



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 more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.carefirst.com](http://www.carefirst.com) or call 833-229-9498. 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 view the Glossary at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 833-229-9498 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p><b>\$500</b> individual / <b>\$1,500</b> family for in-network providers and <b>\$750</b> individual / <b>\$2,250</b> family for out-of-network providers. Out-of-network costs do not apply to the in-network deductible and vice versa. Copayments, pre-certification penalties, and balance-billed charges don't count toward the deductible.</p>	<p>Generally, you must pay all of 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>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. Emergency room or prescription drugs are covered before you meet your <a href="#">deductible</a>. In-network: office visits, preventive care, urgent care services are covered before you meet your <a href="#">deductible</a>.</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>No.</p>	<p>You don't have to meet <a href="#">deductible</a> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p><b>\$7,900</b> individual / <b>\$15,800</b> family for in-network providers and <b>\$15,800</b> individual / <b>\$31,600</b> family for out-of-network providers. Out-of-network costs do not apply to the in-network out-of-pocket limit, and vice versa.</p>	<p>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.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p>Pre-certification penalties, premiums, balance-billed charges and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes. See <a href="http://www.carefirst.com">www.carefirst.com</a> or call 1-833-229-9498 for a list of <a href="#">network providers</a>.</p>	<p>This <a href="#">plan</a> uses a provider <a href="#">network</a>. You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">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>).</p> <p>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.</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>No.</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</p>

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	\$25/visit; Deductible does not apply	40% coinsurance *	—————none—————
	<a href="#">Specialist</a> visit	\$25/visit; Deductible does not apply	40% coinsurance *	—————none—————
	<a href="#">Preventive care/screening/immunization</a>	No charge Deductible does not apply	40% coinsurance *	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% coinsurance *	40% coinsurance *	—————none—————
	Imaging (CT/PET scans, MRIs)	20% coinsurance *	40% coinsurance *	—————none—————

For more information about limitations and exceptions, see plan or policy document at [www.carefirst.com](http://www.carefirst.com) or call 833-229-9498

\* After deductible

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<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">www.carefirst.com</a>	Generic drugs	\$10/prescription (retail) \$20/prescription (mail order) Deductible does not apply	Applicable copayment, plus charges in excess of the allowed amount	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).  If you purchase a brand name drug in lieu of a generic drug, your copayments may be higher, as described in the plan document.  When received at an in-network pharmacy, no charge for over-the-counter drugs related to preventive care, or FDA-approved generic and over-the-counter contraceptive methods for women (prescription required).
	Preferred brand drugs	\$30/prescription (retail) \$60/prescription (mail order) Deductible does not apply	Applicable copayment, plus charges in excess of the allowed amount	
	Non-preferred brand drugs	\$50/prescription (retail) \$100/prescription (mail order) Deductible does not apply	Applicable copayment, plus charges in excess of the allowed amount	
	<a href="#">Specialty drugs</a>	30% coinsurance up to \$300/prescription (retail) 30% coinsurance up to \$600/prescription (mail order)	Applicable copayment, plus charges in excess of the allowed amount	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance *	40% coinsurance *	Pre-certification required (penalty applies).
	Physician/surgeon fees	20% coinsurance *	40% coinsurance *	—————none—————
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$150/visit, then 100% coinsurance Deductible does not apply	\$150/visit, then 100% coinsurance Deductible does not apply	Copayment waived if admitted.
	<a href="#">Emergency medical transportation</a>	20% coinsurance *	20% coinsurance *	Pre-certification required for air ambulance (penalty applies). Maximum \$50,000/trip for out-of-network, if not an emergency.
	<a href="#">Urgent care</a>	\$50/visit Deductible does not apply	40% coinsurance *	—————none—————

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\* After deductible

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance *	40% coinsurance *	Pre-certification required. Failure to pre-certify will reduce benefits by \$400. Failure to request extension of original certification will result in denial of benefits for the remainder of the hospital stay.
	Physician/surgeon fees	20% coinsurance *	40% coinsurance *	—————none—————
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25/visit Deductible does not apply to Office Visit  20% coinsurance * for other outpatient services	40% coinsurance *	Maximum 100 visits/year for partial hospitalization and 100 visits/year for intensive outpatient services.
	Inpatient services	20% coinsurance *	40% coinsurance *	Maximum 100 visits/year for residential treatment facility. Pre-certification required (penalty applies).
<b>If you are pregnant</b>	Office visits	\$25/visit Deductible does not apply	40% coinsurance *	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of service, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance *	40% coinsurance *	—————none—————
	Childbirth/delivery facility services	20% coinsurance *	40% coinsurance *	Pre-certification required for inpatient (penalty applies).

