable dental coverage. You can use any provider for service, but have access to a dental network to lower out-of-pocket costs.

Calendar Year Maximum	Plan Pays up to $500 per Covered Member	
Deductible	You Pay $20 per Visit	
COVERED SERVICES	WAITING PERIOD	COINSURANCE
Preventive & Diagnostic Routine Exams, Cleanings, X-rays, etc.	None	Covered at 100% (U&C Charges)
Basic Treatment Restorative Amalgams and Composites, Endodontics, Periodontics, Extractions, etc.	3 Months	Covered at 60% (U&C Charges)
Major Treatment Onlays, Crowns, Prosthodontics, etc.	12 Months	Covered at 50% (U&C Charges)

WEEKLY RATES	
Associate Only	$4.75
Associate & Spouse	$11.88
Associate & Child(ren)	$8.55
Associate & Family	$12.83

TO FIND A PROVIDER
Call (800) 659-2223 and select option 3
Visit www.Ameritas.com and click on FIND A PROVIDER. Then select DENTAL and click on NETWORK PROVIDER.

VISION (Provided by Ameritas Life Insurance Corporation)

A regular eye exam won't just help you see better, it can also detect the first signs of serious health conditions. With this plan you'll get coverage for exams as well as corrective eyewear. Get the most benefit from the plan by visiting a VSP Choice provider.

Deductibles	You Pay $10 per Exam & $25 for Eye Glass Lenses or Frames[1]	
Frequency Exam / Lens / Frame	Based on Date of Service 12 Months / 12 Months / 24 Months	
COVERED SERVICES	VSP CHOICE NETWORK	OUT-OF-NETWORK
Annual Eye Exam	Covered in Full	VSP Pays Up to $45
Lenses (per pair) Single Vision / Bifocal Trifocal / Lenticular	 Covered in Full Covered in Full	VSP Pays Up to $30 / Up to $50 Up to $65 / Up to $100
Contacts Fit and Follow Up Exams Elective Medically Necessary	 15% Discount VSP Pays Up to $120 Covered in Full	VSP Pays No Benefit Up to $105 Up to $210
Frames	VSP Pays Up to $120[2]	VSP Pays Up to $70

WEEKLY RATES	
Associate Only	$2.07
Associate & Spouse	$4.10
Associate & Child(ren)	$3.82
Associate & Family	$5.84

[1]Deductible applies to a complete pair of glasses or frames, whichever is selected.
[2]The Costco allowance will be the wholesale equivalent.

TO FIND A PROVIDER
Call (800) 877-7195
Visit www.Ameritas.com and click on FIND A PROVIDER. Then select VISION: VSP and click on LOOK UP VSP PROVIDERS.

SHORT-TERM DISABILITY*

Your family and daily life can depend on consistent income. If you get sick or injured and can't work, this benefit will pay you cash. Enroll in this benefit to protect your income when you are unable to work.

Weekly Maximum Benefit	Plan Pays $200 Lump Sum Benefit
Maximum Benefit Period	26 Weeks
Waiting Period	7 Days (Accidents and Sickness)

Coverage includes disability due to pregnancy and childbirth

WEEKLY RATES	
Associate Only	$3.87

Note: CA, NJ, NY & RI residents may be entitled to additional disability benefits through your state.

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)*

Life insurance can help your loved ones during a trying time. This benefit provides cash that can assist your family in the event of your death. Enroll in this benefit to protect the future of the ones that depend on you the most.

Life and Accidental Death & Dismemberment Insurance	
Associate	Plan Pays $20,000
Dependent Life Insurance	
Spouse	Plan Pays $2,500
Child (6 months - 26 years)	Plan Pays $1,250
Infant (10 days - 6 months)	Plan Pays $200

WEEKLY RATES	
Associate Only	$0.60
Associate & Spouse	$0.90
Associate & Child(ren)	$0.90
Associate & Family	$1.80

**Short-term Disability and Life and AD&D, provided by Nationwide Life Insurance Company, are not available to New Hampshire or Vermont residents.*

ENROLLMENT & ELIGIBILITY INFORMATION

For your convenience you can enroll online, by phone or by mobile device. If you have benefit questions contact the enrollment center.

