




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, see [www.associated-admin.com](http://www.associated-admin.com) or 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>	<b>\$200/individual</b>	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: plan ( <u>network</u> and <u>out-of-network providers</u> combined): <b>\$4,000/individual, \$8,000/family</b> ; <u>Prescription drugs</u> ( <u>in-network</u> ): <b>\$2,600/individual, \$5,200/family</b> .	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 to the extent permitted by law, 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</u> medical <u>providers</u> , see <a href="http://www.carefirst.com">www.carefirst.com</a> or call 1-800-810-2583; for <u>network</u> mental health and substance use disorder <u>providers</u> , see <a href="http://www.carelonbehavioralhealth.com">www.carelonbehavioralhealth.com</a> or call 1-800-454-8329.	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 provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	Not covered	None
	<u>Specialist</u> visit	20% <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)	20% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% <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.optumrx.com">www.optumrx.com</a>	Generic drugs	8% <u>coinsurance</u> at Shopper's or Kroger pharmacies; 13% <u>coinsurance</u> at other <u>network</u> pharmacies	Not covered	Retail limited to up to a 34-day supply; mail order limited to up to a 100-day supply. Certain drugs have other dispensing limits. If you request a brand name drug when a generic equivalent is available, you will pay the full cost of the brand name drug. No charge for ACA-required generic preventive drugs (e.g., contraceptives) or a brand name preventive drug if a generic is not medically appropriate. Certain <u>prescription drugs</u> require <u>preauthorization</u> or no benefits are provided. Certain <u>specialty drugs</u> must be ordered by phone through OptumRx Specialty Pharmacy.
	Brand drugs	8% <u>coinsurance</u> at Shopper's or Kroger pharmacies; 13% <u>coinsurance</u> at other <u>network</u> pharmacies, provided there is no generic equivalent	Not covered	
	<u>Specialty drugs</u>	8% <u>coinsurance</u>	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> through Conifer is required or no benefits are provided.
	Physician/surgeon fees	20% <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 20% <u>coinsurance</u>	\$75 <u>copay</u> per visit, plus 20% <u>coinsurance</u>	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	100% after <u>plan</u> pays first \$25 for air ambulance services; 100% after <u>plan</u> pays first \$25, plus <u>balance-billing</u> charges to the extent permitted by law for all other <u>emergency medical transportation</u>	20% <u>coinsurance</u> for hospital-to-hospital transfers.
	<u>Urgent care</u>	20% <u>coinsurance</u>	Not covered	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> through Conifer is required or no benefits are provided. Authorization is required within 24 hours of an emergency admission or no benefits are provided.
	Physician/surgeon fees	20% <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 mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <u>coinsurance</u>	Not covered	None
	Inpatient services	20% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> through Carelon is required or no benefits are provided. Authorization is required within 24 hours of an emergency admission or no benefits are provided.
<b>If you are pregnant</b>	Office visits	20% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> does not apply for ACA-required preventive <u>screenings</u> . 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	20% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> through Conifer is required or no benefits are provided.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> through Conifer is required or no benefits are provided. Limited to 30 inpatient days and 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>	20% <u>coinsurance</u>	Not covered	None
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> through Conifer is required or no benefits are provided. Rental cost limited to amount of purchase cost.
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> through Conifer is required or no benefits are provided. 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)	
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge through Group Vision Service provider. <u>Deductible</u> does not apply.	Not covered	Limited to one exam every 2 years.
	Children's glasses	No charge through Group Vision Service provider. <u>Deductible</u> does not apply.	Not covered	Limited to one pair every 2 years; limited to certain frames.
	Children's dental check-up	No charge through Dentegra provider. <u>Deductible</u> does not apply.	Reimbursed up to the amount of <u>in-network</u> covered charges in certain limited circumstances	Limited to one exam every 6 months. Not covered for children under age 4.

\* To the extent required under the federal No Surprises Act, out-of-network provider services will be covered at the copay and coinsurance rates applicable to in-network provider services, and balance billing will not apply.

## 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 <u>excluded services</u> .)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• <u>Habilitation services</u></li><li>• Infertility treatment</li></ul>	<ul style="list-style-type: none"><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 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>• Hearing aids (discount program only through EPIC Hearing Healthcare)</li><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.

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-638-2972.

*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                    \$200
- Specialist coinsurance                            20%
- Hospital (facility) coinsurance                20%
- Other coinsurance                                 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*)

<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>	\$200
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,660</b>

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

- The plan's overall deductible                    \$200
- Specialist coinsurance                            20%
- Hospital (facility) coinsurance                20%
- Other coinsurance                                 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*)

<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>	\$200
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$590
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$790</b>

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

- The plan's overall deductible                    \$200
- Specialist coinsurance                            20%
- Hospital (facility) coinsurance                20%
- Other coinsurance                                 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*)

<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>	\$200
<u>Copayments</u>	\$80
<u>Coinsurance</u>	\$1,070
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,350</b>