



@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:
<u>What is the overall deductible?</u>	Retirees and dependents eligible for Medicare: \$0 Dependents not eligible for Medicare: \$200/individual; \$400/family.	Retirees and dependents eligible for Medicare: See the Common Medical Events chart below for your costs when this <u>plan</u> pays secondary. Dependents not eligible for Medicare: Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have one non-Medicare-eligible family member on the <u>plan</u> , that family member must meet the individual <u>deductible</u> . If you have other non-Medicare-eligible family members on the <u>plan</u> , two or more family members must pay <u>deductible</u> expenses for the family <u>deductible</u> to be met.
<u>Are there services covered before you meet your deductible?</u>	Retirees and dependents eligible for Medicare: not applicable. Dependents not eligible for Medicare: Yes. <u>In-network preventive care</u> , vision services and dental care are covered before you meet your <u>deductible</u> .	Retirees and dependents eligible for Medicare: These individuals do not have a <u>deductible</u> . Dependents not eligible for Medicare: This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	Medical: \$4,000/individual; \$8,000/family. <u>Prescription drugs</u> : \$1,600/individual; \$3,200/family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<u>What is not included in the out-of-pocket limit?</u>	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> does not cover, dental services under Delta Dental <u>plan</u> , and vision for individuals over 19.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u>?	Yes. See www.carefirst.com or call 800-235-5160 for a list of <u>in-network providers</u> in Maryland, D.C. or northern Virginia. See www.medcost.com /medcost-virginia or call 804-320-3837 for a list of <u>in-network providers</u> in Virginia.	While this <u>plan</u> uses a <u>provider network</u> , the <u>plan</u> treats <u>in- and out-of-network providers</u> the same in determining payment for the same services. However, you may pay more if you use an <u>out-of-network provider</u> primarily because you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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	Medicare-eligible: No charge. Not Medicare-eligible: \$20 <u>copay</u> /visit.	Medicare-eligible: No charge. Not Medicare-eligible: \$20 <u>copay</u> /visit plus charges over <u>allowed amount</u> .	Individuals not Medicare-eligible: no charge for Teladoc visit; no charge for visits to Steamfitters Local 602 Family Medical Center. <u>Plan</u> pays secondary to Medicare.
	<u>Specialist</u> visit	No charge. <u>Deductible</u> does not apply.	20% <u>coinsurance</u> plus charges over <u>allowed amount</u> .	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. <u>Plan</u> pays secondary to Medicare.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u> .	Medicare-eligible: 20% <u>coinsurance</u> plus charges over <u>allowed amount</u> . Not Medicare-eligible: 20% <u>coinsurance</u> plus charges over <u>allowed amount</u> .	<u>Plan</u> pays secondary to Medicare.
	Imaging (CT/PET scans, MRIs)	\$20 <u>copay</u> .	\$20 <u>copay</u> . Not Medicare-eligible: \$20 <u>copay</u> .	

