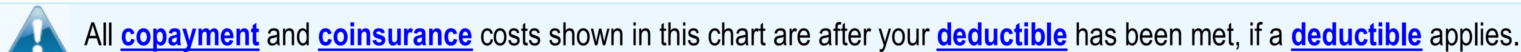
Summary of Benefits and Coverage: What this Plan Covers & What You Pay For: **Coverage for: Individuals / Dependents Plan Type: MAJ MED**

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, by calling 1-877-850-0977 or visit www.associated-admin.com online. 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.cciio.cms.gov or call 1-877-850-0977 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ $ 300 Individual $ 1,000 Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your plan document to see when the **deductible** 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 **deductible**.
Are there services covered before you meet your deductible?	Dental $ 25 Individual $ 75 Family	Dental **deductible** does not apply for routine and preventive dental services.
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?	$$ 4,000 Per Individual	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. After the **out-of-pocket limit** is met in any plan year, plan will pay 100% of charges up to $200,000. Expenses above $200,000 will be paid at 50%.
What is not included in the out-of-pocket limit?	Copays, premiums, balance-billed charges and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward your annual **out-of-pocket maximum limit.**
Will you pay less if you use a network provider?	Yes. For a list of CareFirst participating providers call (800)235-5160 or visit www.carefirst.com	If you use a participating doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Lesser coverage, or no coverage, may be available for out-of-network **providers**. Be aware, your participating doctor or hospital may use a non-participating **provider** for some services.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.

For more information about limitations and exceptions, see the plan document at www.associated-admin.com



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%	20% plus balance over allowed amount	Includes adult and child routine checkups.
	Specialist visit	20%	20% plus balance over allowed amount	
	Preventive care/screening/ immunization	20%	20% plus balance over allowed amount	
If you have a test	Diagnostic test (x-ray, blood work)	20%	20% plus balance over allowed amount	You may use any participating CareFirst lab. Go online at www.carefirst.com or call 1 (800) -235-5160 to locate a lab.
	Imaging (CT/PET scans, MRIs)	20%	20% plus balance over allowed amount	You may use any participating CareFirst lab. Go online at www.carefirst.com or call 1 (800) -235-5160 to locate a lab.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$5 – 30 day retail $10 – 90 day mail or CVS pharmacy	N/A	Mandatory to use CVS pharmacy or mail order for maintenance medications
	Preferred brand drugs	40% of drug cost up to $10,000/year, then 60% of drug cost remainder of year, $2,500 out of pocket limit after which coverage is at 100%	N/A	Formulary medications may be less costly – to check formulary go online to www.caremark.com
	Non-preferred brand drugs	40% of drug cost up to $10,000/year, then 60% of drug cost remainder of year	N/A	

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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)	
	Specialty drugs	Varies	N/A	Must be filled through Caremark dedicated specialty pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20%	20% plus balance over allowed amount	Elective surgeries must be pre-certified by Conifer Health Solutions - Call 1-(844)-739-8913 to pre-certify.
	Physician/surgeon fees	20%	20% plus balance over allowed amount	
If you need immediate medical attention	Emergency room care	20%	20%	Must be true emergency requiring immediate care
	Emergency medical transportation	$0 – up to $100 per incident	$0 – up to $100 per incident	If life-support services provided, balance paid at 50% after **deductible**
	Urgent care	20%	20% plus balance over allowed amount	
If you have a hospital stay	Facility fee (e.g., hospital room)	20%	20% plus balance over allowed amount	Elective surgeries must be pre-certified by Conifer Health Solutions - Call 1-(844)-739-8913 to pre-certify.
	Physician/surgeon fees		20% plus balance over allowed amount	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20%	20% plus balance over allowed amount	Must be pre-authorized by Conifer - Call 1-(844)739-8913
	Inpatient services	20%	20% plus balance over allowed amount	Must be pre-authorized by Conifer Call 1-(844)739-8913
If you are pregnant	Office visits	20%	20% plus balance over allowed amount	Participants / spouses only
	Childbirth/delivery professional services	20%	20% plus balance over allowed amount	Participants / spouses only
	Childbirth/delivery facility services	20%	20% plus balance over allowed amount	Participants / spouses only
If you need help	Home health care	20%	20% plus balance over	Following hospital stay only

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)	
recovering or have other special health needs			allowed amount	
	Rehabilitation services	20%	20% plus balance over allowed amount	Physical Therapy/ Chiropractic 8 visit limit. Pre-cert required thereafter.
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	20%	20% plus balance over allowed amount	Must be pre-authorized by Conifer - Call 1-(844)739-8913
	Durable medical equipment	20%	20% plus balance over allowed amount	Must be approved by Board of Trustees
	Hospice services	20%	20% plus balance over allowed amount	Must be pre-authorized by Conifer - Call 1-(844)739-8913
If your child needs dental or eye care	Children's eye exam	$10	Up to $52	Once per 12 months
	Children's glasses	Amount over $150	Amount over allowance	Once per 12 months
	Children's dental check-up	$0	20%	Every 6 months

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
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility treatment
- Long-term Care
- Non-emergency care outside the U.S
- Private duty nursing
- Routine Eye Care (Adult)
- 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.)

- Hearing Aids (see plan documents for limits)
- Chiropractic care (see plan documents for limits)
- Annual CDL Physical Examination (participant only)

For more information about limitations and exceptions, see the plan document at www.associated-admin.com

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:

Associated Administrators, LLC, 911 Ridgebrook Road, Sparks, MD 21152-9541. Phone numbers are 1-877-850-0977, 410-683-6500.

You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa

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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-877-850-0977
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-850-0977
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-877-850-0977
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-850-0977

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

For more information about limitations and exceptions, see the plan document at www.associated-admin.com

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 *[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)*

Total Example Cost	**$14,150**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$2,730
What isn't covered	
Limits or exclusions	$200
The total Peg would pay is	**$3,230**

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 *[cost sharing]*** **20%**
- **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	**$6,100**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$1,160
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,460**

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

- **The plan's overall deductible** **$300**
- **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)*

Total Example Cost	**$2,400**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$420
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$720**