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, call (410) 872-9500 or toll-free (888) 490-8800. 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 https://www.healthcare.gov/sbc-glossary or call (410) 872-9500 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers $0	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 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 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?	For in-network providers $1,500 individual/$3,000 family Prescription Drug: $3.500 individual/$7,500 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this 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?	Deductible, copayments, penalties, premiums, balance-billing charges, and health care this plan doesn't 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. See www.carefirst.com or call (800) 235-5160 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the full cost if you use an out-of-network provider. 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*
		In-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 copay per visit	Not Covered	None
	Specialist visit	$20 copay per visit	Not Covered	Chiropractic Services are limited to 20 visits per year.
	Preventive care/screening/ immunization	No member liability	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Immunizations are those recommended by the Advisory Committee on Immunization Practices. Pap test – females age 18 and older - once every two years Mammogram for females: Age 40 to 49 – once every other year Age 50 and older – once/year Proctology screening for males: Age 40 to 49 – once every other year Age 50 and older – once/year Routine colonoscopies starting at age 50 – once every 10 years.
If you have a test	Diagnostic test (x-ray, blood work)	No member liability	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Office: $20 copay per visit Facility: No member liability	Not Covered	None

*For more information about limitations and exceptions, see the plan or policy document by calling (888) 490-8800. Covered expenses are limited to the UCR (Usual, Customary and Reasonable) Charge. Out-of-network benefits and UCR apply even if your in-network provider refers you to an out-of-network provider.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-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.caremark.com.	Generic drugs	Retail - $10 copay/prescription Mail - $20 copay/prescription	Not covered	Retail: Up to a 34-day supply Mail: Up to a 90-day supply
	Preferred brand drugs	Retail - $35 copay/prescription Mail - $70 copay/prescription	Not covered	Prior Authorization is required to receive brand oral contraceptives with no deductible, coinsurance or copay.
	Non-preferred brand drugs	Retail - $45 copay/prescription Mail - $90 copay/prescription	Not covered	
	Specialty drugs	20% Coinsurance With a Minimum of $10 Maximum of $100	Not covered	For Participating Providers: Specialty drugs are only covered when purchased through the Exclusive Special Pharmacy Network. For Non-Participating Providers: Specialty Drugs are not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay per visit	Not Covered	None
	Physician/surgeon fees	No member liability	Not Covered	
If you need immediate medical attention	Emergency room care	$250 copay per visit	$250 copay per visit	Copay waived if admitted.
	Emergency medical transportation	No member liability	No member liability	None
	Urgent care	$20 copay per visit	$20 copay per visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 per admission copay	Not Covered	Preauthorization required prior to hospital admission. In an emergency or life-threatening situation, notify American Health Holdings (AHH) within 24 hours of admission. If you don't get preauthorization, benefits could be denied for non-certified hospital expenses.
	Physician/surgeon fees	No member liability	Not Covered	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental/behavioral health/Substance Abuse Facility: $0 Office: $20 copay per visit	Not Covered	None
	Inpatient services	Mental/behavioral health/Substance Abuse $250 per admission copay	Not Covered	Preauthorization required prior to hospital admission. In an emergency or life-threatening situation, notify American Health Holdings (AHH) within 24 hours of admission. If you don't get preauthorization, benefits could be denied for non-certified hospital expenses.
If you are pregnant	Office visits	$20 copay per visit	Not Covered	Copay applies to first visit only
	Childbirth/delivery professional services	100%		None
	Childbirth/delivery facility services	$250 per admission copay		Preauthorization required prior to hospital admission. In an emergency or life-threatening situation, notify American Health Holdings (AHH) within 24 hours of admission. If you don't get preauthorization, benefits could be denied for non-certified hospital expenses.
If you need help recovering or have other special health needs	Home health care	No member liability	Not Covered	Preauthorization required prior to hospital admission. In an emergency or life-threatening situation, notify American Health Holdings (AHH) within 24 hours of admission. If you don't get preauthorization, benefits could be denied for non-certified hospital expenses.
	Rehabilitation services	$20 copay per visit	Not Covered	Rehabilitation Services include Physical, Speech and Occupational Therapies that are limited to 30 visits per condition per year.
	Habilitation services			
	Skilled nursing care	No member liability	Not Covered	Benefits are limited to 100 days per year.
	Durable medical equipment	25% coinsurance	Not Covered	None
	Hospice services	No member liability	Not Covered	None
	Children's eye exam	No Charge	Plan reimburses up to $30	Coverage limited to one exam/year

*For more information about limitations and exceptions, see the plan or policy document by calling (888) 490-8800. Covered expenses are limited to the UCR (Usual, Customary and Reasonable) Charge. Out-of-network benefits and UCR apply even if your in-network provider refers you to an out-of-network provider.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's glasses	Discount program available to all members	Discount program available to all members	Vision benefits are provided through Davis Vision
	Children's dental check-up	No Charge, up to UCR	No Charge, up to UCR	

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 (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- 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.)

- Chiropractic care
- Dental care (Adult)
- Non-emergency care when traveling outside the US
- Routine eye care (Adult

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: Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html. 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 Fund Office at (888) 490-8800 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) https://www.dol.gov/ebsa/healthreform. **The Fund does not have a grievance procedure. All disputes under the Plan are processed through the appeals procedure described in the Summary Plan Description.

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 (888) 490-8800.

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 or policy document by calling (888) 490-8800. Covered expenses are limited to the UCR (Usual, Customary and Reasonable) Charge. Out-of-network benefits and UCR apply even if your in-network provider refers you to an out-of-network provider.

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** **$0**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	None
Copayments	$250
Coinsurance	None
What isn't covered	
Limits or exclusions	$93
The total Peg would pay is	**$343**

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

- **The plan's overall deductible** **$0**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other (Rx) copayments** **$10**

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	None
Copayments	$825
Coinsurance	$488
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,333**

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

- **The plan's overall deductible** **$0**
- **Specialist coinsurance** **0%**
- **Hospital (facility) copayments** **$250**
- **Other coinsurance** **0%**

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	None
Copayments	$140
Coinsurance	$59
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$199**

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