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?	**$500** individual / **$1,000** family for in-network providers Prescription Drug Plan expenses, 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, 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. 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?	Yes. **$250** individual / **$750** family for prescription drug coverage.	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?	**$3,000** individual / **$6,000** family for in-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.
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). Or 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.

Important Questions	Answers	Why This Matters:
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	20% coinsurance*	Not covered	————————none————————
	Specialist visit	20% coinsurance*	Not covered	Acupuncture not covered.
	Preventive care/screening/ immunization	No charge; Deductible does not apply	Not covered	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*	Not covered	————————none————————
	Imaging (CT/PET scans, MRIs)	20% coinsurance*	Not covered	————————none————————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.epiphanyrx.com.	Generic drugs	$15/prescription* (retail) $37.50/prescription* (mail order)	Applicable copayment, plus charges in excess of the allowed amount	Covers up to a 31-day supply (retail prescription); 90-day supply (mail order prescription). 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	$35/prescription* (retail) $87.50/prescription* (mail order)	Applicable copayment, plus charges in excess of the allowed amount	
	Non-preferred brand drugs	$75/prescription* (retail) $187.50/prescription* (mail order)	Applicable copayment, plus charges in excess of the allowed amount	
	Specialty drugs	Not covered	Not covered	————————none————————

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance*	Not covered	Pre-certification required in order to avoid the $250 penalty.
	Physician/surgeon fees	20% coinsurance*	Not covered	——————none——————
If you need immediate medical attention	Emergency room care	20% coinsurance*	20% coinsurance*	In-network deductible applies to out-of-network emergency room care. If admitted as an inpatient directly from the emergency room, the coinsurance and deductible are waived
	Emergency medical transportation	20% coinsurance*	20% coinsurance*	In-network deductible applies to out-of-network ambulance. Pre-certification required for non-emergency use of water ambulance in order to avoid the $250 penalty.
	Urgent care	20% coinsurance*	Not covered	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance*	Not covered	Pre-certification required. Failure to pre-certify will reduce covered charges by $250. Failure to request extension of original certification will result in denial of benefits for the remainder of the hospital stay.
	Physician/surgeon fees	20% coinsurance*	Not covered	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance*	Not covered	——————none——————
	Inpatient services	20% coinsurance*	Not covered	Pre-certification required in order to avoid the $250 penalty.

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 are pregnant	Office visits	20% coinsurance*	Not covered	Cost sharing does not apply for preventive services. Depending on the type of service, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance*	Not covered	——————none——————
	Childbirth/delivery facility services	20% coinsurance*	Not covered	Pre-certification required in order to avoid the $250 penalty.
If you need help recovering or have other special health needs	Home health care	20% coinsurance*	Not covered	Maximum 60 visits/year.
	Rehabilitation services	20% coinsurance*	Not covered	Maximum 30 visits/year for occupational, physical, speech therapies, Pulmonary Rehabilitation and Respiratory Therapy. Maximum 36 visits/lifetime for cardiac rehabilitation. Maximum 60 days/year for inpatient facility. Pre-certification required for inpatient in order to avoid the $250 penalty.
	Habilitation services	20% coinsurance*	Not covered	Pre-certification required in order to avoid the $250 penalty.
	Skilled nursing care	20% coinsurance*	Not covered	Maximum 60 days/year. Pre-certification required in order to avoid the $250 penalty.
	Durable medical equipment	20% coinsurance*	Not covered	Pre-certification required in excess of $1,500 in order to avoid the $250 penalty.

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	Hospice services	20% coinsurance*	Not covered	Maximum 180 days/lifetime for inpatient and outpatient combined. Maximum 10 visits/lifetime for bereavement counseling and 10 visits/lifetime for family counseling. Pre-certification required for inpatient in order to avoid the $250 penalty.
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.)

- Acupuncture
- 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
- Long-term care
- Non-emergency care when traveling outside the U.S., if purpose of travel is to receive care
- Private-duty nursing
- 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.)

- Bariatric surgery, for morbid obesity (maximum 1 surgery/lifetime)
- Chiropractic care (maximum 30 visits/year)
- Infertility treatment (maximum $75,000/lifetime for medical and $25,000/lifetime for prescription drugs)
- Hearing aids (maximum 1 device/ear every 36 months)

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

* After deductible

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. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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	**$500**
Specialist cost sharing	**20%**
Hospital (facility) cost sharing	**%**
Other cost sharing	**%**

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	$500
Copayments	$0
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,900**

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

The plan's overall deductible	**$500**
Specialist cost sharing	**20%**
Hospital (facility) cost sharing	**20%**
Other cost sharing	**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	$750
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,450**

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

The plan's overall deductible	**$500**
Specialist cost sharing	**20%**
Hospital (facility) cost sharing	**20%**
Other cost sharing	**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	$500
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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