



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 general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can see the Glossary at www.carefirst.com/sbcg or call 1-855-258-6518 to request a copy. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.carefirst.com.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| What is the overall deductible ? | In-Network: \$0; Out-of-Network: \$300 individual/\$600 family | Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family member(s) on the plan , each family member may need to meet their own individual deductible , OR all family members may combine to meet the overall family deductible before the plan begins to pay, depending upon plan coverage. Please refer to your contract for further details. |
| Are there services covered before you meet your deductible ? | Yes, all In-Network services are provided without a 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? | There are no other specific deductibles. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | Medical: In-Network: \$1,000 individual/\$2,000 family; Out-of-Network: \$2,000 individual/\$4,000 family. | The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family member(s) on the plan , each family member may need to meet their own out-of-pocket limits , OR all family members may combine to meet the overall family out-of-pocket limit , depending upon plan coverage. Please refer to your contract for further details. |
| What is not included in the out-of-pocket limit ? | Premiums, balance-billing charges, health care this plan doesn't cover, copayments for certain services, and penalties for failure to obtain pre-authorization for services. | 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 855-258-6518 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 . |

| 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 | Provider: \$10 copay per visit Hospital Facility: No Charge | Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit | If a service is rendered at a Hospital Facility, the additional Facility charge may apply |
| | Specialist visit | Provider: \$10 copay per visit Hospital Facility: No Charge | Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit | If a service is rendered at a Hospital Facility, the additional Facility charge may apply |
| | Retail health clinic | \$10 copay per visit | Deductible, then 20% of Allowed Benefit | None |
| | Preventive care/screening/immunization | \$10 copay per visit | Deductible, then 20% of Allowed Benefit | Some services may have limitations or exclusions based on your contract |
| If you have a test | Diagnostic test (x-ray, blood work) | Lab Tests: Non-Hospital & Hospital: No Charge X-Ray: Non-Hospital & Hospital: No Charge | Lab Tests: Non-Hospital & Hospital: No Charge X-Ray: Non-Hospital & Hospital: No Charge | In-Network Lab Test benefits apply only to tests performed at LabCorp. |
| | Imaging (CT/PET scans, MRIs) | Non-Hospital & Hospital: No Charge | Non-Hospital & Hospital: No Charge | None |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available | Generic drugs | Not Covered | Not Covered | None |
| | Preferred brand drugs | Not Covered | Not Covered | |
| | Non-preferred brand drugs | Not Covered | Not Covered | |
| | Preferred Specialty drugs | Not Covered | Not Covered | |
| | Non-preferred Specialty drugs | Not Covered | Not Covered | |

| 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) | Non-Hospital & Hospital: No Charge | Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit | None |
| | Physician/surgeon fees | Non-Hospital & Hospital: No Charge | Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit | None |
| If you need immediate medical attention | Emergency room care | \$25 copay per visit | Paid As In-Network | Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply; Copay waived if admitted |
| | Emergency medical transportation | No Charge | No Charge | None |
| | Urgent care | No Charge | Paid As In-Network | Limited to unexpected, urgently required services |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No Charge | Deductible, then 20% of Allowed Benefit | Prior authorization is required |
| | Physician/surgeon fees | No Charge | Deductible, then 20% of Allowed Benefit | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit: \$10 copay per visit Hospital Facility: No Charge | Office Visit & Hospital Facility: Deductible, then 20% of Allowed Benefit | For treatment at an Outpatient Hospital Facility, additional charges may apply |
| | Inpatient services | No Charge | Deductible, then 20% of Allowed Benefit | Prior authorization is required; Additional professional charges may apply |
| If you are pregnant | Office visits | \$10 copay per visit | Deductible, then 20% of Allowed Benefit | For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply; Copay applies for the first initial visit |
| | Childbirth/delivery professional services | No Charge | Deductible, then 20% of Allowed Benefit | None |
| | Childbirth/delivery facility services | No Charge | Deductible, then 20% of Allowed Benefit | Additional professional charges may apply |

| 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 | Deductible, then 20% of Allowed Benefit | Prior authorization is required Benefits are limited to 90 days per benefit period. Renews when care not received for 60 consecutive days |
| | Rehabilitation services | Provider & Hospital Facility: No Charge | Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit | If a service is rendered at a Hospital Facility, the additional Facility charge may apply Benefits for Speech, Physical and Occupational Therapies are limited to 90 visits per benefit period In-Network only |
| | Habilitation services | Provider & Hospital Facility: No Charge | Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit | Benefits are limited to Members under the age of 19 If a service is rendered at a Hospital Facility, the additional Facility charge may apply |
| | Skilled nursing care | No Charge | Deductible, then 20% of Allowed Benefit | Prior authorization is required Benefits are limited to 100 days per benefit period |
| | Durable medical equipment | No Charge | Paid As In-Network | None |
| | Hospice services | Inpatient and Outpatient Facility: No Charge | Inpatient and Outpatient Facility: Paid As In-Network | Prior authorization is required Hospice Maximum: Benefits are limited to 180 lifetime days inpatient/outpatient combined. 30 days inpatient per lifetime Bereavement: Benefits are limited to 6 months or 15 visits Family Counseling: Applies to the 180-day Hospice Maximum Respite Care: Benefits are limited to 14 days during the Hospice eligibility period |
| If your child needs dental or eye care | Children's eye exam | Not Covered | Not Covered | None |
| | Children's glasses | Not Covered | Not Covered | None |
| | Children's dental check-up | Not Covered | Not Covered | None |

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 | • Long-term care | • Routine foot care |
| • Dental care (Adult) | • Routine eye care | • Weight loss programs |

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

- | | | |
|---------------------|--|---|
| • Abortion | • Chiropractic care | • Infertility treatment |
| • Acupuncture | • Coverage provided outside the US. See www.carefirst.com | • Non-emergency care when travelling outside the US |
| • Bariatric surgery | • Hearing aids | • Private-duty nursing |

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 Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565. 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: Department of Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565.

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, kwijigo holne' 1-855-258-6518.

—————*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](#) \$
- [Specialist \[cost sharing\]](#) \$
- [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:

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

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

- The [plan's](#) overall [deductible](#) \$
- [Specialist \[cost sharing\]](#) \$
- [Hospital \(facility\) \[cost sharing\]](#) %
- [Other \[cost sharing\]](#) %

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:

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

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

- The [plan's](#) overall [deductible](#) \$
- [Specialist \[cost sharing\]](#) \$
- [Hospital \(facility\) \[cost sharing\]](#) %
- [Other \[cost sharing\]](#) %

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:

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

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.