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, [insert contact information]. 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.[insert].com or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0.00	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 does not have any deductible. But a copayment or coinsurance may apply.
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?	No.	This plan does not cover medical providers; only prescription drug benefits.
Do you need a referral to see a specialist?	Not Applicable.	This plan does not cover medical providers (including specialists); only prescription drug benefits.

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	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
	Specialist visit	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
	Preventive care/screening/ immunization	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
If you have a test	Diagnostic test (x-ray, blood work)	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
	Imaging (CT/PET scans, MRIs)	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.associated-admin.com	Generic drugs	Not Applicable.	Not Applicable.	$10 copay per prescription (participating pharmacy); $20 copay per prescription (mail order 90-day supply)
	Preferred brand drugs	Not Applicable.	Not Applicable.	$25 copay per prescription (participating pharmacy); $50 copay per prescription (mail order 90-day supply)
	Non-preferred brand drugs	Not Applicable.	Not Applicable.	$45 copay per prescription (participating pharmacy); $90 copay per prescription (mail order 90-day supply).
	Specialty drugs	Not Applicable.	Not Applicable.	Coverage requires prior authorization: (1) weight loss drugs; (2) Dexedrine, Adderal, and Desoxyn (if participant is age 22 or older). Coverage limited to six tablets per month: erectile dysfunction drugs. Drugs/agents not covered: (1) injectables (except insulin and contraceptives); (2) immunological drugs/agents; (3) smoking cessation drugs; (4) appliances or devices (such as glucose monitors). Coverage limited to $5,000 per prescription: drugs designed to cure hepatitis C.

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)	
	Diabetic supplies	Not Applicable.	Not Applicable.	$50 copay per product (or actual cost of product, if less than $50). Covered only if purchased through mail order program. Needles required for Byetta and Symlin require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
	Physician/surgeon fees	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
If you need immediate medical attention	Emergency room care	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
	Emergency medical transportation	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
	Urgent care	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
	Physician/surgeon fees	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
	Inpatient services	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
If you are pregnant	Office visits	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
	Childbirth/delivery professional services	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
	Childbirth/delivery facility services	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
If you need help recovering or have other special health needs	Home health care	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
	Rehabilitation services	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
	Habilitation services	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
	Skilled nursing care	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
	Durable medical equipment	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
	Hospice services	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
If your child needs dental or eye care	Children's eye exam	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
	Children's glasses	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.
	Children's dental check-up	Not Applicable.	Not Applicable.	Plan only covers prescription drugs.

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
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: Associated Administrators, LLC, 911 Ridgebrook Rd., Sparks, MD 21152, 1-800-638-2972, http://www.associated-admin.com. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. You may also contact Maryland consumer assistance program: Maryland Office of the Attorney General, Health Education and Advocacy Unit, 200 St. Paul Place, 16th Floor, Baltimore, MD 21202, (877) 261-8807, http://www.oag.state.md.us/Consumer.HEAU.htm.

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.

* For more information about limitations and exceptions, see the plan or policy document at http://www.associated-admin.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	$500
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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	$500
Copayments	$300
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,160**

***The condition and treatments in the above example do not include prescription drugs. The Plan only covers prescription drugs. Therefore, the Plan would not cover any of the costs set forth in this example.**

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 *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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	$800
Copayments	$1,200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,360**

+This example includes prescription drugs, subject to co-pays noted on pages 2 and 3 above.

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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**
***In this example, Mia would pay:**	
Cost Sharing	
Deductibles	$700
Copayments	$50
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,050**

***The condition and treatments in the above example do not include prescription drugs. The Plan only covers prescription drugs. Therefore, the Plan would not cover any of the costs set forth in this example.**