



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/sbcq](http://www.carefirst.com/sbcq) 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:  |
|---|--|--|
| What is the overall <a href="#">deductible</a> ?                                | In-Network: \$400 individual/\$800 family;<br>Out-of-Network: \$1,000 individual/\$2,000 family  | 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.  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes, all In-Network preventive care services, as well as the following (non-hospital facilities only, when applicable): Emergency room and Urgent care                       | 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> .  |
| Are there other <a href="#">deductibles</a> for specific services?              | There are no other specific deductibles.   | You don't have to meet <a href="#">deductibles</a> for specific services.  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | Medical: In-Network: \$2,750 individual/\$5,500 family;<br>Out-of-Network: \$4,000 individual/\$8,000 family   | 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.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | 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 <a href="#">out-of-pocket limit</a> .  |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.carefirst.com">www.carefirst.com</a> or call 855-258-6518 for a list of Network providers.  | 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 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. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | 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<br>(You will pay the least)   | Out-of-Network Provider<br>(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: Deductible, then \$20 copay per visit<br>Hospital Facility: Deductible, then 10% of Allowed Benefit  | Provider & Hospital Facility: Deductible, then 35% of Allowed Benefit  | If a service is rendered at a Hospital Facility, the additional Facility charge may apply |
|   | <a href="#">Specialist</a> visit                       | Provider: Deductible, then \$40 copay per visit<br>Hospital Facility: Deductible, then 10% of Allowed Benefit  | Provider & Hospital Facility: Deductible, then 35% of Allowed Benefit  | If a service is rendered at a Hospital Facility, the additional Facility charge may apply |
|   | Retail health clinic                                   | Deductible, then \$20 copay per visit  | Deductible, then 35% of Allowed Benefit  | None  |
|   | <a href="#">Preventive care/screening/immunization</a> | No Charge  | Deductible, then 35% of Allowed Benefit  | Some services may have limitations or exclusions based on your contract                   |
| <b>If you have a test</b>   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | Lab Tests:<br>Non-Hospital: Deductible, then 10% of Allowed Benefit<br>Hospital: Deductible, then No Charge<br>X-Ray:<br>Non-Hospital: Deductible, then 10% of Allowed Benefit<br>Hospital: Deductible, then No Charge | Lab Tests:<br>Non-Hospital: Deductible, then 35% of Allowed Benefit<br>Hospital: Deductible, then No Charge<br>X-Ray:<br>Non-Hospital: Deductible, then 35% of Allowed Benefit<br>Hospital: Deductible, then No Charge | In-Network Lab Test benefits apply only to tests performed at LabCorp.                    |
|   | Imaging (CT/PET scans, MRIs)                           | Non-Hospital: Deductible, then 10% of Allowed Benefit<br>Hospital: Deductible, then No Charge  | Non-Hospital: Deductible, then 35% of Allowed Benefit<br>Hospital: Deductible, then No Charge  | None  |

| Common Medical Event  | Services You May Need                            | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|---|--|---|--|--|
|   |  | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)               |  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available | Generic drugs                                    | \$10 (retail 30-day supply), \$25 (mail order 90-day supply)  | Not Covered  | None   |
|   | Preferred brand drugs                            | 30% coinsurance to \$30 max (retail 30-day supply), 30% to \$75 max (mail order 90-day supply)              | Not Covered  |  |
|   | Non-preferred brand drugs                        | 50% coinsurance to \$50 max (retail 30-day supply), 50% coinsurance to \$125 max (mail order 90-day supply) | Not Covered  |  |
|   | Preferred <a href="#">Specialty drugs</a>        | 50% coinsurance to \$50 max (retail 30-day supply), 50% coinsurance to \$125 max (mail order 90-day supply) | Not Covered  |  |
|   | Non-preferred <a href="#">Specialty drugs</a>    | 50% coinsurance to \$50 max (retail 30-day supply), 50% coinsurance to \$125 max (mail order 90-day supply) | Not Covered  |  |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)   | Non-Hospital: Deductible, then \$40 copay per visit<br>Hospital: Deductible, then 10% of Allowed Benefit    | Non-Hospital & Hospital: Deductible, then 35% of Allowed Benefit | None   |
|   | Physician/surgeon fees                           | Non-Hospital & Hospital: Deductible, then \$40 copay per visit  | Non-Hospital & Hospital: Deductible, then 35% of Allowed Benefit | None   |
| <b>If you need immediate medical attention</b>  | <a href="#">Emergency room care</a>              | \$100 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> | No Charge   | No Charge  | None   |