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\* After deductible

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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>	20% coinsurance *	40% coinsurance *	Maximum 100 visits/year.
	<a href="#">Rehabilitation services</a>	20% coinsurance *	40% coinsurance *	Maximum 36 visits/year for occupational, physical, and respiratory therapies. Maximum 48 visits/year for speech therapy. Maximum 60 days/year for inpatient facility. Pre-certification required for inpatient (penalty applies).
	<a href="#">Habilitation services</a>	20% coinsurance *	40% coinsurance *	Covered for children under age 19. Maximum 100 visits/year. Includes applied behavioral analysis (ABA).
	<a href="#">Skilled nursing facility</a>	20% coinsurance *	40% coinsurance *	Maximum 100 days/year. Pre-certification required (penalty applies).
	<a href="#">Durable medical equipment</a>	20% coinsurance *	40% coinsurance *	Pre-certification required in excess of \$1,500 (penalty applies).
	<a href="#">Hospice services</a>	20% coinsurance *	40% coinsurance *	Maximum 15 visits/lifetime for family counseling. Maximum 14 days/lifetime for respite care. Pre-certification required for inpatient (penalty applies).
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	Not covered under the medical plan.
	Children's glasses	Not covered	Not covered	Not covered under the medical plan.
	Children's dental check-up	Not covered	Not covered	Not covered under the medical plan.

For more information about limitations and exceptions, see plan or policy document at [www.carefirst.com](http://www.carefirst.com) or call 833-229-9498

\* After deductible

## 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, unless restoring bodily function or correcting deformity resulting from non-cosmetic surgery, accidental injury, or congenital defect
- Dental care (adult & child) , unless due to accidental injury
- Glasses (adult & child), unless due to accidental injury or intraocular surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S., if purpose of travel is to receive care
- Routine eye care (adult & child)
- 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.)

- Acupuncture (maximum 12 visits/year)
- Bariatric surgery, for morbid obesity (maximum one/lifetime)
- Chiropractic care
- Hearing aids (maximum one/ear every 36 months)
- Private-duty nursing (maximum 60 visits/year)

For more information about limitations and exceptions, see plan or policy document at [www.carefirst.com](http://www.carefirst.com) or call 833-229-9498

\* After deductible

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at **833-229-9498**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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 the plan at **833-229-9498**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Additionally, a consumer assistance program can help you file your appeal. Contact the Maryland Office of the Attorney General, Health Education and Advocacy Unit, 200 St. Paul Place, 16th Floor, Baltimore, MD 21202, 877-261-8807, [www.oag.state.md.us/Consumer.HEAU.htm](http://www.oag.state.md.us/Consumer.HEAU.htm). A list of states with Consumer Assistance Programs is available at: [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>

**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 **833-229-9498**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **833-229-9498**.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **833-229-9498**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' **833-229-9498**.

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

For more information about limitations and exceptions, see plan or policy document at [www.carefirst.com](http://www.carefirst.com) or call 833-229-9498

\* After deductible



## 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>	\$500
■ <a href="#">Specialist</a> <i>copayment</i>	\$25
■ Hospital (facility) <i>coinsurance</i>	20%
■ Other <i>coinsurance</i>	20%

#### This EXAMPLE event includes services like:

Primary care physician 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:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$90
Coinsurance	\$2,001
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,591</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>	\$500
■ <a href="#">Specialist</a> <i>copayment</i>	\$25
■ Hospital (facility) <i>coinsurance</i>	20%
■ Other <i>coinsurance</i>	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:

<i>Cost Sharing</i>	
Deductibles	\$107
Copayments	\$1,970
Coinsurance	\$27
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,104</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>	\$500
■ <a href="#">Specialist</a> <i>copayment</i>	\$25
■ Hospital (facility) <i>coinsurance</i>	20%
■ Other <i>coinsurance</i>	20%

#### 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>\$1,925</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$225
Coinsurance	\$326
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,051</b>