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 800-618-2879. 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 800-618-2879 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$400**/individual; **$800**/family.	Generally, you must pay all 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 the deductible expenses paid by all family members meets the overall family deductible. For example, once two family members meet their own individual deductibles, the family deductible is met for all family members.
Are there services covered before you meet your deductible?	Yes. In-network preventive care, vision services and dental care 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this Plan?	Medical**: $5,000**/individual; **$10,000**/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, health care this Plan does not cover, dental services under Delta Dental Plan, and vision for individuals over 19.	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 in Maryland, D.C. or northern Virginia. See www.medcost.com/medcost-virginia or call 804-320-3837 for a list of in-network providers in Virginia.	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	$20 copay/visit.	$20 copay/visit plus charges over allowed amount.	No charge for Teladoc visit; no charge for visits to Steamfitters Local 602 Family Medical Center.
	Specialist visit	$20 copay/visit.	$20 copay/visit plus charges over allowed amount.	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	20% coinsurance plus charges over allowed amount.	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)	20% coinsurance.	20% coinsurance plus charges over allowed amount.	None.
	Imaging (CT/PET scans, MRIs)	10% coinsurance.	30% coinsurance plus charges over allowed amount.	

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cvs.com	Generic drugs	Retail: $5 copay/prescription. Mail order: $10 copay/prescription	Plan will reimburse the average wholesale price less copay only.	Limit: Retail 30-day supply (except maintenance medications filled at CVS); Mail order: 90-day supply Maintenance medications: after first 2 retail fills, must fill via CVS mail order or at CVS retail pharmacy. No charge for ACA-required generic preventive drugs (e.g., contraceptives) or a brand preventive drug if a generic is not medically appropriate. If you accept a generic drug in place of a brand drug, the first 6 months of prescriptions are covered at no charge. Prescriptions filled at Steamfitters Local 602 Family Medical Center are available at no charge.
	Preferred brand drugs	Retail: $10 copay/prescription. Mail order: $20 copay/prescription.		
	Non-preferred brand drugs	Retail: $25 copay/prescription. Mail order: $50 copay/prescription.		
	Specialty drugs	Generic: $5 copay/prescription. Preferred brand: $10 copay/prescription. Non-preferred brand: $25 copay/prescription.	Not covered.	Limit: 30-day supply. Must use CVS Health Specialty Pharmacy. Some prescriptions may require precertification.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance.	20% coinsurance plus charges over allowed amount.	None.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	20% coinsurance.	20% coinsurance*	None.
	Emergency medical transportation	20% coinsurance.	20% coinsurance plus charges over allowed amount. *	Limit: 3 trips/year. Coverage for local transportation only.
	Urgent care	$20 copay/visit	$20 copay/visit plus charges over allowed amount. *	None.

*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 the No Surprises Act. See the Plan for more information.

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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance.	20% coinsurance plus charges over allowed amount.	Limited to semi-private room rate unless private room is medically necessary; precertification required or benefits may be reduced.
	Physician/surgeon fees	20% coinsurance.	20% coinsurance plus charges over allowed amount.	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $20 copay/visit. Other outpatient services: 20% coinsurance.	Office visit: $20 copay/visit plus charges over allowed amount. Other outpatient services: 20% coinsurance plus charges over allowed amount.	No charge for Teladoc visit; no charge for visits to Steamfitters Local 602 Family Medical Center.
	Inpatient services	20% coinsurance.	20% coinsurance plus charges over allowed amount.	Limited to semi-private room rate; precertification required or benefits may be reduced.
If you are pregnant	Office visits	No charge for office visits for prenatal care (when required to be covered by law); 20% coinsurance for other prenatal and postnatal care.	20% coinsurance plus charges over allowed amount.	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance.	20% coinsurance plus charges over allowed amount. *	Limited to semi-private room rate and precertification required for childbirth/delivery professional services for stay over 48 hours (96 hours in case of cesarean section) or benefits may be reduced.
	Childbirth/delivery facility services			

*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 the No Surprises Act. See the Plan for more information.

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 help recovering or have other special health needs	Home health care	20% coinsurance.	20% coinsurance plus charges over allowed amount.	Limit: 30 days/year, plus additional 30 days covered with additional precertification. Additional days of Home Health Care Benefits in excess of the additional 30 days of coverage may also be provided when approved by the Plan's case management services provider. Precertification required or benefits may be reduced.
	Rehabilitation services	$20 copay/visit.	$20 copay/visit plus charges over allowed amount.	Physical therapy, occupational therapy and speech therapy for 52 visits/year, plus 50% of the covered medical expenses of an additional 52 visits of physical therapy, occupational therapy and speech therapy per year, when precertified and determined to be medically necessary. Inpatient services limited to 6 weeks per illness, injury, or condition. Precertification required for inpatient services or benefits may be reduced. Referral is required.
	Habilitation services	Not covered.	Not covered.	You must pay 100% of this service, even in-network.
	Skilled nursing care	20% coinsurance.	20% coinsurance plus charges over allowed amount.	Precertification required or benefits may be reduced. Limit: 100 days/lifetime. Must follow, or be an alternative to, hospitalization.
	Durable medical equipment	20% coinsurance.	20% coinsurance plus charges over allowed amount.	Precertification required or benefits may be reduced. Coverage for cost of rental up to purchase price. Motorized wheelchair: 50% coinsurance once/5 years.
	Hospice services	20% coinsurance.	20% coinsurance plus charges over allowed amount.	For terminal illness with 6 months or less life expectancy. Precertification required or benefits may be reduced.

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 your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	Charges over allowed amount.	Limit: 1 exam/year. Separately administered by National Vision Administrators
	Children's glasses	No charge. Deductible does not apply.	Charges over allowed amount.	Limit: 1 set of glasses/year. Separately administered by National Vision Administrators
	Children's dental check-up	No charge. Deductible does not apply.	20% coinsurance and charges over allowed amount.	Precertification required for services in excess of $200. Separately administered by Delta Dental.

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 (except for repair of injury or following mastectomy)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- 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.)

- Acupuncture (limit: 26 visits/year)
- Bariatric surgery (precertification required)
- Private Duty Nursing
- Chiropractic care (limit: 12 visits/year; additional 40 visits/year covered with referral)
- Dental care (Adult) (limit: $4,500/year for individuals 19 and over)
- Hearing aids (limit: $3,000/3 years)
- Routine eye care (Adult) (limit: one exam/year; one set of glasses/year; $275/year for individuals 19 and over; excludes eye exam)

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: the 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 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, call 800-618-2879. 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: Maryland Office of the Attorney General, Health Education and Advocacy Unit at 877-261-8807 or visit http://www.oag.state.md.us/Consumer.HEAU.htm or email 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 800-618-2879.

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** **$400**
- **Specialist copayment** **$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	$400
Copayments	$40
Coinsurance	$2,120
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,580**

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

- **The Plan's overall deductible** **$400**
- **Specialist copayment** **$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	$400
Copayments	$520
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$940**

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

- **The Plan's overall deductible** **$400**
- **Specialist copayment** **$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	$400
Copayments	$90
Coinsurance	$390
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$880**

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