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,contact 1-888-805-7996. 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.healthcare.gov/sbc-glossary.com or call 1-888-494-4443 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Annual** **$100 Individual / $200 Family**	You must pay all of the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to seen when the **deductible** starts over (usually, but not always January 1). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	**Yes**	Preventive care services do not require you to meet the **deductible**.
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?	**Medical: $600**/IND; **$1,200** FAM	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	**Premiums, balance-billing charges 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 preferred providers, visit www.carefirst.com or call **1-800-367-3387**.	This plan uses a preferred provider network. You will pay the most if you use a non-preferred 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. You will pay less if you choose a preferred provider specialist.

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
		Preferred 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% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
	Specialist visit	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
	Preventive care/screening/ immunization	$0	$0 up to allowed amount	Immunizations as recommended by the Department of Health & Human Services
If you have a test	Diagnostic test (x-ray, blood work)	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
	Imaging (CT/PET scans, MRIs)	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
If you need drugs to treat your illness or condition	Generic drugs	Not covered	Not covered	
	Preferred brand drugs	Not covered	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
	Physician/surgeon fees	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
If you need immediate medical attention	Emergency room care	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Covered ONLY for accidental injury within 48 hours or life-threatening illness within 12 hours of onset of illness
	Emergency medical transportation	20% up to $2,500, $0 thereafter	$20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
	Urgent care	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Pre-authorization **required –** call **Conifer Health Solutions @ 1-866-308-7335.**
	Physician/surgeon fees	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
	Inpatient services	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Pre-authorization **required –** call **Conifer Health Solutions @ 1-866-308-7335.**
If you are pregnant	Office visits	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	**Pre-natal care only for dependent children.**. Charges above allowed amount are your responsibility.
	Childbirth/delivery professional services	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	**Members and spouses only**. Charges above allowed amount are your responsibility.
	Childbirth/delivery facility services	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	**Members and spouses only**. Charges above allowed amount are your responsibility.
If you need help recovering or have other special health needs	Home health care	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
	Rehabilitation services	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Annual limit of 50 visits combined for PT / OT / Speech therapy
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
	Durable medical equipment	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
	Hospice services	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Pre-authorization **required –** call **Conifer Health Solutions @ 1-866-308-7335**
If your child needs dental or eye care	Children's eye exam	$0	$0 up to allowed amount	Charges above allowed amount are your responsibility
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	$0 up to allowed amount	Amount above plan allowance	Charges above allowed amount are your responsibility

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.)

- Bariatric Surgery –unless medically necessary
- Cosmetic Surgery
- Dental Care (separate plan)
- Habilitation services
- Hearing aids – only covered for minor children
- Infertility treatment
- Long-term care
- 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.)

- Acupuncture
- Hearing aids – Minor Children 21 years of age or younger.
- Non-emergency care outside U.S.
- Private duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-888-494-4443. You may also contact the Department of Labor Employee Benefits Security Administration at 1-866-444-3272 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 1-888-494-4443. For more information about your rights, this notice, or assistance, contact the plan at 443-573-3632 or 1-866-621-7974. You may also contact the U.S. Department of Labor, Benefits Security Administration (1-866-444-3272 or www.dol.gov/ebsa) or the U.S. Department of Health and Human Services (1-877-267-2323 X61565 or www.cciio.cms.gov)

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.

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	$100
Specialist *[cost sharing]*	20%
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	**$12,035**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$96
The total Peg would pay is	**$696**

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

The plan's overall deductible	$100
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	100%

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	**$2,476**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$4,313
The total Joe would pay is	**$4,913**

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

The plan's overall deductible	$100
Specialist *[cost sharing]*	20%
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	**$1,440**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$485**

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