




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 <u>deductible</u>?	\$300/individual; \$600/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Network preventive care</u> , and COVID-19 vaccinations are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Medical <u>plan</u> (in- <u>network</u> and <u>out-of-network</u> providers combined): \$4,000/individual; \$8,000/family ; <u>Prescription drugs</u> (in- <u>network</u> only): \$2,600/individual; \$5,200/family .	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 <u>plan</u> , 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 <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> , health care this <u>plan</u> doesn't cover, and <u>cost sharing</u> for non-essential health benefits.	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 <u>network provider</u>?	Yes. For <u>network</u> medical <u>providers</u> , see www.carefirst.com or call 1-800-810-2583; for <u>network</u> mental health and substance use disorder <u>providers</u> , see www.beaconhealthoptions.com or call 1-800-353-3572; for <u>network</u> dental <u>providers</u> , see www.dentegra.com or call 1-877-280-4204.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network 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 <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</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
		Network Provider (You will pay the least)	Out-of-Network Provider* (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	20% <u>coinsurance</u> , plus <u>balance-billed</u> charges	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	20% <u>coinsurance</u> , plus <u>balance-billed</u> charges	None
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	20% <u>coinsurance</u> , plus <u>balance-billed</u> charges. COVID-19 vaccination is covered at no charge and <u>deductible</u> does not apply.	Subject to age and frequency guidelines. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. <u>Out-of-network</u> well-child exams limited to 8 visits through age 5.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u> , plus <u>balance-billed</u> charges	Must be provided by Quest or LabCorp, unless provided by an <u>out-of-network provider</u> at an <u>in-network</u> facility.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u> , plus <u>balance-billed</u> 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)	
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com</p>	Generic drugs	8% <u>coinsurance</u> at Giant or Safeway pharmacies; 13% <u>coinsurance</u> at other <u>network</u> pharmacies	Not covered at <u>out-of-network</u> pharmacies. Rite Aid, Walmart, Walgreens and CVS are not in the <u>network</u> .	<p><u>Deductible</u> does not apply.</p> <p>Limit: Retail up to a 34-day supply; mail order up to a 100-day supply.</p> <p>If you request a brand name drug when a generic equivalent is available, you will pay the full cost of the brand name drug.</p>
	Preferred brand drugs	8% <u>coinsurance</u> at Giant or Safeway pharmacies; 13% <u>coinsurance</u> at other <u>network</u> pharmacies, provided there is no generic equivalent	Not covered at <u>out-of-network</u> pharmacies. Rite Aid, Walmart, Walgreens and CVS are not in the <u>network</u> .	<p>No charge for ACA-required generic preventive drugs (e.g., contraceptives) or a brand name preventive drug if a generic is not medically appropriate.</p> <p>Certain <u>specialty drugs</u> require <u>preauthorization</u> or benefits are not covered. Certain <u>specialty drugs</u> must be ordered by phone through Accredo Specialty Pharmacy for which you will pay 8% <u>coinsurance</u>. For drugs listed on the SaveonSP program's current non-essential health benefit specialty drug list: No charge if you participate in the SaveonSP program, or 30% <u>coinsurance</u> if you do not participate in the program.</p>
	<u>Specialty drugs</u>	8% <u>coinsurance</u>	Not covered at <u>out-of-network</u> pharmacies. Rite Aid, Walmart, Walgreens and CVS are not in the <u>network</u> .	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u> , plus <u>balance-billed</u> charges	<u>Preauthorization</u> is required or benefits are not covered.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u> , plus <u>balance-billed</u> 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 immediate medical attention	<u>Emergency room care</u>	\$75 <u>copay</u> per visit, plus 20% <u>coinsurance</u>	\$75 <u>copay</u> per visit, plus 20% <u>coinsurance</u>	Professional/physician charges may be billed separately. <u>Copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	The lesser of 20% <u>coinsurance</u> or 100% after <u>plan</u> pays first \$200.	The lesser of 20% <u>coinsurance</u> or 100% after <u>plan</u> pays first \$200. Includes <u>balance-billing</u> charges except on air ambulance services	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> , plus <u>balance-billed</u> charges	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u> , plus <u>balance-billed</u> charges	<u>Preauthorization</u> is required or benefits are not covered. Authorization is required within 24 hours of an emergency admission or benefits are not covered.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u> , plus <u>balance-billed</u> charges	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u> , plus <u>balance-billed</u> charges	None
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u> , plus <u>balance-billed</u> charges	<u>Preauthorization</u> is required or benefits are not covered. Authorization is required within 24 hours of an emergency admission or benefits are not covered
If you are pregnant	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u> , plus <u>balance-billed</u> charges	<u>Cost sharing</u> does not apply for ACA-required preventive <u>screenings</u> . Depending on the type of services, <u>coinsurance</u> and/or a <u>deductible</u> may apply. Maternity care may include tests and services described somewhere else in the SBC (e.g., ultrasound). Prenatal care (other than ACA-required preventive <u>screenings</u>) is not covered for dependent children. Delivery expenses are not covered for dependent children.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u> , plus <u>balance-billed</u> charges	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u> , plus <u>balance-billed</u> 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	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> , plus <u>balance-billed</u> charges	<u>Preauthorization</u> is required or benefits are not covered.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> , plus <u>balance-billed</u> charges	<u>Preauthorization</u> is required or benefits are not covered. Limit: 30 inpatient days/60 outpatient visits per year. Cardiac rehabilitation limited to 90 days per year.
	<u>Habilitation services</u>	Not covered	Not covered	You must pay 100% of these expenses, even <u>in-network</u> .
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> , plus <u>balance-billed</u> charges	None
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> , plus <u>balance-billed</u> charges	<u>Preauthorization</u> is required or benefits are not covered. Rental benefit limited to purchase price.
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> , plus <u>balance-billed</u> charges	<u>Preauthorization</u> is required or benefits are not covered. Must have life expectancy of six (6) months or less.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limit: One (1) exam every two (2) years. Vision benefits are provided through Superior Vision and are insured.
	Children's glasses	No charge	Not covered	Limit: One (1) pair every two (2) years; limited to certain frames. Vision benefits are provided through Superior Vision and are insured.
	Children's dental check-up	No charge	Reimbursed up to the amount of <u>in-network</u> covered charges in certain limited circumstances	Limit: One (1) exam every six (6) months. Not covered for children under age four (4). Dental benefits are provided through Dentegra and are insured.

* To the extent required under the federal No Surprises Act, out-of-network provider services will be covered at the copay and coinsurance rates applicable to in-network provider services, and balance billing will not apply.

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
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs (except as required by the Affordable Care Act)

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

- Bariatric surgery
- Chiropractic care (limited to \$1,000 per person per year)
- Cosmetic surgery (limited to reconstructive surgery following mastectomy or resulting from traumatic injury)
- Dental care (Adult) (to plan limits)
- Private-duty nursing
- Routine eye care (Adult)(to plan limits)

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 on how 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

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.

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 **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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,380
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,740

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 **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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$570
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$870

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

- The plan's overall deductible **\$300**
- 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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$80
<u>Coinsurance</u>	\$480
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$860