
 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 1-888-494-4443. 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](http://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 <a href="#">deductible</a> ?	Annual \$100 Individual / \$200 Family	You must pay all of the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes	Preventive care services do not require you to meet the <u>deductible</u> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Medical: \$600/IND; \$1,200 FAM Rx: \$5,800IND/ \$11,600 FAM	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 <a href="#">plan</a> , 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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. For a list of preferred providers, visit <a href="http://www.carefirst.com">www.carefirst.com</a> or call 1-800-367-3387.	This <a href="#">plan</a> uses a <u>preferred provider network</u> . You will pay the most if you use a <u>non-preferred provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <a href="#">plan</a> pays (balance billing). Be aware, your <a href="#">network provider</a> might use an <u>out-of-network provider</u> 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 <u>specialist</u> you choose without a referral. You will pay less if you choose a <u>preferred provider specialist</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
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	<a href="#">Primary care</a> 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
	<a href="#">Specialist</a> visit	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Charges above allowed amount are your responsibility
	<a href="#">Preventive care/screening/immunization</a>	\$0	\$0 up to allowed amount	Immunizations as recommended by the Department of Health & Human Services
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (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
	<a href="#">Imaging</a> (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
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>	<a href="#">Generic drugs</a>	\$15 copay retail \$30 copay mail order	N/A	Retail up to a 30 day supply; 31-90 day supply mandatory mail order
	<a href="#">Preferred brand drugs</a>	\$35 copay retail \$70 copay mail order	N/A	Retail up to a 30 day supply; 31-90 day supply mandatory mail order
	<a href="#">Non-preferred brand drugs</a>	\$50 copay retail \$100 copay mail order	N/A	Retail up to a 30 day supply; 31-90 day supply mandatory mail order
	<a href="#">Specialty drugs</a>	Varies by drug – see above copays	N/A	Limited list of injectable drugs. Contact Optum @ <b>1-800-788-4863</b>
<b>If you have outpatient surgery</b>	<a href="#">Facility fee</a> (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
	<a href="#">Physician/surgeon fees</a>	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Charges above allowed amount are your responsibility
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	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
	<a href="#">Emergency medical transportation</a>	20% up to \$2,500, \$0 thereafter	\$20% up to \$2,500, \$0 thereafter	Charges above allowed amount are your responsibility
	<a href="#">Urgent care</a>	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Charges above allowed amount are your responsibility
<b>If you have a hospital</b>	<a href="#">Facility fee</a> (e.g., hospital room)	20% up to \$2,500,	20% up to \$2,500,	Pre-authorization <b>required</b> – call <b>Conifer</b>

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)	
stay		\$0 thereafter	\$0 thereafter	<b>Health Solutions @ 1-866-308-7335.</b>
	<a href="#">Physician/surgeon fees</a>	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	<a href="#">Outpatient services</a>	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Charges above allowed amount are your responsibility
	<a href="#">Inpatient services</a>	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Pre-authorization required – call <b>Conifer Health Solutions @ 1-866-308-7335.</b>
If you are pregnant	<a href="#">Office visits</a>	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	<b>Pre-natal care only for dependent children.</b> Charges above allowed amount are your responsibility.
	<a href="#">Childbirth/delivery professional services</a>	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	<b>Members and spouses only.</b> Charges above allowed amount are your responsibility.
	<a href="#">Childbirth/delivery facility services</a>	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	<b>Members and spouses only.</b> Charges above allowed amount are your responsibility.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Charges above allowed amount are your responsibility
	<a href="#">Rehabilitation services</a>	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
	<a href="#">Habilitation services</a>	Not Covered	Not Covered	
	<a href="#">Skilled nursing care</a>	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Charges above allowed amount are your responsibility
	<a href="#">Durable medical equipment</a>	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Charges above allowed amount are your responsibility
	<a href="#">Hospice services</a>	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Pre-authorization required – call <b>Conifer Health Solutions @ 1-866-308-7335</b>
If your child needs dental or eye care	<a href="#">Children's eye exam</a>	\$0	\$0 up to allowed amount	Charges above allowed amount are your responsibility
	<a href="#">Children's glasses</a>	Not covered	Not covered	
	<a href="#">Children's dental check-up</a>	\$0 up to allowed amount	Amount above <u>plan</u> 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
- 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](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 1-888-494-4443. 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](http://www.dol.gov/ebsa)) or the U.S. Department of Health and Human Services (1-877-267-2323 X61565 or [www.cciio.cms.gov](http://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*)

<b>Total Example Cost</b>	<b>\$12,071</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$0
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$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](#) \$100
- [Specialist](#) [*cost sharing*] 20%
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] \$15

#### 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>\$6,751</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$260
Coinsurance	\$240
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$655</b>

### 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*)

<b>Total Example Cost</b>	<b>\$1,440</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$0
Coinsurance	\$385
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$485</b>