



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.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 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:
<u>What is the overall deductible?</u>	<u>In-Network: \$0</u> Individual / <u>\$0</u> Family	See the Common Medical Events Chart below for your costs for services this <u>plan</u> covers.
<u>Are there services covered before you meet your deductible?</u>	Not Applicable	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. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	Medical and Prescription Drug combined: <u>In-Network: \$1,500</u> Individual / <u>\$3,000</u> 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 <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<u>What is not included in the out-of-pocket limit?</u>	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>preauthorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. See www.carefirst.com or call 855-258-6518 for a list of Network providers.	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 most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</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.
<u>Do you need a referral to see a specialist?</u>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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	\$15 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	Virtual visits - \$15 <u>copay</u> per visit by a Designated Virtual <u>Network Provider</u> , <u>deductible</u> does not apply. *Cost share applies to any other Telehealth service based on provider type. If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Specialist</u> visit	\$25 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	Retail health clinic	\$15 <u>copay</u> per visit, <u>deductible</u> does not apply.	Not Covered	None
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	None

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 <u>prescription drug coverage</u> is available at www.carefirst.com/rxgroup	Generic drugs	Retail / Mail-Order : \$10 copay / \$20 copay	Not Covered	Retail: copay applies to 31-day supply; 90-day supply of maintenance drugs is 3 copays; Mail-Order: copay applies to 90-day supply of maintenance drugs;
	Preferred brand drugs	Retail / Mail-Order : \$20 copay / \$40 copay	Not Covered	No Charge for preventive drugs or contraceptives;
	Non-preferred brand drugs	Retail / Mail-Order : \$30 copay / \$60 copay	Not Covered	Specialty Drugs: Covered when purchased through the Exclusive Specialty Pharmacy Network; 90-day supply for retail is 2 copays.
	Preferred <u>Specialty</u> drugs	Retail / Mail-Order : \$75 copay / \$150 copay	Not Covered	Certain drugs may have a preauthorization requirement. If you use a non-network pharmacy, you are responsible for any amount over the allowed amount.
	Non-preferred <u>Specialty</u> drugs	Retail / Mail-Order : \$100 copay / \$200 copay	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$100 copay per visit	\$100 copay per visit	Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply; Copay waived if admitted
	<u>Emergency medical transportation</u>	No Charge	No Charge	None
	<u>Urgent care</u>	\$25 copay per visit	Not Covered	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	<u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 20% of <u>allowed amount</u> .
	Physician/surgeon fees	No Charge	Not Covered	None

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 mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copay</u> per visit, <u>deductible</u> does not apply	Not Covered	Preauthorization is required <u>out-of-network</u> or benefit reduces to 20% of <u>allowed amount</u> .
	Inpatient services	No Charge	Not Covered	Preauthorization is required <u>out-of-network</u> or benefit reduces to 20% of <u>allowed amount</u> .
If you are pregnant	Office visits	No Charge	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	No Charge	Not Covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge	Not Covered	None
	<u>Rehabilitation services</u>	No Charge	Not Covered	Benefits for Speech, Physical and Occupational Therapies are limited to 90 visits combined per benefit period
	<u>Habilitation services</u>	No Charge	Not Covered	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	No Charge	Not Covered	Limited to 180 days per calendar year (combined with inpatient rehabilitation).
	<u>Durable medical equipment</u>	No Charge	Not Covered	Covers 1 per type of DME (including repair/replacement) every 3 years.
	<u>Hospice services</u>	No Charge	Not Covered	Prior authorization is required Bereavement: Benefits are limited to 6 months or 15 visits Respite Care: Benefits are limited to 14 days
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	• Dental care (Adult)	• Routine eye care
• Coverage provided outside the US. See www.carefirst.com	• Long-term care	• Routine foot care
	• Private-duty nursing	• Non-emergency care when travelling outside the US

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

• Abortion	• Bariatric surgery	• Infertility treatment
• Acupuncture	• Chiropractic care	• Weight loss programs
	• Hearing aids	

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, kwijjigo 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 <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist Copayment</u>	\$25
■ <u>Hospital (facility) Copayment</u>	\$0
■ <u>Other Copayment</u>	\$0

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	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Peg would pay is	\$10

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist Copayment</u>	\$25
■ <u>Hospital (facility) Copayment</u>	\$0
■ <u>Other Copayment</u>	\$0

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	\$0
Copayments	\$450
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$450

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist Copayment</u>	\$25
■ <u>Hospital (facility) Copayment</u>	\$100
■ <u>Other Copayment</u>	\$0

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	\$0
Copayments	\$260
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$260

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