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, visit www.cfablue.com or call **877-889-2478**. 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.healthcare.gov/sbc-glossary or call **877-889-2478** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,700** individual / **$3,400** family for in-network providers and **$3,400** individual / **$6,800** family for out-of-network providers. Pre-certification penalties and balance-billed charges don't count toward the deductible.	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network, preventive care is 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$6,800** individual / **$13,600** family for in-network and out-of-network providers.	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?	Pre-certification penalties, premiums, balance-billed 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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See **www.cfablue.com** or call **1-877-889-2478** 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	$25/visit* Same as any covered service for telemedicine (non-designated provider)	40% coinsurance* Same as any covered service for telemedicine (non-designated provider)	——————none——————
	Specialist visit	$25/visit*	40% coinsurance*	——————none——————
	Preventive care/screening/ immunization	No charge Deductible does not apply	40% coinsurance*	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)	10% coinsurance*	40% coinsurance*	——————none——————
	Imaging (CT/PET scans, MRIs)	10% coinsurance*	40% coinsurance*	Pre-certification required in order to avoid a 50% reduction in covered charges.

For more information about limitations and exceptions, see plan or policy document at www.cfablue.com or call 877-889-2478

* After deductible

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.optumrx.com	Generic drugs	$10/prescription* (retail) $20prescription* (mail order)	Applicable copayment, plus charges in excess of the allowed amount	Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription). Deductible applies to all but preventive care drugs. If you purchase a brand name drug in lieu of a generic drug, your copayments may be higher, as described in the plan document. When received at an in-network pharmacy, no charge for over-the-counter drugs related to preventive care, or FDA-approved generic and over-the-counter contraceptive methods for women (prescription required).
	Preferred brand drugs	$55/prescription* (retail) $110prescription* (mail order)	Applicable copayment, plus charges in excess of the allowed amount	
	Non-preferred brand drugs	$80/prescription* (retail) $160prescription* (mail order)	Applicable copayment, plus charges in excess of the allowed amount	
	Specialty drugs	Applicable copayment	Applicable copayment, plus charges in excess of the allowed amount	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance*	40% coinsurance*	——————none——————
	Physician/surgeon fees	10% coinsurance*	40% coinsurance*	——————none——————
If you need immediate medical attention	Emergency room care	$50/visit* up to maximum of $500, then 10% coinsurance* for facility $250/visit* for first 72 hours, then 10% coinsurance* if admitted 10% coinsurance* for professional	$50/visit* up to maximum of $500, then 10% coinsurance* for facility $250/visit* for first 72 hours, then 10% coinsurance* if admitted 10% coinsurance* for professional	In-network deductible applies to out-of-network emergency room care. Use of the emergency room for non-emergency care will be denied. Copayment waived if admitted.
	Emergency medical transportation	10% coinsurance*	10% coinsurance*	In-network deductible applies to out-of-network ambulance.
	Urgent care	10% coinsurance*	40% coinsurance*	——————none——————

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 have a hospital stay	Facility fee (e.g., hospital room)	$250 copayment*, then 10% coinsurance*	$250 copayment*, then 40% coinsurance*	Pre-certification required in order to avoid a 50% reduction in covered charges. Failure to request extension of original certification will result in denial of benefits for the remainder of the hospital stay.
	Physician/surgeon fees	10% coinsurance*	40% coinsurance*	————————none————————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25/visit* 10% coinsurance* for other outpatient services Same as any covered service for telemedicine (non-designated provider)	40% coinsurance* Same as any covered service for telemedicine (non-designated provider)	Maximum 100 visits/year for intensive outpatient services. Pre-certification required for intensive outpatient services in order to avoid a 50% reduction in covered charges.
	Inpatient services	$250 copayment*, then 10% coinsurance* for hospital, detoxification, and rehabilitation facility 10% coinsurance* for residential treatment facility	$250 copayment*, then 40% coinsurance* for hospital, detoxification, and rehabilitation facility 40% coinsurance* for residential treatment facility	Pre-certification required in order to avoid a 50% reduction in covered charges.
If you are pregnant	Office visits	10% coinsurance*	40% coinsurance*	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance*	40% coinsurance*	————————none————————
	Childbirth/delivery facility services	$250 copayment*, then 10% coinsurance*	$250 copayment*, then 40% coinsurance*	Pre-certification is required for inpatient in order to avoid a 50% reduction in covered charges.

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 help recovering or have other special health needs	Home health care	10% coinsurance*	40% coinsurance*	Maximum 100 visits/year. Pre-certification required in order to avoid a 50% reduction in covered charges.
	Rehabilitation services	$25/visit* for professional 10% coinsurance* for inpatient, outpatient facility, cardiac rehabilitation, and respiratory therapy	40% coinsurance*	Maximum 60 visits/year for occupational, physical, and speech therapies. Pre-certification required for inpatient in order to avoid a 50% reduction in covered charges.
	Habilitation services	$25/visit*	40% coinsurance*	Includes applied behavioral analysis (ABA).
	Skilled nursing care	10% coinsurance*	40% coinsurance*	Pre-certification required in order to avoid a 50% reduction in covered charges.
	Durable medical equipment	10% coinsurance*	40% coinsurance*	——————none——————
	Hospice services	10% coinsurance*	40% coinsurance*	Maximum 180 days/lifetime for inpatient and outpatient. Maximum 6 visits/lifetime for bereavement counseling and 9 months after patient's death for family counseling. Maximum 45 reserve days/lifetime. Pre-certification required for inpatient in order to avoid a 50% reduction in covered charges.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered under the medical plan.
	Children's glasses	Not covered	Not covered	Not covered under the medical plan.
	Children's dental check-up	Not covered	Not covered	Not covered under the medical plan.

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.)

- Cosmetic surgery, unless restoring bodily function or correcting deformity resulting from non-cosmetic surgery, accidental injury, or congenital defect
- Dental care (adult & child), unless due to accidental injury
- Glasses (adult & child), unless due to accidental injury or intraocular surgery
- Hearing aids, unless due to accidental injury
- Long-term care
- Non-emergency care when traveling outside the U.S., if purpose of travel is to receive care
- Routine eye care (adult & child)
- Routine foot care
- Weight loss programs, except as covered under the Affordable Care Act

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

- Acupuncture (maximum 30 visits/year)
- Bariatric surgery, for morbid obesity
- Chiropractic care (maximum 30 visits/year)
- Infertility treatment (maximum $5,000/year)
- Private-duty nursing, outpatient

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, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact Maryland Office of the Attorney General, Health Education and Advocacy Unit, 200 St. Paul Place, 16th Floor, Baltimore, MD 21202, 877-261-8807, www.oag.state.md.us/Consumer.HEAU.htm.

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 **877-889-2478**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **877-889-2478**.

Chinese (中文): **如果需要中文的帮助**，请拨打这个号码 **877-889-2478**.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf **877-889-2478** uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni **877-889-2478**.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye **877-889-2478**.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang **877-889-2478**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **877-889-2478**.

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	**$1,700**
Specialist copayment	**$25**
Hospital (facility) copayment	**$250**
Other coinsurance	**10%**

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	$1,700
Copayments	$300
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,400**

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

The plan's overall deductible	**$1,700**
Specialist copayment	**$25**
Hospital (facility) copayment	**$250**
Other coinsurance	**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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,700
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,200**

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

The plan's overall deductible	**$1,700**
Specialist copayment	**$25**
Hospital (facility) copayment	**$250**
Other coinsurance	**10%**

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	$1,700
Copayments	$200
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,940**

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