




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, go to <http://www.bridgedeck.org/hbforms.htm> or call 1-877-667-5522 or 410-850-8500. 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 by calling 1-877-667-5522 or 410-850-8500 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|--|
| What is the overall <u>deductible</u> ? | \$250 Individual/ \$500 Family | 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 other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay. |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Preventive care</u> and <u>prescription drugs</u> are covered before you meet your deductible. | 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. |
| Are there other <u>deductibles</u> for specific services? | Yes. \$150 for a non-PPO primary care provider visit and \$150 for an inpatient admission. There are no other specific <u>deductibles</u> . | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? | \$3,000 Individual/ \$10,000 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 plan, the overall family <u>out-of-pocket</u> limit must be met. |
| What is not included in the <u>out-of-pocket limit</u> ? | <u>Premiums</u> , charges in excess of the allowable amount (<u>balance-billing</u> charges), non-covered services/health care this <u>plan</u> does not cover, <u>deductibles</u> , and penalties for failure to obtain precertification for services | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u> ? | Yes. For a list of PPO providers, see http://www.bridgedeck.org/hbproviders.htm or call Cigna at 1-800-768-4695 or MultiPlan at 1-800-464-0292 | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the full cost if you use an <u>out-of-network provider</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 specialist 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 |
|---|--|---|---|--|
| | | PPO Provider (You will pay the least) | Non-PPO Provider (You will pay the most) | |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$15 <u>copay</u> /visit | 10% <u>coinsurance</u> after \$150 non-PPO <u>deductible</u> | None |
| | <u>Specialist</u> visit | \$25 <u>copay</u> /visit Acupuncture & Chiropractic: 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | Acupuncture and chiropractic care combined limited to 30 visits per calendar year and/or \$2,100. |
| | <u>Preventive care/screening/immunization</u> | No charge first \$1,250/family, <u>deductible</u> does not apply; then 10% <u>coinsurance</u> . | No charge first \$1,250/family, <u>deductible</u> does not apply; then 30% <u>coinsurance</u> . | Subject to age and frequency schedule. The following are not subject to any <u>deductible</u> or <u>copay</u> , and are not part of the \$1,250 limit: colorectal cancer screening using sigmoidoscopy or colonoscopy starting at age 50 until 75 once every 5 years, a mammogram for women over age 40 every year, and cervical cancer every three years. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | Must be recommended by physician. |
| | Imaging (CT/PET scans, MRIs) | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|--|
| | | PPO Provider (You will pay the least) | Non-PPO 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.caremark.com</p> | Generic drugs | Retail - 20% <u>coinsurance</u> , minimum \$7.50 <u>copay</u> per prescription fill or refill; Mail Order - 20% <u>coinsurance</u> , maximum \$75 <u>copay</u> per prescription fill or refill | Retail Only - 20% <u>coinsurance</u> , minimum \$7.50 <u>copay</u> per prescription fill or refill plus difference in cost between participating and non-participating pharmacy | <p>Covers up to a 30-day supply plus 2 refills (retail prescription); 31-60-day supply (mail order prescription). Mandatory mail order after 2 refills. Controlled substance limited to 30 days. No non-participating pharmacy benefits available for mail order.</p> <p>If a generic equivalent of a brand name drug is available, and you or your eligible dependent(s) request the brand name version, you will be responsible for paying the difference in cost between the brand name drug and the generic equivalent, in addition to the minimum <u>copay</u> amounts.</p> |
| | Brand drugs without Generic Equivalent | Retail - 20% <u>coinsurance</u> , minimum \$15 <u>copay</u> per prescription fill or refill; Mail Order - 20% <u>coinsurance</u> , maximum \$75 <u>copay</u> per prescription fill or refill | Retail Only - 20% <u>coinsurance</u> , minimum \$15 <u>copay</u> per prescription fill or refill plus difference in cost between participating and non-participating pharmacy | |
| | Brand drugs with Generic Equivalent | Retail only: 20% <u>coinsurance</u> , minimum \$15 <u>copay</u> per prescription fill or refill plus cost between generic and brand name drug | Retail Only - 20% <u>coinsurance</u> , minimum \$15 <u>copay</u> per prescription fill or refill plus cost between generic and brand and difference in cost between participating and non-participating pharmacy | |
| | <u>Specialty drugs</u> | Subject to applicable <u>coinsurance/copay</u> above | Subject to applicable <u>coinsurance/copay</u> above | |
| <p>If you have outpatient surgery</p> | Facility fee (e.g., ambulatory surgery center) | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| | Physician/surgeon fees | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> ; Multiple surgeries – 50% <u>coinsurance</u> for 2 nd surgery and 75% <u>coinsurance</u> thereafter | No charge for 2 nd and 3 rd surgical opinion. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|--|---|
| | | PPO Provider (You will pay the least) | Non-PPO Provider (You will pay the most) | |
| If you need immediate medical attention | <u>Emergency room care</u> | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | Non-PPO PCP <u>deductible</u> does not apply if PPO emergency room is used. |
| | <u>Emergency medical transportation</u> | Balances over <u>Plan allowance</u> | Balances over <u>Plan allowance</u> | Emergency only. Transport to nearest facility. Air ambulance limited to maximum of \$10,000 per instance. |
| | <u>Urgent care</u> | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$150/admission then 10% <u>coinsurance</u> | \$150/admission then 30% <u>coinsurance</u> | \$250 reduction for 1st failure to precertify and 50% for subsequent claims. Maximum \$400,000/transplant; maximum for kidney \$300,000/transplant. Donor expenses up to \$10,000 PPO only. |
| | Physician/surgeon fees | 10% <u>coinsurance</u> and 5% for transplant | 30% <u>coinsurance</u> ; Multiple surgeries - 50% <u>coinsurance</u> for 2nd and 75% <u>coinsurance</u> thereafter | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visits: 10% <u>coinsurance</u> up to maximum \$15 <u>copay/visit</u> Substance abuse office visits: 10% <u>coinsurance</u> up to maximum \$15 <u>copay/visit</u> Other outpatient: 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| | Inpatient services | \$150 <u>deductible/admission</u> then 10% <u>coinsurance</u> | \$150 <u>deductible/admission</u> then 30% <u>coinsurance</u> | \$250 reduction for 1st failure to precertify and 50% for subsequent claims. |
| If you are pregnant | Office visits | \$15 <u>copay/PCP visit</u> , \$25 <u>copay/specialist visit</u> | 10% <u>coinsurance/PCP</u> , 30% <u>coinsurance/specialist</u> | None |
| | Childbirth/delivery professional services | \$150/admission then 10% <u>coinsurance</u> | \$150/admission then 30% <u>coinsurance</u> | None |
| | Childbirth/delivery facility services | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------------|--|---|---|
| | | PPO Provider (You will pay the least) | Non-PPO Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | Covers up to 30 days/year for RN, LPN or LVN. Must follow hospital stay or outpatient procedure. |
| | <u>Rehabilitation services</u> | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | \$60 visits/days/year, inpatient and outpatient combined following hospital stay or outpatient procedure for heart disease or stroke; all other, 90 visits/days/year combined inpatient and outpatient. |
| | <u>Habilitation services</u> | Not covered | Not covered | Not covered. |
| | <u>Skilled nursing care</u> | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | \$250 reduction for 1st failure to pre-certify and 50% for subsequent claims. Outpatient nursing care must follow hospital stay or outpatient procedure. |
| | <u>Durable medical equipment</u> | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | Pre-determination required. Any purchase is property of <u>Plan</u> . |
| | <u>Hospice services</u> | 10% <u>coinsurance</u> | 30% <u>coinsurance</u> | Bereavement not covered. |
| If your child needs dental or eye care | Children's eye exam | No charge | No charge | One exam/year for children under age 19. |
| | Children's glasses | No charge up to <u>Plan</u> allowance | No charge up to <u>Plan</u> allowance | <u>Plan</u> allowance of \$280 for a pair of glasses and \$200/contacts every two years. |
| | Children's dental check-up | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | One exam/6 months |

