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. 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 call 410-872-9500 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$100** Individual / **$300** Family	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 your deductible. A copayment or coinsurance may apply to those 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?	**No**	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	**Not applicable**	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. **Visit www.carefirst.com or call 1-800-235-5160** 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 the 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, 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
		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	$0 copayment/visit, up to $50,000, then 20% coinsurance	$0 copayment/visit, up to $50,000, then 30% coinsurance	When benefits exceed $1,000,000, your share of the cost is 50%.
	Specialist visit	$0 copayment/visit, up to $50,000, then 20% coinsurance	$0 copayment/visit, up to $50,000, then 30% coinsurance	When benefits exceed $1,000,000, your share of the cost is 50%.
	Preventive care/screening/ immunization	$0 copayment/visit, up to $50,000, then 20% coinsurance	$0 copayment/visit, up to $50,000, then 30% coinsurance	When benefits exceed $1,000,000, your share of the cost is 50%.
If you have a test	Diagnostic test (x-ray, blood work)	$0 up to $50,000, then 20% coinsurance	10% up to $50,000, then 30% coinsurance	When benefits exceed $1,000,000, your share of the cost is 50%.
	Imaging (CT/PET scans, MRIs)	$0 up to $50,000, then 20% coinsurance	10% up to $50,000, then 30% coinsurance	When benefits exceed $1,000,000, your share of the cost is 50%.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$10 copayment retail $20 copayment mail	Not covered out-of-network	Retail up to a 30-day supply; 31-90 day supply mail order. Maintenance drugs must be purchased through mail order or at CVS pharmacy. Generic drugs required unless physician specifically requires brand drug be dispensed.
	Preferred brand drugs	$25 copayment retail $50 copayment mail	Not covered out-of-network	
	Non-preferred brand drugs	$40 copayment retail $80 copayment mail	Not covered out-of-network	
	Specialty drugs	$75 copayment	Not covered out-of-network	Contact Caremark @ 866-282-8503
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0 up to $50,000, then 20% coinsurance	10% up to $50,000, then 30% coinsurance	When benefits exceed $1,000,000, your share of the cost is 50%.
	Physician/surgeon fees	$0 up to $50,000, then 20% coinsurance	10% up to $50,000, then 30% coinsurance	Out-of-Network ancillary services rendered at a Network Hospital or Facility will be paid as In-Network. When benefits exceed $1,000,000, your share of the cost is 50%.

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	$0 up to $50,000, then 20% coinsurance	10% up to $50,000, then 30% coinsurance	Out-of-Network emergency room care is covered as In-Network until stabilization. Post-stabilization paid as Out-of-Network unless transferred to In-Network Facility When benefits exceed $1,000,000, your share of the cost is 50%.
	Emergency medical transportation	$0 up to $50,000, then 20% coinsurance	10% up to $50,000, then 30% coinsurance	Out-of-Network air ambulance services paid as In-Network. When benefits exceed $1,000,000, your share of the cost is 50%.
	Urgent care	$10 copayment/visit, up to $50,000, then copayment +20% coinsurance	$10 copayment/visit, up to $50,000, then copayment +30% coinsurance	When benefits exceed $1,000,000, your share of the cost is 50%.
If you have a hospital stay	Facility fee (e.g., hospital room)	$0 up to $50,000, then 20% coinsurance	10% up to $50,000, then 30% coinsurance	**Requires pre-approval. Call American Health Holdings @ 800-641-5566.** When benefits exceed $1,000,000, your share of cost is 50%.
	Physician/surgeon fees	$0 up to $50,000, then 20% coinsurance	10% up to $50,000, then 30% coinsurance	Out-of-Network ancillary services rendered at a Network Hospital or Facility will be paid as In-Network. When benefits exceed $1,000,000, your share of cost is 50%.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 copayment/visit, up to $50,000, then 20% coinsurance	$0 copayment/visit, up to $50,000, then 30% coinsurance	When benefits exceed $1,000,000, your share of cost is 50%.
	Inpatient services	$0 up to $50,000, then 20% coinsurance	10% up to $50,000, then 30% coinsurance	**Requires pre-approval. Call American Health Holdings @ 800-641-5566.** When benefits exceed $1,000,000, your share of cost is 50%.

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 are pregnant	Office visits	$0 copayment/visit, up to $50,000, then 20% coinsurance	$0 copayment/visit, up to $50,000, then 30% coinsurance	When benefits exceed $1,000,000, your share of the cost is 50%.
	Childbirth/delivery professional services	$0 up to $50,000, then 20% coinsurance	10% up to $50,000, then 30% coinsurance	Member / Spouse only. **Requires pre-approval. Call American Health Holdings @ 800-641-5566**. When benefits exceed $1,000,000, your share of cost is 50%.
	Childbirth/delivery facility services	$0 up to $50,000, then 20% coinsurance	10% up to $50,000, then 30% coinsurance	Member / Spouse only. **Requires pre-approval. Call American Health Holdings @ 800-641-5566**. When benefits exceed $1,000,000, your share of cost is 50%.
If you need help recovering or have other special health needs	Home health care	$0 up to $50,000, then 20% coinsurance	10% up to $50,000, then 30% coinsurance	When benefits exceed $1,000,000, your share of cost is 50%.
	Rehabilitation services	$0 up to $50,000, then 20% coinsurance	10% up to $50,000, then 30% coinsurance	Physical therapy only – speech and occupational therapy not covered
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	$0 up to $50,000, then 20% coinsurance	10% up to $50,000, then 30% coinsurance	When benefits exceed $1,000,000, your share of cost is 50%.
	Durable medical equipment	$0 up to $50,000, then 20% coinsurance	10% up to $50,000, then 30% coinsurance	When benefits exceed $1,000,000, your share of cost is 50%.
	Hospice services	$0 up to $50,000, then 20% coinsurance	10% up to $50,000, then 30% coinsurance	When benefits exceed $1,000,000, your share of cost is 50%.
If your child needs dental or eye care	Children's eye exam	$0		Limited to one exam and one pair of glasses per year
	Children's glasses	$0		
	Children's dental check-up	$0 up to $500, 20% of next $2,000	$0 up to $500, 20% of next $2,000	Benefits above $2,500 paid at 50% for children under 18.

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.)

- Bariatric Surgery
- Cosmetic Surgery
- Habilitation Services
- Infertility treatment
- Long term care
- Non-emergency care outside U.S.
- Private duty nursing
- Weight loss programs

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

- Acupuncture ($50 visit/24 visits/year)
- Chiropractic ($50 visit)
- Hearing aids ($4,000 every 2 years)
- Routine foot care
- Routine Dental care (adult)
- Routine Vision 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 **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, visit www.HealthCare.gov or call 1-800-318- 2596.

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 **and assume costs have not yet exceeded $20,000.**

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$100
Specialist cost sharing	$0
Hospital (facility) cost sharing*	0%
Other cost sharing*	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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$170**

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

The plan's overall deductible	$100
Specialist cost sharing	$0
Hospital (facility) cost sharing*	0%
Other cost sharing*	0%

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$820**

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

The plan's overall deductible	$100
Specialist cost sharing	$0
Hospital (facility) cost sharing*	0%
Other cost sharing*	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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$110**

The plan would be responsible for the other costs of these EXAMPLE covered services.
*Coinsurance applies when annual benefit exceeds $50,000