



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 1-800-242-8923. 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://healthcare.gov/sbc-glossary> or call 1-800-242-8923 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$300/individual; \$600/family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive services</a> , <a href="#">prescription drugs</a> dental services and urgent care center services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, the <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before your meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$1,500/person, \$3,000/family combined medical and <a href="#">prescription drugs</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. For a list of <a href="#">Network</a> providers, see <a href="http://www.carefirst.com">www.carefirst.com</a> or call 1-800-626-0173 or 410-581-3660.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	---none---
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	---none---
	<a href="#">Preventive care/screening/immunization</a>	No Charge. <a href="#">Deductible</a> does not apply.	No charge up to \$500 annual family maximum, then <a href="#">deductible</a> and 30% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> covers.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Certain services received from <a href="#">non-network providers</a> while at an in- <a href="#">network</a> facility may be covered as in- <a href="#">network</a>
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs	Retail: \$15 <a href="#">copay</a> /script Mail Order: \$30 <a href="#">copay</a> /script	Same as in- <a href="#">network</a> plus any <a href="#">balance billing</a>	Retail: limited to up to a 30-day supply; Mail Order: limited to up to a 90-day supply. Certain drugs may require <a href="#">prior authorization</a> . Coverage for <a href="#">non-network</a> pharmacies is limited to the amount that would have been paid had the prescription been obtained in- <a href="#">network</a> . Specialty Drugs through the CVS Caremark Specialty Pharmacy only.
	Preferred Brand name drugs	Retail: \$30 <a href="#">copay</a> /script Mail Order: \$60 <a href="#">copay</a> /script	Same as in- <a href="#">network</a> plus any <a href="#">balance billing</a>	
	Non-Preferred Brand Drugs	Retail: \$50 <a href="#">copay</a> ; Mail Order: \$100 copay	Same as in- <a href="#">network</a> plus any <a href="#">balance billing</a>	
	Specialty Drugs	20% co-insurance; \$250 maximum	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Certain services received from <a href="#">non-network providers</a> while at an in- <a href="#">network</a> facility may be covered as in- <a href="#">network</a>
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	Covered as in- <a href="#">network</a>	---none---
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	Covered as in- <a href="#">network</a>	---none---

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Urgent care</a>	No Charge. <a href="#">Deductible</a> does not apply.	No Charge. <a href="#">Deductible</a> does not apply.	Emergency services provided at a <a href="#">non-network</a> Urgent Care center licensed to operate as a freestanding emergency department may be covered as in- <a href="#">network</a> .
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required; failure to obtain <a href="#">preauthorization</a> will result in denial of benefits.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Certain services received from <a href="#">non-network providers</a> while at an in- <a href="#">network</a> facility may be covered as in- <a href="#">network</a> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	---none---
	Inpatient services	20% <a href="#">coinsurance</a> based on average semi-private room rate	30% <a href="#">coinsurance</a> based on average semi-private room rate	<a href="#">Preauthorization</a> required; failure to obtain <a href="#">preauthorization</a> will result in denial of benefits. Certain services received from <a href="#">non-network providers</a> while at an in- <a href="#">network</a> facility may be covered as in- <a href="#">network</a> .
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Certain prenatal services may be covered under the <a href="#">preventive care</a> benefit outlined on page 2. Expectant mothers should participate in the Maternity Management Program by contacting American Health Holding at 1-800-641-3224 and selecting option 3 when prompted.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> based on average semi-private room rate	30% <a href="#">coinsurance</a> based on average semi-private room rate	No coverage for dependent child pregnancy, except for mandated <a href="#">preventive services</a> . Certain services received from <a href="#">non-network providers</a> while at an in- <a href="#">network</a> facility may be covered as in- <a href="#">network</a> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Care must commence within 7 days following hospital confinement; limited to 30 visits per calendar year; services provided by a social worker and services not included in home health care plan are not covered.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	---none---
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	---none---
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Limited to 120 days per confinement.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Limited to rental of equipment or, if more economical, purchase.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Inpatient services limited to \$3,000 per period of care; outpatient services limited to \$2,000 per period of care; must have life expectancy of 6 months or less.
If your child needs dental or eye care	Children's eye exam	No Charge. <a href="#">Deductible</a> does not apply.	Charges in excess of \$40.	Limited to one exam per calendar year.
	Children's glasses	No Charge for lenses. All Charges in excess of \$130 for frames. <a href="#">Deductible</a> does not apply.	Charges in excess of \$40 (single vision lenses); \$45 (frames); <a href="#">Deductible</a> does not apply.	Limited to one set (pair) of frames and lenses or contacts per calendar year.
	Children's dental check-up	No Charge. <a href="#">Deductible</a> does not apply.	Coverage limited to Allowed Amount. <a href="#">Deductible</a> does not apply.	---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](#).)

- Cosmetic surgery, except to repair disfigurement caused by an accident, cleft lip/cleft palette or where required by law
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pregnancy of dependent child, except for mandated preventive services
- 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.)

- Acupuncture
- Bariatric surgery (generally must have had a body mass index (BMI) of 40 or greater for at least the last 24 months and must meet other criteria)
- Chiropractic care
- Dental care (Adult) (limited to \$2,000 per family per calendar year)
- Hearing Aids (limited to \$2,000 per ear every 2 years for individuals 18 and under; generally limited to \$2,000 per ear every 5 years for individuals 19 and older)
- Infertility treatments (limited to diagnostic infertility tests to determine the condition, and treatment of the condition causing infertility)
- Private-duty nursing
- Routine eye care (Adult) subject to annual limits and corrective vision products

**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 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 1-800-242-8923 or 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 1-800-242-8923.

*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](#) \$300
- [Specialist coinsurance](#) \$0
- 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>
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,190
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,560</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$300
- [Specialist coinsurance](#) \$0
- 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>
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$950
<a href="#">Coinsurance</a>	\$180
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,430</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$300
- [Specialist coinsurance](#) \$0
- 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>
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles*</a>	\$300
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$500
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$810</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.