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 deductible?	**$200**/individual; **$400**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services, prescription drugs dental services and urgent care center services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, the plan covers certain preventive services without cost-sharing and before your meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$1,000**/person, **$2,000**/family combined medical and prescription drugs.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billing and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of Network providers, see www.carefirst.com or call 1-800-626-0173 or 410-581-3660.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	---none---
	Specialist visit	10% coinsurance	30% coinsurance	---none---
	Preventive care/screening/ immunization	No Charge. Deductible does not apply.	No charge up to $500 annual family maximum, then deductible and 30% coinsurance plus any balance billing	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan covers.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Certain services received from non-network providers while at an in-network facility may be covered as in-network
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	Retail: $15 copay/script Mail Order: $30 copay/script	Same as in-network plus any balance billing	Retail: limited to up to a 30-day supply; Mail Order: limited to up to a 90-day supply. Certain drugs may require prior authorization. Coverage for non-network pharmacies is limited to the amount that would have been paid had the prescription been obtained in-network.
	Preferred Brand name drugs	Retail: $30 copay/script Mail Order: $60 copay/script	Same as in- network plus any balance billing	
	Non-Preferred Brand Drugs	Retail: $50 copay; Mail Order: $100 copay	Same as in- network plus any balance billing	
	Specialty Drugs	20% co-insurance; $250 maximum	Not covered	Specialty Drugs through the CVS Caremark Specialty Pharmacy only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Certain services received from non-network providers while at an in-network facility may be covered as in-network
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copay/visit. Deductible does not apply	Covered as in-network	$150 copay/visit waived if admitted to the hospital from the ER.
	Emergency medical transportation	10% coinsurance	Covered as in-network	---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)	
	Urgent care	No Charge. Deductible does not apply.	No Charge. Deductible does not apply.	Emergency services provided at a non-network Urgent Care center licensed to operate as a freestanding emergency department may be covered as in-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization required; failure to obtain preauthorization will result in denial of benefits. Certain services received from non-network providers while at an in-network facility may be covered as in-network.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	---none---
	Inpatient services	10% coinsurance based on average semi-private room rate	30% coinsurance based on average semi-private room rate	Preauthorization required; failure to obtain preauthorization will result in denial of benefits. Certain services received from non-network providers while at an in-network facility may be covered as in-network.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Certain prenatal services may be covered under the preventive care 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. No coverage for dependent child pregnancy, except for mandated preventive services. Certain services received from non-network providers while at an in-network facility may be covered as in-network.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance based on average semi-private room rate	30% coinsurance based on average semi-private room rate	

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	Home health care	10% coinsurance	30% coinsurance	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.
	Rehabilitation services	10% coinsurance	30% coinsurance	---none---
	Habilitation services	10% coinsurance	30% coinsurance	---none---
	Skilled nursing care	10% coinsurance	30% coinsurance	Limited to 120 days per confinement.
	Durable medical equipment	10% coinsurance	30% coinsurance	Limited to rental of equipment or, if more economical, purchase.
	Hospice services	10% coinsurance	30% coinsurance	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. Deductible 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. Deductible does not apply.	Charges in excess of $40 (single vision lenses); $45 (frames); Deductible does not apply.	Limited to one set (pair) of frames and lenses or contacts per calendar year.
	Children's dental check-up	No Charge. Deductible does not apply.	Coverage limited to Allowed Amount. Deductible 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 $4,000 per family per calendar year)
- Hearing Aids (limited to $3,000 per ear every 2 years for individuals 18 and under; generally limited to $3,000 per ear every 5 years for individuals 19 and older)
- Infertility treatments (limited to $100,000 lifetime maximum)
- 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. 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 1-800-242-8923 or 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.
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	$200
Specialist coinsurance	$0
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$10
Coinsurance	$790
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,060**

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	$0
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,000**

Mia's Simple Fracture

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

The plan's overall deductible	$200
Specialist coinsurance	$0
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$200
Copayments	$160
Coinsurance	$140
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

The plan would be responsible for the other costs of these EXAMPLE covered services.