



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](http://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](http://www.carefirst.com).

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p>In-Network: \$600 individual/\$1,200 family; Out-of-Network: \$1,200 individual/\$2,400 family</p>	<p>Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family member(s) on the <a href="#">plan</a>, each family member may need to meet their own individual <a href="#">deductible</a>, OR all family members may combine to meet the overall family <a href="#">deductible</a> before the <a href="#">plan</a> begins to pay, depending upon plan coverage. Please refer to your contract for further details.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes, all In-Network preventive care services, as well as the following (non-hospital facilities only, when applicable): Primary care, Specialist, Retail health, Diagnostic testing, Prescription drugs, Urgent care and Mental health outpatient services</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>There are no other specific deductibles.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p>Medical and Prescription Drug combined: In-Network: \$3,000 individual/\$6,000 family; Out-of-Network: \$6,000 individual/\$12,000 family.</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a <a href="#">plan</a> year for covered services. If you have other family member(s) on the <a href="#">plan</a>, each family member may need to meet their own <a href="#">out-of-pocket limits</a>, OR all family members may combine to meet the overall family <a href="#">out-of-pocket limit</a>, depending upon <a href="#">plan</a> coverage. Please refer to your contract for further details.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p>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.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes. See <a href="http://www.carefirst.com">www.carefirst.com</a> or call 855-258-6518 for a list of Network providers.</p>	<p>This <a href="#">plan</a> uses a <a href="#">provider network</a>. You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a>. You will pay the most if you use an <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays (<a href="#">balance billing</a>). Be aware</p>

		your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	Provider: \$25 copay per visit Hospital Facility: Deductible, then 20% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 40% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	<a href="#">Specialist</a> visit	Provider: \$40 copay per visit Hospital Facility: Deductible, then 20% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 40% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Retail health clinic	\$25 copay per visit	Deductible, then 40% of Allowed Benefit	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge	40% of Allowed Benefit	Some services may have limitations or exclusions based on your contract

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)	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Lab Tests: Non-Hospital: \$25 PCP/\$40 Specialist copay per visit Hospital: Deductible, then 20% of Allowed Benefit X-Ray: Non-Hospital: \$25 PCP/\$40 Specialist copay per visit Hospital: Deductible, then 20% of Allowed Benefit	Lab Tests: Non-Hospital & Hospital: Deductible, then 40% of Allowed Benefit X-Ray: Non-Hospital & Hospital: Deductible, then 40% of Allowed Benefit	In-Network Lab Test benefits apply only to tests performed at LabCorp.
	Imaging (CT/PET scans, MRIs)	Non-Hospital: \$25 PCP/\$40 Specialist copay per visit Hospital: Deductible, then 20% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 40% of Allowed Benefit	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.carefirst.com/rxgroup">www.carefirst.com/rxgroup</a>	Generic drugs	\$10 copay	Paid As In-Network	For all prescription drugs: Prior authorization may be required for certain drugs; No Charge for preventive drugs or contraceptives; Copay applies to up to 34-day supply; Up to 90-day supply of maintenance drugs is 2 copays; Specialty Drugs: Participating Providers: covered when purchased through the Exclusive Specialty Pharmacy Network Non-Participating Providers: Not Covered
	Preferred brand drugs	\$35 copay	Paid As In-Network	
	Non-preferred brand drugs	\$60 copay	Paid As In-Network	
	Preferred <a href="#">Specialty drugs</a>	\$10/\$35/\$60 copay; 50% of Allowed Benefit up to \$75	Not Covered	
	Non-preferred <a href="#">Specialty drugs</a>	\$10/\$35/\$60 copay; 50% of Allowed Benefit up to \$75	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: Deductible, then \$100 copay per visit, then 20% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 40% of Allowed Benefit	None
	Physician/surgeon fees	Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 40% of Allowed Benefit	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	Deductible, then \$150 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
	<a href="#">Emergency medical transportation</a>	Deductible, then 20% of Allowed Benefit	Paid As In-Network	None
	<a href="#">Urgent care</a>	\$40 copay per visit	Deductible, then 40% of Allowed Benefit	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$25 copay per visit Hospital Facility: \$100 copay per visit, then 20% of Allowed Benefit	Office Visit & Hospital Facility: Deductible, then 40% of Allowed Benefit	For treatment at an Outpatient Hospital Facility, additional charges may apply
	Inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required; Additional professional charges may apply
If you are pregnant	Office visits	No Charge	Deductible, then 40% of Allowed Benefit	For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
	Childbirth/delivery professional services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
	Childbirth/delivery facility services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% 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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Deductible, then 20% of Allowed Benefit	Deductible, then 40% 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
	<a href="#">Rehabilitation services</a>	Provider: Deductible, then \$40 copay per visit, then 20% of Allowed Benefit Hospital Facility: Deductible, then 20% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 40% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	<a href="#">Habilitation services</a>	Provider & Hospital Facility: Not Covered	Provider & Hospital Facility: Not Covered	None
	<a href="#">Skilled nursing care</a>	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required Benefits are limited to 60 days per benefit period
	<a href="#">Durable medical equipment</a>	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
	<a href="#">Hospice services</a>	Inpatient and Outpatient Facility: Deductible, then 20% of Allowed Benefit	Inpatient and Outpatient Facility: Deductible, then 40% of Allowed Benefit	Prior authorization is required Hospice Maximum: Benefits are limited to 180 lifetime days inpatient/outpatient combined. 180 days inpatient per lifetime Bereavement: Services must be rendered within 90 days following the death of a covered Member Respite Care: Benefits are limited to 3 period of 48 hours in 180-day period
<b>If your child needs dental or eye care</b>	Children's eye exam	\$10 copay per visit	Plan pays \$33; Member pays balance	Benefits are limited to 1 visit per benefit period
	Children's glasses	Discount programs available to all Members	Not Covered	Benefits are limited to 1 set of glasses/lenses per benefit period
	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.)

- |                    |                        |                        |
|--------------------|------------------------|------------------------|
| • Acupuncture      | • Dental care (Adult)  | • Routine foot care    |
| • Cosmetic surgery | • Long-term care       | • Weight loss programs |
|                    | • Private-duty nursing |                        |

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

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|---------------------|--|---|
| • Abortion          | • Coverage provided outside the US. See <a href="http://www.carefirst.com">www.carefirst.com</a> | • Infertility treatment                             |
| • Bariatric surgery |  | • Non-emergency care when travelling outside the US |
| • Chiropractic care | • Hearing aids   | • Routine eye 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: 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](http://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.

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

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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](#) \$600
- [Specialist Copayment](#) \$40
- Hospital (facility) [Coinsurance](#) 20%
- Other [Copayment](#) \$25

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$125
Coinsurance	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$2,435</b>

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

- The [plan's](#) overall [deductible](#) \$600
- [Specialist Copayment](#) \$40
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$710
Coinsurance	\$124
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,434</b>

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

- The [plan's](#) overall [deductible](#) \$600
- [Specialist Copayment](#) \$40
- Hospital (facility) [Copayment](#) \$150
- Other [Copayment](#) \$25

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$450
Coinsurance	\$118
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,168</b>