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 800-741-9249. 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.dol.gov/ebsa/healthreform or call 800-800-741-9249 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: **$200**/individual or **$400**/family. Out-of-network providers: **$500**/individual or **$1,000**/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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. "Basic benefits" including preventive services, physician office visits, hospital expenses, diagnostic tests and other services; vision; dental; and prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. Dental: **$50**/individual; **$150**/family. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical: Network providers: **$5,000**/individual; **$10,000**/family. Medical: Out-of-network providers: **$10,000**/individual; **$20,000**/family.* Prescription drugs: **$1,600**/individual; **$3,200**/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?	Premiums, balance-billing charges, penalties for failure to obtain preauthorization, separately administered vision, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

* Charges for out-of-network Emergency Services, air ambulance services, and care provided by an out-of-network provider at an in-network facility will be paid as required by No Surprises Act. Amounts paid for these services are applied to the in-network deductible and out-of-pocket expense maximum. See the plan for more information.

Will you pay less if you use a network provider?	Yes. See www.carefirst.com or call 866-505-8719 for a list of 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 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
		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	No charge up to $100/visit, then 20% coinsurance (after deductible).	No charge up to $100/visit, then 40% coinsurance (after deductible), plus charges over allowed amount.	Basic benefit for office visits: limit 15 visits and/or $1,500/year.
	Specialist visit			
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Charges over allowed amount.	Age and frequency limitations apply. You may have to pay for services that aren't preventive. Ask your provider 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)	No charge up to first $800/year, then 20% coinsurance (after deductible).	No charge up to first $800/year, then 40% coinsurance (after deductible), plus charges over allowed amount.	None.
	Imaging (CT/PET scans, MRIs)			

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: $5 copay/ prescription. Mail order: $10 copay/prescription.	Retail: Same as In-Network provider plus charges over allowed amount. Mail order: not covered.	Deductible does not apply. No charge for FDA-approved contraceptives. Retail limit: 30-day supply. Mail order limit: 90-day supply. Covered through CVS pharmacy. Maintenance medications: mandatory mail order or CVS pharmacy after 3 retail fills. Prior authorization is required for some prescription drugs (including any prescription in excess of $1,000) or benefits may be reduced.
	Formulary (preferred brand) drugs	Retail: $15 copay/ prescription. Mail order: $30 copay/prescription.		
	Non-Formulary (non-preferred brand) drugs	Retail: $30 copay/ prescription. Mail order: $60 copay/prescription.		
	Specialty drugs	Same as other prescription drugs.	Same as other prescription drugs.	Covered through CVS/Caremark Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge up to first $1,250/year, then 20% coinsurance (after deductible).	No charge up to first $1,250/year, then 40% coinsurance (after deductible), plus charges over allowed amount.	None.
	Physician/surgeon fees	Primary surgeon: No charge. Assistant surgeon: 80% coinsurance.	Same as In-Network provider plus charges over allowed amount.*	None.
If you need immediate medical attention	Emergency room care	Emergency Services: No charge up to first $500/illness or injury, then 20% coinsurance (after deductible). Non-emergency: 20% coinsurance.	Emergency Services: No charge up to first $500/illness or injury, then 20% of recognized amount (after deductible).* Non-emergency: 40% coinsurance, plus charges over allowed amount.	**Recognized amount** is the lesser of the Qualifying Payment Amount and the amount actually billed by the Provider. **Qualifying Payment Amount** is an amount determined in accordance with regulations, which generally equals the median contracted rate for an item or service as of January 31, 2019 and adjusted annually thereafter according to guidance from the IRS.
	Emergency medical transportation	20% coinsurance.	40% coinsurance, plus charges over allowed amount.*	Must be to/from nearest hospital equipped to provide required care. See the plan regarding cost sharing for air ambulance services.

	Urgent care	No charge up to $100/visit, then 20% coinsurance (after deductible).	No charge up to $100/visit, then 40% coinsurance (after deductible), plus charges over allowed amount.	Basic benefit for office visits: limit 15 visits and/or $1,500/year. Combined with all office visits.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge up to $450 room and board/day and $2,500 miscellaneous hospital charges/confinement. Then 20% coinsurance (after deductible).	No charge up to $450 room and board/day and $2,500 miscellaneous hospital charges/confinement. Then 40% coinsurance (after deductible), plus charges over allowed amount.*	Basic benefit inpatient hospital limit: 70 days/confinement. Coverage limited to rate for semi-private room. Prior authorization required or benefits may not be paid (Except for Emergency Services).
	Physician/surgeon fees	No charge up to $100/visit; then 20% coinsurance (after deductible).	No charge up to $100/visit; then 40% coinsurance (after deductible), plus charges over allowed amount.*	Basic benefit inpatient physician limit: 15 visits and/or $1,500/year. Prior authorization required or benefits may not be paid.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental or behavioral health: 20% coinsurance.	Mental or behavioral health: 40% coinsurance, plus charges over allowed amount.*	Treatment for substance use disorder not covered.
	Inpatient services	Mental or behavioral health: No charge up to $450 room and board/day and $2,500 miscellaneous hospital charges/confinement. Then 20% coinsurance (after deductible).	Mental or behavioral health: No charge up to $450 room and board/day and $2,500 miscellaneous hospital charges/confinement. Then 40% coinsurance (after deductible), plus charges over allowed amount.*	Treatment for substance use disorder not covered. Basic benefit inpatient hospital limit (mental or behavioral health): 70 days/confinement; rate for semi-private room. Prior authorization required or benefits may not be paid.
If you are pregnant	Office visits	No charge up to $100/visit; then 20% coinsurance (after deductible).	No charge up to $100/visit; then 40% coinsurance (after deductible), plus charges over allowed amount.	Basic benefit office visit limit: 15 visits and/or $1,500 /year. Combined with all office visits. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance or deductible may apply.