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)	
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.silverscript.com and www.cvs.com</p>	Generic drugs	<p>Retail (up to 31-day supply): \$5 <u>copay</u>/prescription.</p> <p>Retail (up to 90-day supply) Preferred <u>Network</u>: \$10 <u>copay</u>/prescription.</p> <p>Retail (up to 90-day supply) Non-Preferred <u>Network</u>: \$15 <u>copay</u>/prescription.</p> <p>Mail order: \$10 <u>copay</u>/prescription.</p>	<p>Retirees and dependents eligible for Medicare: generally not covered <u>out-of-network</u>.</p> <p>Dependents not eligible for Medicare: <u>plan</u> will reimburse average wholesale price less <u>copay</u>.</p>	<p>Medicare-eligible participants may only use <u>out-of-network</u> pharmacies in limited situations.</p> <p>Medicare-eligible participants may obtain up to 90 days of maintenance medications at Preferred <u>Network</u> pharmacies.</p>
	Preferred brand drugs	<p>Retail (up to 31-day supply): \$10 <u>copay</u>/prescription.</p> <p>Retail (up to 90-day supply) Preferred <u>Network</u>: \$20 <u>copay</u>/prescription.</p> <p>Retail (up to 90-day supply) Non-Preferred <u>Network</u>: \$30 <u>copay</u>/prescription.</p> <p>Mail order: \$20 <u>copay</u>/prescription.</p>	<p>Retirees and dependents eligible for Medicare: generally not covered <u>out-of-network</u>.</p> <p>Dependents not eligible for Medicare: <u>plan</u> will reimburse average wholesale price less <u>copay</u>.</p>	<p>Mail order: limited to up to a 90-day supply</p> <p>Some prescriptions may require precertification.</p> <p>After yearly drug costs for Medicare-eligible individuals reach \$7,050, they pay: the greater of 5% of the drug cost or \$3.95 but no more than \$5.00/generic prescription; the greater of 5% of the drug cost or \$9.85 but no more than \$10.00/preferred brand prescription; the greater of 5% of the drug cost or \$9.85 but no more than \$25.00/non-preferred brand prescription.</p>
	Non-preferred brand drugs	<p>Retail (up to 31-day supply): \$25 <u>copay</u>/prescription.</p> <p>Retail (up to 90-day supply) Preferred <u>Network</u>: \$50 <u>copay</u>/prescription.</p> <p>Retail (up to 90-day supply) Non-Preferred <u>Network</u>: \$75 <u>copay</u>/prescription.</p> <p>Mail order: \$50 <u>copay</u>/prescription.</p>	<p>Retirees and dependents eligible for Medicare: generally not covered <u>out-of-network</u>.</p> <p>Dependents not eligible for Medicare: <u>plan</u> will reimburse average wholesale price less <u>copay</u>.</p>	<p>No charge for ACA-required generic preventive drugs (e.g., contraceptives) or a brand preventive drug if a generic is not medically appropriate.</p> <p>Prescriptions filled at Steamfitters Local 602 Family Medical Center are available at no charge.</p>
	Specialty drugs	Same as above based on whether drug is generic drug, preferred brand drug or non-preferred brand drug.	<p>Retirees and dependents eligible for Medicare: generally not covered <u>out-of-network</u>.</p> <p>Dependents not eligible for Medicare: not covered.</p>	

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> .	20% <u>coinsurance</u> plus charges over <u>allowed amount</u> .	<u>Plan</u> pays secondary to Medicare.
	Physician/surgeon fees			
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> .	20% <u>coinsurance</u> plus charges over <u>allowed amount</u> .*	<u>Plan</u> pays secondary to Medicare.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> .	20% <u>coinsurance</u> plus charges over <u>allowed amount</u> .*	No limit. Coverage for local transportation only. <u>Plan</u> pays secondary to Medicare.
	<u>Urgent care</u>	Office visit (Medicare-eligible): no charge. Office visit (not Medicare-eligible): \$20 <u>copay</u> /visit. X-rays and lab work: 10% <u>coinsurance</u> .	Office visit (Medicare-eligible): no charge. Office visit (not Medicare-eligible): \$20 <u>copay</u> /visit plus charges over <u>allowed amount</u> .* X-rays and lab work (Medicare-eligible): 10% <u>coinsurance</u> plus charges over <u>allowed amount</u> .* X-rays and lab work (not Medicare-eligible): 30% <u>coinsurance</u> plus charges over <u>allowed amount</u> .*	<u>Plan</u> pays secondary to Medicare.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> .	20% <u>coinsurance</u> plus charges over <u>allowed amount</u> .	Limited to semi-private room rate unless private room is <u>medically necessary</u> ; precertification required or benefits may be reduced. <u>Plan</u> pays secondary to Medicare.
	Physician/surgeon fees	20% <u>coinsurance</u> .	20% <u>coinsurance</u> plus charges over <u>allowed amount</u> .	<u>Plan</u> pays secondary to Medicare.

