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, you may visit http://www.myhhmibenefits.com/ or call 1-800-448-4882 ext. 8920 or you may visit CareFirst at www.carefirst.com. 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/.

Important Questions		
What is the overall deductible?	In-network Providers $250 Individual; $500 Family Out-of-network Providers $500 Individual; $1,000 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 primary care services 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?	In-network providers $1,250 individual / $2,500 family Out-of-network providers $3,000 individual / $6,000 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, 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, 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.carefirst.com or call 1-855-6518 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). 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	$30 copay/office visit Deductible does not apply	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Out-of-Network providers may balance bill for charges above the plan allowed amounts.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	$0 copay/ 34-day supply Deductible does not apply	$0 copay/ 34-day supply Deductible does not apply	Preauthorization may be required for certain drugs. Covers up to a 34-day supply (retail pharmacy); Maintenance Drugs: Up to 90-day supply is covered at 2 copays in a retail pharmacy and 1 copay through mail order. No charge for preventative drugs or contraceptives. Preferred brand name drugs may have additional costs if selected over generic equivalent. Specialty are only covered when purchased through the Exclusive Specialty Pharmacy
	Preferred brand drugs	$25 copay/ 34-day supply Deductible does not apply	$25 copay/ 34-day supply Deductible does not apply	
	Non-preferred brand drugs	$50 copay/ 34-day supply Deductible does not apply	$50 copay/ 34-day supply Deductible does not apply	

* For more information about limitations and exceptions, see the plan or policy document at www.myHHMIbenefits.com or call us at 1-800-448-4882 ext. 8920 to request a paper copy.

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)	
	Specialty drugs	Same as Above Deductible does not apply	Not covered	Network. Out of Network claims are processed at the allowed amount. Amounts above the allowed amount will be the participant's responsibility.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance Deductible does not apply	20% coinsurance Deductible does not apply	Licensed private ambulance firms or a municipal department or division authorized to provide such services pursuant to an existing law or ordinance.
	Urgent care	$30 copay / visit Deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/office visit Deductible does not apply	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Additional professional charges may apply.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have	Home health care	20% coinsurance	40% coinsurance	Benefits are limited to 90 days of unlimited home health care visits per benefit period,

* For more information about limitations and exceptions, see the plan or policy document at www.myHHMIbenefits.com or call us at 1-800-448-4882 ext. 8920 to request a paper copy.

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)	
other special health needs				and home health aide limited to 40 home health care visits per benefit period except following childbirth, mastectomy, or removal of testicle.
	Rehabilitation services	20% coinsurance	40% coinsurance	60 visits per benefit period for Speech Therapy. 60 visits per benefit period combined for Physical and Occupational Therapies 60 visits per benefit period for Cardiac Rehabilitation. Pulmonary Rehabilitation limited to 1 program per lifetime.
	Habilitation services	20% coinsurance	40% coinsurance	Preauthorization is required after the first visit; benefits are available for a Dependent until age 19. Outpatient rehabilitative limits do not apply.
	Skilled nursing care	20% coinsurance	40% coinsurance	60 visits/calendar year
	Durable medical equipment	20% coinsurance	40% coinsurance	Approved plan of treatment required. No inpatient private duty nursing. Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	20% coinsurance	40% coinsurance	Respite Care limited to 14 days annually. Bereavement counselling limited to 15 visits in six months.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

* For more information about limitations and exceptions, see the plan or policy document at www.myHHMIbenefits.com or call us at 1-800-448-4882 ext. 8920 to request a paper copy.

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 • Dental Care • Experimental/Investigational Services	• Long Term Care • Routine Eye Care	• Routine Foot Care • Services that are Not Medically Necessary • Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (60 visits per benefit period) • Bariatric Surgery • Chiropractic Care (60 visits per benefit period)	• Hearing Aids • Infertility Treatment • Most coverage provided outside the United States. See https://hugheshub.hhmi.org	• Non-emergency care when traveling outside the U.S. • Outpatient Private-Duty Nursing

* For more information about limitations and exceptions, see the plan or policy document at www.myHHMIbenefits.com or call us at 1-800-448-4882 ext. 8920 to request a paper copy.

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 http://www.dol.gov/ebsa. 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: www.carefirst.com or 1-855-258-6518. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal, for example in Maryland contact 877-861-8807 or www.oag.state.md.us/consumer/heau.htm. To find out if there is a consumer assistance program in your state, visit https://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 1-855-258-6518.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-258-6518.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-6518.

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

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* For more information about limitations and exceptions, see the plan or policy document at www.myHHMIbenefits.com or call us at 1-800-448-4882 ext. 8920 to request a paper copy.

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 coinsurance	**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	$250
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,310**

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 coinsurance	**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	$250
Copayments	$800
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,270**

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

The plan's overall deductible	**$250**
Specialist coinsurance	**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	$250
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$750**

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