	Childbirth/delivery professional services	No charge up to $100/visit, then 20% coinsurance (after deductible).	No charge up to $100/visit, then 40% coinsurance (after deductible), plus charges over allowed amount.*	Basic benefit inpatient provider limit: 15 visits and/or $1,500/year.
	Childbirth/delivery facility services	No charge up to $450 room and board/day and $2,500 miscellaneous hospital charges/confinement. Then 20% coinsurance (after deductible).	No charge up to $450 room and board/day and $2,500 miscellaneous hospital charges/confinement. Then 40% coinsurance (after deductible), plus charges over allowed amount.*	Coverage limited to rate for semi-private room.
If you need help recovering or have other special health needs	Home health care	20% coinsurance.	40% coinsurance, plus charges over allowed amount.	Limit: 30 days/year. Prior authorization required or benefits may not be paid.
	Rehabilitation services	Inpatient: no charge up to $100/day; then 20% coinsurance (after deductible). Outpatient: 20% coinsurance.	Inpatient: no charge up to $100/day; then 40% coinsurance (after deductible). Outpatient: 40% coinsurance. Plus charges over allowed amount.*	Inpatient limit: 6 weeks/illness. Outpatient physical therapy: 26 visits/year. Outpatient speech therapy: 26 visits/year.
	Habilitation services	20% coinsurance.	40% coinsurance, plus charges over allowed amount.	None.
	Skilled nursing care	No charge up to $100/day; then 20% coinsurance (after deductible).	No charge up to $100/day; then 40% coinsurance (after deductible), plus charges over allowed amount.	Limit: 100 days/lifetime. Prior authorization required or benefits may not be paid.
	Durable medical equipment	20% coinsurance.	40% coinsurance, plus charges over allowed amount.	Coverage for less expensive of rental or purchase.
	Hospice services	No charge up to $30,000, then 20% coinsurance (after deductible).	No charge up to $30,000, then 40% coinsurance (after deductible), plus charges over allowed amount.*	Limit: 180 days/lifetime. Prior authorization required or benefits may not be paid.

If your child needs dental or eye care	Children's eye exam	$15 copay/visit.	No charge up to $35, then 40% coinsurance plus charges over allowed amount.	Network providers limit: 1 exam/12 months. Out-of-network providers limit: 1 exam/12 months. Vision screenings for children required to be covered as a Preventive Service shall be paid at 100%. Separately administered by VSP. Medical plan deductible does not apply. Cost sharing does not count toward out-of-pocket limit.
	Children's glasses	$20 copay/pair of glasses.	No charge up to $35 (frames) or $25 (single vision lenses), then charges over allowed amount.	Limit: 1 pair glasses/12 months. Separately administered. Medical plan deductible does not apply. Cost sharing does not count toward out-of-pocket limit.
	Children's dental check-up	No charge after dental deductible of $50/individual or $150/family.	No charge after dental deductible of $50/individual or $150/family.	No deductible applies to Covered Expenses for pediatric dental services that are Preventive Services.

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
- Cosmetic surgery (except for injury or congenital defect, or following mastectomy)
- Infertility treatment
- Long-term care
- Treatment for substance use disorder
- Weight loss programs (except as required by ACA)

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

- Bariatric surgery
- Chiropractic services (limit: 12 visits/year)
- Dental care (Adult) ($3,500 annual maximum)
- Hearing aids (limit: 1 pair and $2,000/3 years)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (limitations apply)
- Routine eye care (Adult) (limitations apply)
- Routine foot care (limitations apply)

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 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, contact: call 800-741-9249. You may also contact the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Maryland Office of the Attorney General Health Education and Advocacy Unit at 877-261-8807 or heau@oag.state.md.us.

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 800-741-9249.

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.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$ 200
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$10
Coinsurance	$1,490
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,760**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$200
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$350
Coinsurance	$240
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$790**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$200
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$10
Coinsurance	$270
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$480**

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