2019 OPEN ENROLLMENT: Monday, October 1 - Wednesday, October 31, 2018
COVERAGE EFFECTIVE DATE: Monday, December 31, 2018

Enroll Online: Visit www.TheAmericanWorker.com

Click "**Register and Enroll**" at the top of the page
Select "**Returning User?**" or "**New User?**"

- **Returning Users:** Login using your username and password
- **New Users:** Select "**Employee ID**" and in the fields below enter
  - Employee ID #: **Your Social Security Number**
  - Group #: **98418**
  - Date of Birth: **Your Date of Birth**

Click "**Continue**" to elect coverage for yourself and your dependents

Note: New users will need to create an account before enrolling

Enroll By Phone: Call (877) 220-1862

Monday - Friday, 8 AM to 8 PM ET

Enroll By Mobile Device:

Text **Staff2019** to **24587**

If you need assistance please call the EmployBridge Benefits Department at (877) 785-5125

Para asistencia en Español llame al (877) 220-1862

YOU WILL NEED THE FOLLOWING INFORMATION TO ENROLL

Associate Information: Full Name, Social Security Number, Date of Birth, Home Address, Phone Number, and Email Address

Dependent Information: Full Name, Social Security Number, and Date of Birth

IMPORTANT BENEFIT INFORMATION

PRETAX PREMIUM DEDUCTIONS (SECTION 125)

Premium for your coverage is deducted from your paycheck on a pretax basis. **By enrolling you agree to the following:**

I hereby elect to participate in The American Worker Plan for benefits made available under the Internal Revenue Code Section 79, 105, 106, 125, and these sections as amended. I understand that the Plan will automatically convert to pretax status any eligible payroll deductions which are provided through the Plan. I understand that by participating in this Plan my Social Security benefits may be reduced since these premiums will be deducted before my salary is taxed. This election will remain in effect for the entire Plan Year. My election CANNOT be changed during the Plan Year in accordance with the Internal Revenue Service Guidelines unless a qualifying event occurs. Qualifying events include: marriage, divorce, legal separation, death of spouse, birth or legal adoption of a child, death of a child, or spousal change of employment affecting insurance coverage.

PAYING FOR YOUR BENEFITS

Your coverage begins the Monday following the date you receive a paycheck with a premium deduction and continues uninterrupted as long as premiums are deducted from your paycheck. If you receive a paycheck without a deduction, your benefits will be suspended until the Monday following the date you receive your next paycheck with a deduction, unless you make a payment for the missed deduction. To avoid having coverage suspended you must pay missed premium every time a deduction is not processed from your paycheck.

MISSED PREMIUM PAYMENTS

You have 30 days from the date of your paycheck without a deduction to make a missed premium payment. If you do not pay for the missed deduction within 30 days, you will not be able to pay for that coverage period at a later date. If you missed a premium deduction and want to find out the balance due or make a payment, visit www.TheAmericanWorker.com or call (877) 220-1862.

You can pay for missed deductions online, by phone or by mail. Payment options include credit or debit card, personal check, and money order. You can also authorize an automatic payment be processed every time premium is not deducted from your paycheck.

IMPORTANT... If you setup automatic payments, you MUST contact The American Worker to cancel the automatic payment when your employment ends. If you do not, your account will be charged for coverage and you will NOT receive a refund.

NONPAYMENT COVERAGE TERMINATION

You must make a premium payment every week, either through payroll deduction or directly to The American Worker using one of the missed premium payment options above. If you do not pay your premium for six weeks in a row, your coverage will be terminated for nonpayment. Please review your paycheck every week to make sure your premium is deducted. If it is not, contact The American Worker immediately to make a payment and avoid having your coverage terminated.

DISCLOSURES

This enrollment guide provides an overview of some of the benefit plans you are eligible for as an EmployBridge associate. If there is any discrepancy between the information in this guide and the applicable official plan documents, the official plan documents will govern how your benefits are determined and administered. EmployBridge, in its sole discretion, reserves the right to amend or terminate at any time the benefit plans described in this enrollment guide.

MED BASIC PLAN

This plan is not comprehensive health insurance and is not intended or recommended to replace comprehensive health insurance in which you currently participate. The plan provides fixed indemnity insurance benefits. This enrollment guide is for summary purposes only. The insurance benefits of the Med Basic Plan are underwritten by Nationwide Life Insurance Company. A detailed Certificate of Coverage is available upon enrollment. **Limitations and exclusions apply.**

The Med Basic Plan (a) is not a substitute for minimum essential health coverage under the Affordable Care Act (ACA), and (b) does not qualify as minimum essential coverage under ACA.

MED ADVANTAGE, MED ADVANTAGE PLUS, MED ENHANCED, & MED ENHANCED PLUS PLANS

These plans are designed to provide Plan Participants with minimum essential coverage under the federal income tax rules. Individuals that do not enroll in these plans may be eligible for a federal tax credit that lowers their monthly premium or a reduction in certain cost-sharing if they enroll in a health insurance plan through the federal or state exchange. Individuals that enroll in these plans may not be eligible for a federal tax credit though a federal or state exchange while enrolled in these plans. **These plans do not provide comprehensive health insurance. Limitations and exclusions apply.**

You can access a Summary of Benefits and Coverage (SBC) for these plans online at www.TheAmericanWorker.com. If you are unable to access the SBC online or want a copy mailed to your home call (877) 220-1862.

