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 **1-800-941-2752**. 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 **1-800-941-2752** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$3,000** Individual / **$7,500** 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 some items and services even if you haven't yet met your deductible. Preventive care services do not require you to meet a deductible.
Are there other deductibles for specific services?	**Yes.** Rx - **$3,000** Ind/ **$7,500** Family	You must meet the Rx deductible before Rx copayments apply
What is the out-of-pocket limit for this plan?	**$7,000** Ind / **$14,100** Family **Rx: $7,000 Ind /$14,100 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?	**Copayments**, **premiums**, **balance-billed** charges, **out of network coinsurance**, health care this plan doesn't cover	Even though you pay these expenses, they don't count toward your out-of-pocket limit.
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 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.

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	First 3 visits No Charge, Fourth and Subsequent visits 50% coinsurance	Not covered out-of-network	Charges above allowed amount are your responsibility
	Specialist visit	50% coinsurance	Not covered out-of-network	Charges above allowed amount are your responsibility
	Preventive care/screening/ immunization	$0	Not covered out-of-network	You may have to pay for services that are not preventive. Check with your doctor to confirm.
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance	Not covered out-of-network	Charges above allowed amount are your responsibility
	Imaging (CT/PET scans, MRIs)	50% coinsurance	Not covered out-of-network	Charges above allowed amount are your responsibility
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cvs.com.	Generic drugs	50% coinsurance	Not covered out-of-network	Requires Calendar year deductible of **$100** /Ind and **$300**/ Family before coinsurance applies. Generic drugs required unless physician specifically requires brand drug be dispensed.
	Preferred brand drugs	50% coinsurance	Not covered out-of-network	
	Non-preferred brand drugs	50% coinsurance	Not covered out-of-network	
	Specialty drugs	50% coinsurance	Not covered out-of-network	Covered through CVS Specialty Pharmacy. **Prior approval required.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	Not covered out-of-network	Charges above allowed amount are your responsibility
	Emergency room care	$250 copayment/visit	$250 copayment/visit	Covered for life-threatening illness or accidental injury.

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 medical transportation	50% coinsurance	Not covered out-of-network	
	Urgent care	$50 copayment/visit	Not covered out-of-network	Charges above allowed amount are your responsibility
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copayment per day, max ten days	Not covered out-of-network	**Requires pre-approval. Call 1-800-925-8573.** Charges above allowed amount are your responsibility.
	Physician/surgeon fees	50% coinsurance	Not covered out-of-network	Charges above allowed amount are your responsibility.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% coinsurance	Not covered out-of-network	Charges above allowed amount are your responsibility
	Inpatient services	50% coinsurance	Not covered out-of-network	**Requires pre-approval. Call 1-800-925-8573.** Charges above allowed amount are your responsibility.
If you are pregnant	Office visits	50% coinsurance	Not covered out-of-network	Charges above allowed amount are your responsibility
	Childbirth/delivery professional services	50% coinsurance	Not covered out-of-network	Member / Spouse only. **Requires pre-approval. Call 1-800-925-8573.** Charges above allowed amount are your responsibility.
	Childbirth/delivery facility services	50% coinsurance	Not covered out-of-network	Member / Spouse only. **Requires pre-approval. Call 1-800-925-8573.** Charges above allowed amount are your responsibility.
If you need help recovering or have	Home health care	50% coinsurance	Not covered out-of-network	**Requires pre-approval.** 40 visits per illness.
	Rehabilitation services	50% coinsurance	Not covered out-of-network	**Requires pre-approval.** Charges above allowed amount are your responsibility.
	Habilitation services	Not Covered	Not covered out-of-network	

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)	
other special health needs	Skilled nursing care	50% coinsurance	Not covered out-of-network	**Requires pre-approval.** 120 day limit per admission. Charges above allowed amount are your responsibility.
	Durable medical equipment	50% coinsurance	Not covered out-of-network	Fund will cover lesser of cost of rental or purchase price.
	Hospice services	50% coinsurance	Not covered out-of-network	**Requires pre-approval.** 40 visits per illness.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not covered out-of-network	
	Children's glasses	Not Covered	Not covered out-of-network	
	Children's dental check-up	Not Covered	Not covered out-of-network	

Excluded Services & Other Covered Services:

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

- Acupuncture
- Chiropractic care
- Mastectomy Supplies ($750 limit/calendar year)

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
- Hearing aids
- Infertility treatment
- Long term care
- Private duty nursing
- Routine foot care
- Routine vision care
- Weight loss programs
- Non-emergency care outside U.S.

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 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: :1-800-941-2752 or call the Fund Office at 410-872-9500 or 800-638-8824. You may also contact the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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	$2,000
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	**$12,991**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2000
Copayments	$280
Coinsurance	$720
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

The plan's overall deductible	$2,000
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	30%

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	**$7,441**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1814
Copayments	$780
Coinsurance	$406
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,055**

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

The plan's overall deductible	$2,000
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing*	30%

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1460
Copayments	$60
Coinsurance	$405
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

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