



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:
What is the overall <a href="#">deductible</a> ?	In-Network: \$600 individual/ \$1,200 family Out-of-Network: \$1,200 individual/ \$2,400 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 members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, all In-Network preventive care Services and prescription drugs.	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> ?	In-Network Medical: \$1,800 individual/\$3,600 family Out-of-Network Medical: \$3,600 individual/\$7,200 family Prescription Drug Program: \$4,800 individual/\$9,600 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billing charges, health care this plan doesn't cover, 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 1-844-405-2160 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 (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: \$30 copay per visit Hospital Facility: Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
	<a href="#">Specialist</a> visit	Provider: \$30 copay per visit Hospital Facility: Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
	Retail health clinic	\$30 copay per visit	Deductible, then 40% of Allowed Benefit	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Deductible, then 40% of Allowed Benefit	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for. Some services may have limitations or exclusions. Please see your contract
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	Deductible, then 40% of Allowed Benefit	None
	Imaging (CT/PET scans, MRIs)	Deductible, then 20% of Allowed Benefit	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.expressscripts.com">www.expressscripts.com</a>	Generic drugs (non-specialty & specialty)	Retail: \$10 copay Mail Order: \$20 copay	Same copays as in-network, plus amounts over the in-network rate (balance billed.)	♦ Retail non-specialty limited to a 31-day supply. Mail Order non-specialty limited to a 93-day supply. All specialty drugs limited to a 30-day supply and most must be obtained (after the first fill) through Express Scripts' home delivery service, Accredo. ♦ If a brand drug is requested when a generic drug is available, you pay the generic copay plus the difference in cost between the brand drug and
	Preferred brand drugs (non-specialty & specialty)	Retail: \$30 copay Mail Order: \$60 copay	Same copays as in-network, plus amounts over the in-network rate (balance billed.)	
	Non-preferred brand drugs (non-specialty & specialty)	Retail: \$60 copay Mail Order: \$100 copay	Same copays as in-network, plus amounts over the in-network rate (balance billed.)	

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)	
	<u>Insulin, syringes, and diabetic supplies.</u>	Retail: \$30 copay Mail Order: \$60 copay	Same copays as in-network, plus amounts over the in-network rate (balance billed).	the generic drug. ♦ Over-the-counter and erectile dysfunction drugs are not covered. ♦ Prior authorization and step therapy are required for certain drug categories. Without prior authorization and step therapy, the drugs are not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
If you need immediate medical attention	<u>Emergency room care</u>	Deductible, then 20% of Allowed Benefit	In-Network Deductible, then 20% of Allowed Benefit	None
	<u>Emergency medical transportation</u>	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	None
	<u>Urgent care</u>	\$30 copay per visit	Deductible, then 40% of Allowed Benefit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Out-of-Network: Without prior authorization, the Allowed Benefit is reduced by 50% (reduction not to exceed \$1000).
	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 Visits: No Charge Hospital Facility: Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
	Inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Out-of-Network: Without prior authorization, the Allowed Benefit is reduced by 50% (reduction not to exceed \$1000).
If you are pregnant	Office visits	No Charge	Deductible, then 40% of Allowed Benefit	"No Charge" applies to routine pre/postnatal visits only.
	Childbirth/delivery professional services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	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)	
	Childbirth/delivery facility services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
<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	Out-of-Network: Without prior authorization, the Allowed Benefit is reduced by 50% (reduction not to exceed \$1000). Benefits are limited to 100 visits per benefit period.
	<a href="#">Rehabilitation services</a>	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Benefits are limited to 30 visits per benefit period for Speech Therapy, 60 combined visits per benefit period for Physical and Occupational Therapies, and 90 visits per benefit period for Cardiac Rehab.
	<a href="#">Habilitation services</a>	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Benefits are limited to 30 visits per benefit period for Speech Therapy, 60 combined visits per benefit period for Physical and Occupational Therapies, and 90 visits per benefit period for Cardiac Rehab.
	<a href="#">Skilled nursing care</a>	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Out-of-Network Skilled Nursing Facility: Without prior authorization, the Allowed Benefit is reduced by 50% (reduction not to exceed \$1000). Benefits are limited to 100 days per benefit period. Outpatient Private Duty Nursing: Prior authorization is required. Without prior authorization, benefits will not be paid. Benefits are limited to 30 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 & Outpatient Care: Deductible, then 20% of Allowed Benefit	Inpatient & Outpatient Care: Deductible, then 40% of Allowed Benefit	Without prior authorization, the Allowed Benefit is reduced by 50% (reduction not to exceed \$1000). Limited to 185 days per lifetime for hospice care, 15 days per lifetime for inpatient hospice respite care, 15 days per lifetime for outpatient hospice respite care. Respite care must be used in increments of no more than 5 days at a time.
	Children's eye exam	Not Covered	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 your child needs dental or eye care	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Cosmetic surgery</li></ul>	<ul style="list-style-type: none"><li>• Dental care (Adult)</li><li>• Long-term care</li><li>• Hearing aids</li><li>• Infertility treatment</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Chiropractic care (limited to 12 visits per coverage period)</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></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing (limited to 30 days per coverage period)</li><li>• Non-emergency care when travelling outside the US</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**  
If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$600
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">copayment</a>	\$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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$0
Coinsurance	\$1,480
What isn't covered	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$2,090</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$600
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$880
Coinsurance	\$246
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,726</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$600
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">copayment</a>	\$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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$180
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$880</b>

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