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 www.bridgedeck.org/health-benefit-forms/ 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 https://www.healthcare.gov/sbc-glossary/ 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 deductible?	$250 Individual/$500 Family	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and prescription drugs 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.
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?	$3,000 Individual/$10,000 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance billing 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. For a list of participating providers, see www.medicare.gov/care-compare/ for medical benefits; www.caremark.com or call CVS Caremark at 1-888-364-6815 for pharmacy and www.eyemed.com/en-us/ or call 1-866-299-1358 for vision benefits.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the full cost if you use an out-of-network provider. 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	No charge	80% coinsurance	Plan pays second to Medicare based on the Medicare allowance. If you are not enrolled in Medicare, you pay 80% coinsurance. Acupuncture and chiropractic care: Limited to 30 visits (combined) per calendar year and/or $2,100 per year.
	Specialist visit	No charge	80% coinsurance	
	Preventive care/screening/ immunization	No charge, deductible does not apply	80% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	80% coinsurance	Plan pays second to Medicare based on the Medicare allowance. If you are not enrolled in Medicare, you pay 80% coinsurance.
	Imaging (CT/PET scans, MRIs)	No charge	80% coinsurance	

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.caremark.com	Generic drugs	Participating Pharmacy Retail: 20% coinsurance, minimum $7.50 copay per prescription fill or refill Mail Order: 20% coinsurance, maximum $75 copay per prescription fill or refill	Non-Participating Pharmacy Retail Only: 20% coinsurance, minimum $7.50 copay per prescription fill or refill plus difference in cost between participating and non-participating pharmacy	Deductible does not apply. You have Creditable Coverage under the plan and you do not have to enroll in Medicare Part D. Retail: 30-day supply plus 2 refills. Mail order: 31-60 days supply. Mandatory mail order after 2 refills. Controlled substance limited to 30 days. No non-participating pharmacy benefits available for mail order.
	Preferred brand drugs	Retail: 20% coinsurance, minimum $15 copay per prescription fill or refill Mail Order: 20% coinsurance, maximum $75 copay per prescription fill or refill	Retail only: 20% coinsurance, minimum $15 copay per prescription fill or refill plus difference in cost between participating and non-participating pharmacy	
	Non-preferred brand drugs	Retail only: 20% coinsurance, minimum $15 copay per prescription fill or refill plus difference in cost between generic and brand name	Retail only: 20% coinsurance, minimum $15 copay per prescription fill or refill plus difference in cost between participating and non-participating pharmacy and generic and brand name	
	Specialty drugs	Retail: 20% coinsurance, minimum $15 copay per prescription fill or refill Mail Order: 20% coinsurance, maximum $75 copay per prescription fill or refill plus difference in cost between generic and brand name	Retail only: 20% coinsurance, minimum $15 copay per prescription fill or refill plus difference in cost between participating and non-participating pharmacy and generic and brand name	

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)	No charge	80% coinsurance	Plan pays second to Medicare based on the Medicare allowance. If you are not enrolled in Medicare, you pay 80% coinsurance.
	Physician/surgeon fees	No charge	80% coinsurance	
If you need immediate medical attention	Emergency room care	No charge	80% coinsurance	Plan pays second to Medicare. If you are not enrolled in Medicare, you pay 80% coinsurance.
	Emergency medical transportation	No charge	80% coinsurance	
	Urgent care	No charge	80% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	80% coinsurance	Plan pays second to Medicare based on the Medicare allowance. If you are not enrolled in Medicare, you pay all but the Part A deductible(s) for inpatient services and 80% coinsurance for physician/surgeon.
	Physician/surgeon fees	No charge	80% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	80% coinsurance	Plan pays second to Medicare based on the Medicare allowance. If you are not enrolled in Medicare, you pay 80% coinsurance for outpatient services and all but the Part A deductible(s) for inpatient services.
	Inpatient services	No charge	80% coinsurance	
If you are pregnant	Office visits	No charge	80% coinsurance	Plan pays second to Medicare based on the Medicare allowance. If you are not enrolled in Medicare, you pay 80% coinsurance for outpatient services and all but the Part A deductible(s) for inpatient services.
	Childbirth/delivery professional services	No charge	80% coinsurance	
	Childbirth/delivery facility services	No charge	80% coinsurance	

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	No charge	80% coinsurance	Covers up to 30 days/year for RN, LPN or LVN. Must follow hospital stay or outpatient procedure. Plan pays second to Medicare based on the Medicare allowance. If you are not enrolled in Medicare, you pay 80% coinsurance for outpatient services and all but the Part A deductible(s) for inpatient services.
	Rehabilitation services	No charge	80% coinsurance	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. Plan pays second to Medicare based on the Medicare allowance. If you are not enrolled in Medicare, you pay 80% coinsurance for outpatient services and all but the Part A deductible(s) for inpatient services.
	Habilitation services	No charge	80% coinsurance	Plan pays second to Medicare based on the Medicare allowance. If you are not enrolled in Medicare, you pay 80% coinsurance for outpatient services and all but the Part A deductible(s) for inpatient services. Out-of-network hospice services covered only if there is no network facility or provider within 30 miles of the individual's primary caregiver's residence.
	Skilled nursing care	No charge	80% coinsurance	
	Durable medical equipment	No charge	80% coinsurance	
	Hospice services	No charge	80% coinsurance	
If your child needs dental or eye care	Children's eye exam	No charge for contracted provider	No charge up to plan allowance	1 exam/year for children under age 19; children over 19, included in plan allowance. Benefits provided through EyeMed, contact 866-299-1358.
	Children's glasses	No charge for contracted provider	No charge up to plan allowance	Maximum allowance for $280 for glasses or $200 for contacts every two calendar years under age 19. Benefits provided through EyeMed, contact 866-299-1358.
	Children's dental check-up	20% coinsurance for contracted provider	30% coinsurance	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)
- Long-term care
- Non-emergency care when traveling outside the U.S. (If you live outside the U.S., benefits are paid subject to 30% coinsurance after deductible)
- 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/calendar year and/or $2,100)
- Bariatric surgery (if medically necessary to treat morbid obesity)
- Chiropractic care (chiropractic care and acupuncture combined limited to 30 visits/calendar year and/or $2,100)
- Dental care (Adult) (Periodontal: $2,000 annual maximum; Orthodontic: $3,000 lifetime maximum)
- Hearing aids (Exam $75 maximum; Hearing Aids: Adults, $3,000 maximum once every 36 months; Children under age 19, payable as medically necessary once every 12 months.)
- Infertility treatment and family building benefits (covered through Progyny's network providers with member paying 30% coinsurance with no deductible and out-of-pocket maximum not applicable)
- 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 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: 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 contact 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**

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? **No**

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, kwiijigo 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	**$0**
Hospital (facility) coinsurance	**0%**
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	$250
Copayments	$0
Coinsurance	$10
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$320**

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	**$0**
Hospital (facility) coinsurance	**0%**
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	$250
Copayments	$0
Coinsurance	$1,610
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,880**

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

The plan's overall deductible	**$250**
Specialist copay	**$0**
Hospital (facility) coinsurance	**0%**
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	$250
Copayments	$0
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$260**

Medicare and the **plan** would be responsible for the other costs of these EXAMPLE covered services.