| Common Medical Event   | Services You May Need                     | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|--|---|---|---|--|
|  |   | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)                        |  |
|  | <a href="#">Urgent care</a>               | \$40 copay per visit  | \$40 copay per visit  | Limited to unexpected, urgently required services  |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)        | Deductible, then \$250 per admission copay, then 10% of Allowed Benefit   | Deductible, then 35% of Allowed Benefit                                   | Prior authorization is required  |
|  | Physician/surgeon fees                    | Deductible, then 10% of Allowed Benefit   | Deductible, then 35% of Allowed Benefit                                   | None   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | Office Visit: Deductible, then \$20 copay per visit<br>Hospital Facility: Deductible, then 10% of Allowed Benefit | Office Visit & Hospital Facility: Deductible, then 35% of Allowed Benefit | For treatment at an Outpatient Hospital Facility, additional charges may apply   |
|  | Inpatient services                        | Deductible, then \$250 per admission copay, then 10% of Allowed Benefit   | Deductible, then 35% of Allowed Benefit                                   | Prior authorization is required; Additional professional charges may apply   |
| <b>If you are pregnant</b>   | Office visits                             | No Charge   | Deductible, then 35% 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 10% of Allowed Benefit   | Deductible, then 35% of Allowed Benefit                                   | None   |
|  | Childbirth/delivery facility services     | Deductible, then \$250 per admission copay, then 10% of Allowed Benefit   | Deductible, then 35% of Allowed Benefit                                   | Additional professional charges may apply  |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | Deductible, then 10% of Allowed Benefit   | Deductible, then 35% of Allowed Benefit                                   | Prior authorization is required  |
|  | <a href="#">Rehabilitation services</a>   | Office Visit: Deductible, then \$40 copay per visit<br>Hospital Facility: Deductible, then 10% of Allowed Benefit | Provider & Hospital Facility: Deductible, then 35% of Allowed Benefit     | If a service is rendered at a Hospital Facility, the additional Facility charge may apply; Benefits are limited to 40 visits per condition per benefit period for Physical Therapy. The In-network and Out of network are not combined |
|  | <a href="#">Habilitation services</a>     | Office Visit: Deductible, then \$40 copay per visit<br>Hospital Facility: Deductible, then 10% of Allowed Benefit | Provider & Hospital Facility: Deductible, then 35% of Allowed Benefit     | Prior authorization is required after the first visit<br>Benefits are limited to Members under the age of 21<br>If a service is rendered at a Hospital Facility, the additional Facility charge may apply                              |

| Common Medical Event                          | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information   |
|---|---|--|--|--|
|   |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
|   | <a href="#">Skilled nursing care</a>      | Deductible, then 10% of Allowed Benefit      | Deductible, then 35% of Allowed Benefit            | Prior authorization is required  |
|   | <a href="#">Durable medical equipment</a> | Deductible, then 10% of Allowed Benefit      | Deductible, then 35% of Allowed Benefit            | None   |
|   | <a href="#">Hospice services</a>          | Deductible, then 10% of Allowed Benefit      | Deductible, then 35% of Allowed Benefit            | <p>Prior authorization is required;</p> <p>Must be authorized Services limited to Hospice Maximum: 180 day Hospice Eligibility; 45 Lifetime Reserve days are available if the 180 day Hospice Eligibility Period has been exhausted. Benefits available during the last 6 months of life. Limitations same in and out of network.</p> <p>Inpatient care limited to 60 days per Hospice Eligibility Period</p> <p>Respite Care: Limited to 3 periods of 48 hours during the Hospice Eligibility Period</p> <p>Bereavement: Must be rendered within 90 days following the death of the patient - Maximum of 3 visits</p> |
| <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 program 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](#).)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine foot care
- Weight loss programs

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

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Abortion</li><li>• Bariatric surgery</li><li>• Chiropractic care</li></ul> | <ul style="list-style-type: none"><li>• Coverage provided outside the US. See <a href="http://www.carefirst.com">www.carefirst.com</a></li><li>• Hearing aids</li><li>• Private-duty nursing</li></ul> | <ul style="list-style-type: none"><li>• Infertility treatment</li><li>• Non-emergency care when travelling outside the US</li><li>• Routine eye care</li></ul> |
|--|--|--|

**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.

————— *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.

|  |   |  |
|--|---|--|
| <b>Peg is Having a Baby</b><br>(9 months of in-network pre-natal care and a hospital delivery) | <b>Managing Joe's type 2 Diabetes</b><br>(a year of routine in-network care of a well-controlled condition) | <b>Mia's Simple Fracture</b><br>(in-network emergency room visit and follow up care) |
|--|---|--|

- The [plan's](#) overall [deductible](#) \$400
- [Specialist Copayment](#) \$40
- [Hospital \(facility\) Copayment](#) \$250
- [Other Copayment](#) 10%

**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> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$400          |
| Copayments                        | \$330          |
| Coinsurance                       | \$700          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$1,430</b> |

- The [plan's](#) overall [deductible](#) \$400
- [Specialist Copayment](#) \$40
- [Hospital \(facility\) Copayment](#) \$250
- [Other Copayment](#) 10%

**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> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$400        |
| Copayments                        | \$180        |
| Coinsurance                       | \$375        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Joe would pay is</b> | <b>\$955</b> |

- The [plan's](#) overall [deductible](#) \$400
- [Specialist Copayment](#) \$40
- [Hospital \(facility\) Copayment](#) \$250
- [Other Copayment](#) 10%

**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> |
|---------------------------|----------------|

**In this example, Mia would pay:**

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$400        |
| Copayments                        | \$220        |
| Coinsurance                       | \$150        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$770</b> |

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

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