


 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 ?	\$250 Individual / \$500 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 ?	\$3,600 Medical/\$3,000 Rx/Ind \$7,200 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 .

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 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)	60% coinsurance	60% coinsurance	Balance Billing may apply to out-of-network services.
	Imaging (CT/PET scans, MRIs)	60% coinsurance	60% 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	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)	60% coinsurance	60% coinsurance	Balance Billing may apply to out-of-network services.
	Physician/surgeon fees	60% coinsurance	60% coinsurance	Balance Billing may apply to out-of-network services.
If you need immediate medical attention	Emergency room care	60% coinsurance	60% coinsurance	Expenses must be incurred within 72 hours of onset of illness or injury – must be true emergency
	Emergency medical transportation	60% coinsurance	60% coinsurance	Expenses must be incurred within 72 hours of onset of illness or injury – must be true emergency

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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)	
	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)	60% coinsurance	60% coinsurance	Requires pre-certification – contact AHH at 1-800-641-5566
	Physician/surgeon fees	60% coinsurance	60% 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	60% coinsurance	60% 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	Maternity benefits available to members and spouses only
	Childbirth/delivery professional services	60% coinsurance	60% coinsurance	Maternity benefits available to members and spouses only
	Childbirth/delivery facility services	60% coinsurance	60% coinsurance	Maternity benefits available to members and spouses only
If you need help recovering or have other special health needs	Home health care	60% coinsurance	60% coinsurance	Balance Billing may apply to out-of-network services.
	Rehabilitation services	60% coinsurance	60% coinsurance	Maximum plan payment \$25/visit. Maximum treatment duration 6 month/injury or illness.
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	60% coinsurance	60% coinsurance	Balance Billing may apply to out-of-network services.
	Durable medical equipment	60% coinsurance	60% coinsurance	Balance Billing may apply to out-of-network services.
	Hospice services	60% coinsurance	60% 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

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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](#).)

- | | | |
|--|---|---|
| <ul style="list-style-type: none">• Acupuncture• Bariatric Surgery• Chiropractic Care• Cosmetic Surgery | <ul style="list-style-type: none">• Habilitation Services• Hearing aids• Infertility treatment• Long term care | <ul style="list-style-type: none">• 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.)

- | | |
|---|---|
| <ul style="list-style-type: none">• Routine Dental care (separate plan – up to \$1,000 person/year) | <ul style="list-style-type: none">• Routine Vision care (separate plan – up to \$150/person/year) |
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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](#)

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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](#) \$250
- [Specialist](#) [*cost sharing*] \$25
- Hospital (facility) [*cost sharing*] 60%
- Other [*cost sharing*] 60%

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	\$9,035
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$3,350
<i>What isn't covered</i>	
Limits or exclusions	\$96
The total Peg would pay is	\$3,696

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist](#) [*cost sharing*] \$25
- Hospital (facility) [*cost sharing*] 60%
- Other [*cost sharing*] 60%

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	\$1,540
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$250
Coinsurance	\$1,037
<i>What isn't covered</i>	
Limits or exclusions	\$4,313
The total Joe would pay is	\$5,850

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist](#) [*cost sharing*] \$25
- Hospital (facility) [*cost sharing*] 60%
- Other [*cost sharing*] 60%

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	\$621
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$75
Coinsurance	\$979
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,304