*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 mental health, behavioral health, or substance abuse services	Outpatient services	Office visits (Medicare-eligible): no charge. Office visit (not Medicare-eligible): \$20 <u>copay</u> /visit. Other outpatient services: 20% <u>coinsurance</u> .	Office visits (Medicare-eligible): no charge. Office visit (not Medicare-eligible): \$20 <u>copay</u> /visit plus charges over <u>allowed amount</u> . Other outpatient services: 20% <u>coinsurance</u> plus charges over <u>allowed amount</u> .	No charge for Teladoc visit; no charge for visits to Steamfitters Local 602 Family Medical Center. <u>Plan</u> pays secondary to Medicare.
	Inpatient services	20% <u>coinsurance</u> .	20% <u>coinsurance</u> plus charges over <u>allowed amount</u> .	Limited to semi-private room rate; precertification required or benefits may be reduced. <u>Plan</u> pays secondary to Medicare.
If you are pregnant	Office visits	No charge for office visits for prenatal care (when required to be covered by law); 20% <u>coinsurance</u> for other prenatal and postnatal care.	20% <u>coinsurance</u> plus charges over <u>allowed amount</u> *.	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). <u>Plan</u> pays secondary to Medicare.
	Childbirth/delivery professional services	No cost.	20% <u>coinsurance</u> plus charges over <u>allowed amount</u> *.	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. <u>Plan</u> pays secondary to Medicare.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u> .	20% <u>coinsurance</u> plus charges over <u>allowed amount</u> .	Limit: 30 days/year, plus additional 30 days covered with additional precertification.* Additional days of <u>Home Health Care</u> Benefits in excess of the additional 30 days of coverage may also be provided when approved by the <u>Plan's</u> case management services provider. <u>Preadmission</u> required or benefits may be reduced. <u>Plan</u> pays secondary to Medicare.

*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
If you need help recovering or have other special health needs (continued)	<u>Rehabilitation services</u>	No charge.	\$20 copay/visit plus charges over <u>allowed amount</u> .	Physical therapy, occupational therapy and speech therapy for 52 visits/year, plus 50% of the covered medical expenses of an additional 52 sessions of physical therapy, occupational therapy and speech therapy per year, when precertified and determined to be <u>medically necessary</u> . Inpatient services limited to 6 weeks per illness, injury, or condition. Precertification required for inpatient services or benefits may be reduced. <u>Referral</u> is required. <u>Plan</u> pays secondary to Medicare.
	<u>Habilitation services</u>	No charge.	20% copay/visit plus charges over <u>allowed amount</u> .	Speech therapy for congenital disorders when precertified and determined to be <u>medically necessary</u> . Precertification required or benefits may be reduced.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> .	20% <u>coinsurance</u> plus charges over <u>allowed amount</u> .	Precertification required or benefits may be reduced. Limit: 100 days/lifetime. Must follow, or be an alternative to, <u>hospitalization</u> . <u>Plan</u> pays secondary to Medicare.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> .	20% <u>coinsurance</u> plus charges over <u>allowed amount</u> .	Precertification required or benefits may be reduced. Coverage for cost of rental up to purchase price. Motorized wheelchair: 50% <u>coinsurance</u> once/5 years. <u>Plan</u> pays secondary to Medicare.
	<u>Hospice services</u>	20% <u>coinsurance</u> .	20% <u>coinsurance</u> plus charges over <u>allowed amount</u> .	For terminal illness with 6 months or less life expectancy. Precertification required or benefits may be reduced. <u>Plan</u> pays secondary to Medicare.
If your child needs dental or eye care	Children's eye exam	No charge. <u>Deductible</u> does not apply.	Charges over <u>allowed amount</u> .	Limit: 1 exam/year. Separately administered by National Vision Administrators
	Children's glasses	No charge. <u>Deductible</u> does not apply.	Charges over <u>allowed amount</u> .	Limit: 1 set of glasses/year. Separately administered by National Vision Administrators

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
	Children's dental check-up	No charge. <u>Deductible</u> does not apply.	20% <u>coinsurance</u> and charges over <u>allowed amount</u> .	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)
- Non-emergency care when traveling outside the U.S.
- Infertility treatment
- Long-term care
- 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 <http://www.oag.state.md.us/Consumer.HEAU.htm> 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 800-618-2879.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples: These coverage examples illustrate costs for a dependent not eligible for Medicare.



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 <u>plan's</u> overall <u>deductible</u>	\$200
■ <u>Specialist copayment</u>	\$20
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$120
<u>Coinsurance</u>	\$140
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Peg would pay is	\$480

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$200
■ <u>Specialist copayment</u>	\$20
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$520
<u>Coinsurance</u>	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$760

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$200
■ <u>Specialist copayment</u>	\$20
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$330
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$540

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