TELADOC

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Arkansas and Delaware require initial consultations to be done via video. Idaho requires all consultations are done via video.

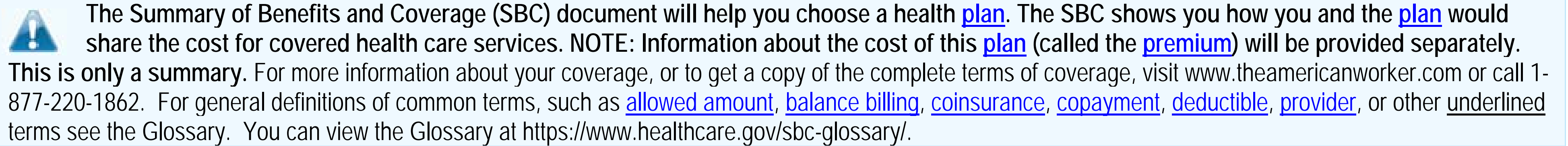
STATE RESTRICTIONS

The benefit plans described in this enrollment guide are not available in all states. Restrictions include but are not limited to the following.

Massachusetts: Residents of Massachusetts are eligible for the Med Basic, Med Advantage, Med Advantage Plus, Med Enhanced and Med Enhanced Plus Plans, but none of these plans meet the individual health insurance requirements and do not satisfy the individual mandate in Massachusetts.

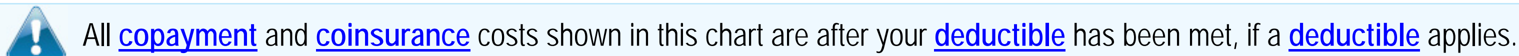
New Hampshire and Vermont: Residents of New Hampshire and Vermont are not eligible for the Med Basic, Med Advantage Plus, Med Enhanced Plus, Short-term Disability or Life and Accident Death & Dismemberment insurance plans.

Hawaii: Residents of Hawaii are not eligible for any of the benefits plans described in this enrollment guide.



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, visit www.theamericanworker.com or call 1-877-220-1862. 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/.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	**Yes.** See www.firsthealthlbp.com or call 1-877-220-1862 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral. NOTE: the only services by a specialist that are covered are preventive services.



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 provider's office or clinic	Primary care visit to treat an injury or illness	Not Covered	Not Covered	---None---
	Specialist visit	Not Covered	Not Covered	---None---
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Certain age restrictions may apply.
If you have a test	Diagnostic test (x-ray, blood work)	Not Covered	Not Covered	---None---
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	---None---
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling 877-220-1862	Generic drugs	Not Covered	Not Covered	FDA approved contraceptive methods as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs).
	Preferred brand drugs	Not Covered	Not Covered	FDA approved contraceptive methods as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs).
	Non-preferred brand drugs	Not Covered	Not Covered	FDA approved contraceptive methods as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs).
	Specialty drugs	Not Covered	Not Covered	---None---
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	---None---
	Physician/surgeon fees	Not Covered	Not Covered	---None---
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	---None---
	Emergency medical transportation	Not Covered	Not Covered	---None---
	Urgent care	Not Covered	Not Covered	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	---None---
	Physician/surgeon fees	Not Covered	Not Covered	---None---

* For more information about limitations and exceptions, see the plan or policy document at www.theamericanworker.com.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Covered	---None---
	Inpatient services	Not Covered	Not Covered	---None---
If you are pregnant	Office visits	Not Covered	Not Covered	Cost sharing does not apply for preventive services
	Childbirth/delivery professional services	Not Covered	Not Covered	---None---
	Childbirth/delivery facility services	Not Covered	Not Covered	---None---
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	---None---
	Rehabilitation services	Not Covered	Not Covered	---None---
	Habilitation services	Not Covered	Not Covered	---None---
	Skilled nursing care	Not Covered	Not Covered	---None---
	Durable medical equipment	Not Covered	Not Covered	---None---
	Hospice services	Not Covered	Not Covered	---None---
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	---None---
	Children's glasses	Not Covered	Not Covered	---None---
	Children's dental check-up	Not Covered	Not Covered	---None---

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Hearing aids
- Mental Health services
- Private-duty nursing
- Weight loss programs
- Bariatric surgery
- Dental care (Adult)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Chiropractic care
- Habilitation services
- Long-term care
- Prescription drugs
- Routine foot care

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

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* For more information about limitations and exceptions, see the plan or policy document at www.theamericanworker.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? No
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 877-220-1862.

