**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, 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 or call 1-888-494-4443 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$500** Individual / **$1,000** Family | 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** | This plan covers certain preventive services without cost-sharing and before you meet your 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?** | **$3,850 Medical/$3,000 Rx/Ind**<br>**$7,700 Medical/$6,000 Rx/Family** | If you have other family members on the 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, deductibles, balance-billed charges and health care this plan does not 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. **Visit www.carefirst.com or call 1-800-367-3387** for a list of preferred providers. | This plan uses a provider network, You will pay less if you use a provider in the plan's network. You will pay 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 you 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 | $25 copayment per visit | $25 copayment per visit | Balance Billing may apply to out-of-network services. |
| | Specialist visit | $25 copayment per visit | $25 copayment per visit | Balance Billing may apply to out-of-network services. |
| | Preventive care/screening/ immunization | $0 | $0 | You may have to pay for services that aren't preventive. Ask your doctor if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 20% coinsurance | Balance Billing may apply to out-of-network services. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 20% coinsurance | Balance Billing may apply to out-of-network services. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at **www.express-scripts.com** | Generic drugs | $5 copayment/ retail<br>$10 copayment/ mail | Full cost of prescription – submit claim for reimbursement | Covers up to 30-day supply for retail; 31-90 day supply for mail order prescriptions |
| | Preferred brand drugs | 25% coinsurance / retail to maximum $75/fill<br>25% coinsurance / maill to maximum $150/fill | Full cost of prescription – submit claim for reimbursement | Covers up to 30-day supply for retail; 31-90 day supply for mail order prescriptions, Mandatory Generic program. |
| | Non-preferred brand drugs | 40% coinsurance / retail and mail order | Full cost of prescription – submit claim for reimbursement | Covers up to 30-day supply for retail; 31-90 day supply for mail order prescriptions, Mandatory Generic program |
| | Specialty drugs | 25% coinsurance for preferred drugs; 40% coinsurance for non-preferred drugs | Full cost of prescription – submit claim for reimbursement | Limited injectable drugs; some require pre-approval – Contact Express Scripts at 800-451-6245 |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 20% coinsurance | Balance Billing may apply to out-of-network services. |
| | Physician/surgeon fees | 20% coinsurance | 20% coinsurance | Balance Billing may apply to out-of-network services. |

| 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** | Emergency room care | 20% coinsurance | 20% coinsurance | Expenses must be incurred within 72 hours of onset of illness or injury – must be true emergency |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Expenses must be incurred within 72 hours of onset of illness or injury – must be true emergency |
| | Urgent care | $25 copayment per visit | $25 copayment per visit | Balance Billing may apply to out-of-network services. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 20% coinsurance | Requires pre-certification – contact **AHH** at **1-800-641-5566** |
| | Physician/surgeon fees | 20% coinsurance | 20% coinsurance | Balance Billing may apply to out-of-network services. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copayment per visit | $25 copayment per visit | Balance Billing may apply to out-of-network services. |
| | Inpatient services | 20% coinsurance | 20% coinsurance | Requires pre-certification – contact **AHH** at **1-800-641-5566** |
| **If you are pregnant** | Office visits | $25 copayment per visit | $25 copayment per visit | **Pre-natal care only for dependent children.** Charges above allowed amount are your responsibility. |
| | Childbirth/delivery professional services | 20% coinsurance | 20% coinsurance | **Members and spouses only**. Charges above allowed amount are your responsibility. |
| | Childbirth/delivery facility services | 20% coinsurance | 20% coinsurance | **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% coinsurance | 20% coinsurance | Balance Billing may apply to out-of-network services. |
| | Rehabilitation services | 20% coinsurance | 20% coinsurance | Maximum plan payment $25/visit. Maximum treatment duration 6 month/injury or illness. |
| | Habilitation services | Not Covered | Not Covered | |

| 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) | |
| | Skilled nursing care | 20% coinsurance | 20% coinsurance | Balance Billing may apply to out-of-network services. |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | Balance Billing may apply to out-of-network services. |
| | Hospice services | 20% coinsurance | 20% coinsurance | Requires pre-certification – contact **AHH** at **1-800-641-5566**services. |
| **If your child needs dental or eye care** | Children's eye exam | **$0** | | Limited to on exam and one pair of glasses per year |
| | Children's glasses | **$0** | | |
| | Children's dental check-up | **$0** | | No Limit for children |

**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
- Bariatric Surgery
- Chiropractic Care
- Cosmetic Surgery
- Habilitation Services
- Hearing aids
- Infertility treatment
- Long term care
- Non-emergency care outside U.S.
- Private duty nursing
- 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.)**

- Routine Dental care (separate plan – up to $1,000 person/year)
- Routine Vision care (separate plan – up to $150/person/year)

**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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: 1-888-494-4443.

**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

## 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 | $500 |
| Specialist *[cost sharing]* | $25 |
| 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** | **$9,798** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $70 |
| Coinsurance | $2,304 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,934** |

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist *[cost sharing]* | $25 |
| Hospital (facility) *[cost sharing]* | 20% |
| Other *[cost sharing]* | 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** | **$5,188** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $405 |
| Coinsurance | $1,241 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$2,201** |

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist *[cost sharing]* | $25 |
| 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** | **$1,024** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $75 |
| Coinsurance | $326 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$901** |

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