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 necessary due to accident or breast reconstruction)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

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

- Acupuncture (acupuncture and chiropractic care combined limited to 30 visits per calendar year and/or \$2,100)
- Bariatric surgery (medically necessary to treat morbid obesity)
- Chiropractic care (chiropractic care and acupuncture combined limited to 30 visits per calendar year and/or \$2,100)
- Dental care (Adult) (\$2,000 annual maximum for periodontal; \$2,000 lifetime orthodontic)
- Hearing aids (Exam - \$75 maximum; Hearing Aids: For adults, \$3,000 maximum once every 36 months; for individuals under 19, payable as medically necessary once in each 12-month period.)
- Private-duty nursing (when provided by RN, LPN, LVN or nursing assistant in hospital)
- Routine eye care (Adult) (once every 2 years, non-contracted providers limited to \$540)
- Routine foot care

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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 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: the MM&P Plan Office at 700 Maritime Boulevard, Suite A, Linthicum Heights, MD 21090-1996; Phone: 410-850-8500; Toll-free: 1-877-667-5522. You may also contract the Department of Labor's Employees Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 (410)-850-8500/1-(877)-667-5522.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (410)-850-8500/1-(877)-667-5522.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(410)-850-8500/1-(877)-667-5522.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (410)-850-8500/1-(877)-667-5522.

-----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 \$250
- Specialist copay \$25
- Hospital (facility) coinsurance 10%
- 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 | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles* | \$400 |
| Copayments | \$180 |
| Coinsurance | \$1,150 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,790 |

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

- The plan's overall deductible \$250
- Specialist copay \$25
- Hospital (facility) coinsurance 10%
- 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 | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$250 |
| Copayments | \$210 |
| Coinsurance | \$1,450 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Joe would pay is | \$1,970 |

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

- The plan's overall deductible \$250
- Specialist copay \$25
- Hospital (facility) coinsurance 10%
- 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 | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$250 |
| Copayments | \$100 |
| Coinsurance | \$100 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$450 |

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

*NOTE: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.