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 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 or call 1-800-638-2972 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$100**/individual	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.
Are there services covered before you meet your deductible?	Yes. Basic Benefits, prescription drugs, dental and vision 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.
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?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.carefirst.com. Call 1-800-235-5160 for a list of network providers in MD/DC/Northern VA or call 1-800-810-2583 for a list of network providers outside MD/DC/Northern VA.	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
		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% coinsurance	20% coinsurance, plus balance-billing charges	None
	Specialist visit	20% coinsurance	20% coinsurance, plus balance-billing charges	None
	Preventive care/screening/ immunization	Physical exam: no charge up to $50 Basic Benefit, then 20% coinsurance. Well-child care: no charge up to Basic Benefit, then 100%	Physical exam: no charge up to $50 Basic Benefit, then 20% coinsurance, plus balance-billing charges. Well-child care: no charge up to Basic Benefit, then 100%, plus balance-billing charges	Basic Benefit for physical exam is for employee only and is limited to once every 24 months. Well-child care is limited to 8 visits through age 5.
If you have a test	Diagnostic test (x-ray, blood work)	Inpatient: No charge up to $300, then 25% of next $2,000 (both Basic Benefits), then 20% coinsurance. Outpatient: No charge up to $150 Basic Benefit per year, then 20% coinsurance	Inpatient: No charge up to $300, then 25% of next $2,000 (both Basic Benefits), then 20% coinsurance, plus balance-billing charges. Outpatient: No charge up to $150 Basic Benefit per year, then 20% coinsurance, plus balance-billing charges	None
	Imaging (CT/PET scans, MRIs)	Inpatient: No charge up to $300, then 25% of next $2,000 (both Basic Benefits), then 20% coinsurance. Outpatient: No charge up to $150 Basic Benefit per year, then 20% coinsurance	Inpatient: No charge up to $300, then 25% of next $2,000 (both Basic Benefits), then 20% coinsurance, plus balance-billing charges. Outpatient: No charge up to $150 Basic Benefit per year, then 20% coinsurance, plus balance-billing charges	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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	$.50 copay per prescription	Not covered	Deductible does not apply. Limited to up to a 34-day supply (100-day supply for maintenance drugs). Certain drugs have other dispensing limits. Certain prescription drugs require preauthorization or no benefits are provided. Certain specialty drugs must be ordered by phone through Briova Specialty Pharmacy.
	Preferred brand drugs	$.50 copay per prescription	Not covered	
	Non-preferred brand drugs	$.50 copay per prescription	Not covered	
	Specialty drugs	$.50 copay per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge up to $200 Basic Benefit, then 20% coinsurance	No charge up to $200 Basic Benefit, then 20% coinsurance, plus balance-billing charges	Preauthorization required or no benefits provided.
	Physician/surgeon fees	Surgery: No charge up to maximum Basic Benefit (according to Surgical Schedule), then 20% coinsurance. Non-surgery: 20% coinsurance	Surgery: No charge up to maximum Basic Benefit (according to Surgical Schedule), then 20% coinsurance, plus balance-billing charges. Non-surgery: 20% coinsurance, plus balance-billing charges	Second surgical opinion required for certain surgeries or only 75% of allowed amount is considered.
If you need immediate medical attention	Emergency room care	No charge up to $200 Basic Benefit, then 20% coinsurance	No charge up to $200 Basic Benefit, then 20% coinsurance, plus balance-billing charges	Must be for an actual medical emergency. Professional/physician charges may be billed separately.
	Emergency medical transportation	20% coinsurance, plus balance-billing charges	20% coinsurance, plus balance-billing charges	Limited to local ambulance services to and from hospital.
	Urgent care	20% coinsurance in urgent care setting	20% coinsurance in urgent care setting, plus balance-billing charges	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge up to Basic Benefit of $180 per day for up to 70 days per disability, then 20% coinsurance	No charge up to Basic Benefit of $180 per day for up to 70 days per disability, then 20% coinsurance, plus balance-billing charges	Elective admissions must be preauthorized and emergency admissions must be authorized within 24 hours of admission or no benefits provided.

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)	
	Physician/surgeon fees	No charge up to $20 per visit Basic Benefit, then 20% coinsurance	No charge up to $20 per visit Basic Benefit, then 20% coinsurance, plus balance-billing charges	Second surgical opinion required for certain surgeries or only 75% of allowed amount is considered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance, plus balance-billing charges	None
	Inpatient services	Mental/behavioral health: No charge up to 30 days/year for semi-private room and board, 20% coinsurance for miscellaneous charges and room and board in excess of 30 days; Substance abuse services: No charge up to 7 days/year for detox or 30 days/year for rehabilitation for semi-private room and board, 20% coinsurance for miscellaneous charges and room and board in excess of 30 days	20% coinsurance, plus balance-billing charges	Elective admissions must be preauthorized and emergency admissions must be authorized within 24 hours of admission or no benefits provided.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance, plus balance-billing charges	Not covered for dependent children. Maternity care may include tests and services described somewhere else in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance, plus balance-billing charges	Not covered for dependent children. Maternity care may include tests and services described somewhere else in the SBC (e.g., ultrasound).
	Childbirth/delivery facility services	No charge up to Basic Benefit of $180 per day for up to 70 days per disability, then 20% coinsurance	No charge up to Basic Benefit of $180 per day for up to 70 days per disability, then 20% coinsurance, plus balance-billing charges	

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 need help recovering or have other special health needs	Home health care	No charge for services provided through HomeCare Program	Not covered	Preauthorization required or no benefits provided. Care must be in lieu of hospitalization.
	Rehabilitation services	No charge for up to 30 inpatient visits or 60 outpatient visits per injury/sickness	No charge for up to 30 inpatient visits or 60 outpatient visits per injury/sickness, plus balance-billing charges	Preauthorization required or no benefits provided. Limited to 30 inpatient days and 60 outpatient visits per year; cardiac rehab limited to 90 days per year. Speech and occupational therapy not covered.
	Habilitation services	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
	Skilled nursing care	20% coinsurance	20% coinsurance, plus balance-billing charges	Preauthorization required or no benefits provided.
	Durable medical equipment	20% coinsurance	20% coinsurance, plus balance-billing charges	Covers rental or, at the plan's discretion, purchase. Preauthorization required or no benefits provided.
	Hospice services	First 30 days of inpatient hospice services covered as other inpatient hospital services; 20% coinsurance for days beyond 30	First 30 days of inpatient hospice services covered as other inpatient hospital services; 20% coinsurance, plus balance-billing charges for days beyond 30	Preauthorization required or no benefits provided.
If your child needs dental or eye care	Children's eye exam	No charge through Group Vision Service provider. Deductible does not apply.	Not covered	Limited to once every two years. No benefits for dependents of retirees.
	Children's glasses	No charge through Group Vision Service provider. Deductible does not apply.	Not covered	Limited to once every two years. No benefits for dependents of retirees.
	Children's dental check-up	No charge through Group Dental Service provider. Deductible does not apply.	Not covered	Prophylaxis limited to once every six months. No benefits for dependents of retirees.

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.)

- Acupuncture
- Cosmetic surgery
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (if medically necessary)
- Chiropractic care (preauthorization required or no benefits provided)
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (if for diabetes)

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 1-800-638-2972. 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.

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.

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	**$100**
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*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$2,340
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$2,540**

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 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*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$40
Coinsurance	$430
What isn't covered	
Limits or exclusions	$170
The total Joe would pay is	**$740**

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

The plan's overall deductible	**$100**
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*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$280
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$380**

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