




The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-638-2972. 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.dol.gov/ebsa/healthreform or call 1-800-638-2972 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$500/individual	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> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Network preventive care</u> is 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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Medical <u>plan</u> (<u>network</u> and <u>out-of-network providers</u> combined): \$5,000/individual, \$10,000/family; <u>Prescription drugs</u> (in-network): \$1,600/individual, \$3,200/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.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> , health care this <u>plan</u> doesn't cover and <u>cost sharing</u> for non-essential health benefits.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. For <u>network</u> medical <u>providers</u> , see www.carefirst.com or call 1-800-810-2583; for <u>network</u> mental health and substance use disorder <u>providers</u> , see www.beaconhealthoptions.com or call 1-800-353-3572.	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 charge</u> 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.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	30% <u>coinsurance</u>	Not covered	None
	<u>Specialist</u> visit	30% <u>coinsurance</u>	Not covered	None
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	Not covered	Subject to age and frequency guidelines. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	Not covered	Must be provided by Quest or LabCorp.
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	Not covered	None

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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	The greater of \$5 or 5% <u>coinsurance</u>	Not covered at <u>out-of-network</u> pharmacies. Rite Aid, Walmart, Walgreens and CVS are not in the <u>network</u> .	<u>Deductible</u> does not apply. Limit: up to a 30-day supply; mail order up to a 90-day supply.
	Preferred brand drugs	The greater of \$15 or 15% <u>coinsurance</u>	Not covered at <u>out-of-network</u> pharmacies. Rite Aid, Walmart, Walgreens and CVS are not in the <u>network</u> .	If you request a brand name drug when a generic equivalent is available, you will be charged the difference in the cost between the brand name drug and the generic substitute.
	Non-preferred brand drugs	The greater of \$15 or 15% <u>coinsurance</u>	Not covered at <u>out-of-network</u> pharmacies. Rite Aid, Walmart, Walgreens and CVS are not in the <u>network</u> .	Maintenance drugs purchased at retail are subject to reimbursement limitation. Drugs obtained from an out-of-network pharmacy are limited to the in-network allowance.
	<u>Specialty drugs</u>	Same structure as above depending on classification	Not covered at <u>out-of-network</u> pharmacies. Rite Aid, Walmart, Walgreens and CVS are not in the <u>network</u> .	For <u>specialty drugs</u> , you must use Express Scripts' specialty pharmacy. No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required or benefits are not covered.
	Physician/surgeon fees	30% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$75 <u>copay</u> /visit, plus 30% <u>coinsurance</u>	\$75 <u>copay</u> /visit, plus 30% <u>coinsurance</u> , plus <u>balance-billing</u> charges	Professional/physician charges may be billed separately. <u>Copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	100% after <u>plan</u> pays first \$25, plus <u>balance-billing</u> charges	100% after <u>plan</u> pays first \$25, plus <u>balance-billing</u> charges	None
	<u>Urgent care</u>	30% <u>coinsurance</u>	Not covered	None

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 have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required or benefits are not covered. Authorization is required within 24 hours of an emergency admission or benefits are not covered.
	Physician/surgeon fees	30% <u>coinsurance</u>	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required or benefits are not covered. Authorization is required within 24 hours of an emergency admission or benefits are not covered.
	Inpatient services	30% <u>coinsurance</u>	Not covered	
If you are pregnant	Office visits	30% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> does not apply for ACA-required preventive <u>screenings</u> . Depending on the type of services, <u>coinsurance</u> and/or a <u>deductible</u> may apply. Maternity care may include tests and services described somewhere else in the SBC (e.g., ultrasound). Prenatal care (other than ACA-required preventive <u>screenings</u>) is not covered for dependent children. Delivery expenses are not covered for dependent children.
	Childbirth/delivery professional services	30% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required or benefits are not covered.
	<u>Rehabilitation services</u>	30% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required or benefits are not covered. Limit: Thirty (30) inpatient days and sixty (60) outpatient visits per year. Cardiac rehabilitation limited to 90 days per year.
	<u>Habilitation services</u>	Not covered	Not covered	You must pay 100% of these expenses, even <u>in-network</u> .
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	Not covered	None
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required or benefits are not covered. Rental benefit limited to purchase price.
	<u>Hospice services</u>	30% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required or benefits are not covered. Must have life expectancy of 6 months or less.

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 your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limit: One (1) exam every two (2) years.
	Children's glasses	No charge	Not covered	Limit: One (1) pair every two (2) years; limited to certain frames.
	Children's dental check-up	No charge	Reimbursed up to the amount of in-network covered charges in certain limited circumstances	Limit: One (1) exam every six (6) months. Not covered for children under age 4.

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.)		
<ul style="list-style-type: none"> Acupuncture Habilitation services Hearing aids 	<ul style="list-style-type: none"> Infertility treatment Long-term care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Routine foot care Weight loss programs (except as required by the Affordable Care Act)
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Bariatric surgery Chiropractic care (limited to \$1,000 per person per year) 	<ul style="list-style-type: none"> Cosmetic surgery (limited to reconstructive surgery following mastectomy or resulting from traumatic injury) Dental care (Adult) (to plan limits) 	<ul style="list-style-type: none"> Private-duty nursing Routine eye care (Adult)(to plan limits)

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 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: the plan at 1-800-638-2972. You may also contact the 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? 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.

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

About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist coinsurance</u>	30%
■ <u>Hospital (facility) coinsurance</u>	30%
■ <u>Other coinsurance</u>	30%

This **EXAMPLE** event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$3,590
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,150

Managing Joe's type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist coinsurance</u>	30%
■ <u>Hospital (facility) coinsurance</u>	30%
■ <u>Other coinsurance</u>	30%

This **EXAMPLE** event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,530
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,030

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist coinsurance</u>	30%
■ <u>Hospital (facility) coinsurance</u>	30%
■ <u>Other 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*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$80
<u>Coinsurance</u>	\$440
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,020