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

* For more information about limitations and exceptions, see the plan or policy document at www.theamericanworker.com.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible $0
- Specialist *[cost sharing]* 100%
- Hospital (facility) *[cost sharing]* 100%
- Other *[cost sharing]* 100%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,694
The total Peg would pay is	**$12,694**

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

- The plan's overall deductible $0
- Specialist *[cost sharing]* 100%
- Hospital (facility) *[cost sharing]* 100%
- Other *[cost sharing]* 100%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$7,239
The total Joe would pay is	**$7,239**

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

- The plan's overall deductible $0
- Specialist *[cost sharing]* 100%
- Hospital (facility) *[cost sharing]* 100%
- Other *[cost sharing]* 100%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,925

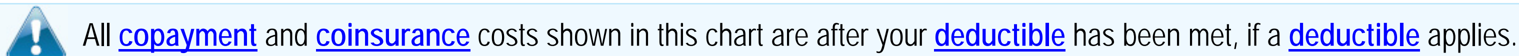
In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,925
The total Mia would pay is	**$1,925**

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

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, visit www.theamericanworker.com or call 1-877-220-1862. 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/.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	**Yes.** See www.firsthealthlbp.com or call 877-220-1862 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral. NOTE: the only services by a specialist that are covered are preventive services.



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 provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/office visit	Not Covered	Combined limit of 4 Visits per Person per Year for all office visits.
	Specialist visit	$75 copay/office visit	Not Covered	Limit of 1 Visit per Person per Year.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Certain age restrictions may apply.
If you have a test	Diagnostic test (x-ray, blood work)	$20 copay/testing day	Not Covered	Combined limit of 4 Testing Days per Person per Year.
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	---None---
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling 877-220-1862	Generic drugs	$15 copay/prescription	Not Covered	Covers up to a 30-day supply (retail subscription); 31-90-day supply (mail order prescription) are Not Covered. Includes FDA approved contraceptive methods as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). Only Generic drugs are covered. Brand and Specialty drugs are Not Covered. Drugs from out-of-network providers are Not Covered
	Preferred brand drugs	Not Covered	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	---None---
	Physician/surgeon fees	Not Covered	Not Covered	---None---
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	---None---
	Emergency medical transportation	Not Covered	Not Covered	---None---
	Urgent care	Not Covered	Not Covered	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	---None---
	Physician/surgeon fees	Not Covered	Not Covered	---None---

* For more information about limitations and exceptions, see the plan or policy document at www.theamericanworker.com.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/office visit; all other Outpatient services Not Covered	Not Covered	Combined limit of 4 Visits per Person per Year for all office visits.
	Inpatient services	Not Covered	Not Covered	---None---
If you are pregnant	Office visits	Not Covered	Not Covered	Cost sharing does not apply for preventive services
	Childbirth/delivery professional services	Not Covered	Not Covered	---None---
	Childbirth/delivery facility services	Not Covered	Not Covered	---None---
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	---None---
	Rehabilitation services	Not Covered	Not Covered	---None---
	Habilitation services	Not Covered	Not Covered	---None---
	Skilled nursing care	Not Covered	Not Covered	---None---
	Durable medical equipment	Not Covered	Not Covered	---None---
	Hospice services	Not Covered	Not Covered	---None---
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	---None---
	Children's glasses	Not Covered	Not Covered	---None---
	Children's dental check-up	Not Covered	Not Covered	---None---

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.)

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- Cosmetic surgery
- Hearing aids
- Mental Health services
- Private-duty nursing
- Weight loss programs
- Bariatric surgery
- Dental care (Adult)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Chiropractic care
- Habilitation services
- Long-term care
- Prescription drugs (other than Generic)
- Routine foot care

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

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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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- Other *[cost sharing]* 100%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$440
Coinsurance	$0
What isn't covered	
Limits or exclusions	$11,451
The total Peg would pay is	$11,891

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

- The plan's overall deductible $0
- Specialist *[cost sharing]* 100%
- Hospital (facility) *[cost sharing]* 100%
- Other *[cost sharing]* 100%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,015
Coinsurance	$0
What isn't covered	
Limits or exclusions	$5,515
The total Joe would pay is	$6,530

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

- The plan's overall deductible $0
- Specialist *[cost sharing]* 100%
- Hospital (facility) *[cost sharing]* 100%
- Other *[cost sharing]* 100%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,925

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$245
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,601
The total Mia would pay is	$1,846

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