




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](http://www.dol.gov/ebsa/healthreform) or call 1-800-638-2972 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	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 <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>	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> ( <u>in-network</u> ): \$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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. For <u>network medical providers</u> , see <a href="http://www.carefirst.com">www.carefirst.com</a> or call 1-800-810-2583; for <u>network mental health and substance use disorder providers</u> , see <a href="http://www.beaconhealthoptions.com">www.beaconhealthoptions.com</a> 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.

Important Questions	Answers	Why This Matters:
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</u> office or clinic	Primary care visit to treat an injury or illness	25% <u>coinsurance</u>	Not covered	None
	<u>Specialist</u> visit	25% <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)	25% <u>coinsurance</u>	Not covered	Must be provided by Quest or LabCorp.
	Imaging (CT/PET scans, MRIs)	25% <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)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	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: Retail up to a 30-day supply; mail order up to a 90-day supply.  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.  Maintenance drugs purchased at retail are subject to reimbursement limitation.
	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.
	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> .	Drugs obtained from an <u>out-of-network</u> pharmacy are limited to the <u>in-network</u> 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 ACA-required generic preventive drugs (e.g., contraceptives) or a brand name preventive drug if a generic is not medically appropriate.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required or benefits are not covered.
	Physician/surgeon fees	25% <u>coinsurance</u>	Not covered	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$75 <u>copay</u> per visit, plus 25% <u>coinsurance</u>	\$75 <u>copay</u> per visit, plus 20% <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 \$200 per trip, plus <u>balance-billing</u> charges	100% after <u>plan</u> pays first \$200 per trip, plus <u>balance-billing</u> charges	None
	<u>Urgent care</u>	25% <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)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	25% <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	25% <u>coinsurance</u>	Not covered	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	25% <u>coinsurance</u>	Not covered	None
	Inpatient services	25% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required or no benefits are covered. Authorization is required within 24 hours of an emergency admission or benefits are not covered.
<b>If you are pregnant</b>	Office visits	25% <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	25% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	25% <u>coinsurance</u>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	25% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required or benefits are not covered.
	<u>Rehabilitation services</u>	25% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required or benefits are not covered. Limit: 30 inpatient days/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>	25% <u>coinsurance</u>	Not covered	None
	<u>Durable medical equipment</u>	25% <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>	25% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required or benefits are not covered. Must have life expectancy of 6 months or less.
<b>If your child needs dental or eye care</b>	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 <u>in-network</u> 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"><li>• Acupuncture</li><li>• <u>Habilitation services</u></li><li>• Hearing aids</li></ul>	<ul style="list-style-type: none"><li>• Infertility treatment</li><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Routine foot care</li><li>• Weight loss programs (except as required by the Affordable Care Act)</li></ul>
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"><li>• Bariatric surgery</li><li>• Chiropractic care (limited to \$1,000 per person per year)</li></ul>	<ul style="list-style-type: none"><li>• Cosmetic surgery (limited to reconstructive surgery following mastectomy or resulting from traumatic injury)</li><li>• Dental care (Adult) (to <u>plan</u> limits)</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine eye care (Adult)(to <u>plan</u> limits)</li></ul>

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

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the plan at 1-800-638-2972. 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](http://www.dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*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 deductible \$500
- Specialist coinsurance 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

This EXAMPLE event includes services like:

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

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

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,930
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,490</b>

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

- The plan's overall deductible \$500
- Specialist coinsurance 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

This EXAMPLE event includes services like:

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

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

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,080
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,580</b>

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

- The plan's overall deductible \$500
- Specialist coinsurance 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

This EXAMPLE event includes services like:

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

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

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$80
<u>Coinsurance</u>	\$870
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,450</b>