Versant Health Holdco:
BlueChoice Advantage Standard Plan

Coverage Period: 01/01/2022 – 12/31/2022
Coverage for: Individual | **Plan Type:** POS

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 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. For more information about your prescription drug coverage with CVS / Caremark, or to get a copy of the complete terms of coverage, please contact RXBenefits at 1-800-334-8134 or CustomerCare@rxbenefits.com.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $1,500 individual/$3,000 family; Out-of-Network: $3,000 individual/$6,000 family. 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.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family member(s) on the plan, each family member may need to meet their own individual deductible, OR all family members may combine to meet the overall family deductible before the plan begins to pay, depending upon plan coverage. Please refer to your contract for further details.
Are there services covered before you meet your deductible?	Yes, all In-Network preventive care services, as well as the following (non-hospital facilities only, when applicable): Primary care, Specialist, Retail health, Urgent care, Mental health office visit and Rehabilitation	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical and Prescription Drug combined: In-Network: $8,700 individual/$17,400 family; Out-of-Network: $17,400 individual/$34,800 family. Out-of-network costs do not apply to the in-network out-of-pocket limit, and vice versa.	The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family member(s) on the plan, each family member may need to meet their own out-of-pocket limits, OR all family members may combine to meet the overall family out-of-pocket limit, depending upon plan coverage. Please refer to your contract for further details.
What is not included in the out-of-pocket limit?	Pre-certification penalties, premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Will you pay less if you use a network provider?	Yes. See www.carefirst.com or call 1-833-229-9498 for a list of Network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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	Provider: $35 copay per visit Hospital Facility: Deductible, then 30% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 50% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Specialist visit	Provider: $35 copay per visit Hospital Facility: Deductible, then 30% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 50% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Retail health clinic	$35 copay per visit	Deductible, then 50% of Allowed Benefit	None
	Preventive care/screening/ immunization	No Charge	Deductible, then 50% of Allowed Benefit	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.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Tests: Non-Hospital: $35 copay per visit Hospital: Deductible, then 30% of Allowed Benefit X-Ray: Non-Hospital: $35 copay per visit Hospital: Deductible, then 30% of Allowed Benefit	Lab Tests: Non-Hospital & Hospital: Deductible, then 50% of Allowed Benefit X-Ray: Non-Hospital & Hospital: Deductible, then 50% of Allowed Benefit	None
	Imaging (CT/PET scans, MRIs)	Non-Hospital: $35 copay per visit Hospital: Deductible, then 30% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 50% 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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com/rxgroup	Generic drugs	$15 copay	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	$60 copay	Applicable copayment, plus charges in excess of the allowed amount	
	Non-preferred brand drugs	$120 copay	Applicable copayment, plus charges in excess of the allowed amount	
	Preferred Specialty drugs	30% of Allowed Benefit up to $500	Applicable copayment, plus charges in excess of the allowed amount	
	Non-preferred Specialty drugs	30% of Allowed Benefit up to $500	Applicable copayment, plus charges in excess of the allowed amount	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 50% of Allowed Benefit	Pre-certification required (penalty applies).
	Physician/surgeon fees	Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 50% of Allowed Benefit	None
If you need immediate medical attention	Emergency room care	Deductible, then 30% of Allowed Benefit	Paid As In-Network	Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply
	Emergency medical transportation	Deductible, then 30% of Allowed Benefit	Paid As In-Network	Benefits for air ambulance are limited to $50,000 per trip if not an emergency
	Urgent care	$70 copay per visit	In-Network Deductible, then 50% 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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Prior authorization is required
	Physician/surgeon fees	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $35 copay per visit Hospital Facility: Deductible, then 30% of Allowed Benefit	Office Visit & Hospital Facility: Deductible, then 50% of Allowed Benefit	For treatment at an Outpatient Hospital Facility, additional charges may apply
	Inpatient services	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Prior authorization is required; Additional professional charges may apply
If you are pregnant	Office visits	No Charge	Deductible, then 50% 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 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	None
	Childbirth/delivery facility services	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Additional professional charges may apply
If you need help recovering or have other special health needs	Home health care	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Prior authorization is required Benefits are limited to 100 visits per benefit period
	Rehabilitation services	Office Visit: $35 copay per visit Hospital Facility: Deductible, then 30% of Allowed Benefit	Office Visit & Hospital Facility: Deductible, then 50% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply Benefits for Speech Therapy are limited to 48 visits per benefit period. Benefits for Physical and Occupational Therapies are limited to 36 visits per benefit period
	Habilitation services	Office Visit: $35 copay per visit Hospital Facility: Deductible, then 30% of Allowed Benefit	Office Visit & Hospital Facility: Deductible, then 50% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply Benefits are limited to 100 visits per benefit period Includes applied behavioral analysis (ABA)

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)	
	Skilled nursing care	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Prior authorization is required Benefits are limited to 100 days per benefit period
	Durable medical equipment	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	None
	Hospice services	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Prior authorization is required Respite Care: Benefits are limited to 14 days per lifetime Family Counseling: Benefits are limited to 15 days per lifetime
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)
- 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
- 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.)

- Abortion
- Acupuncture
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the US. See www.carefirst.com
- Hearing aids (maximum one/ear every 36 months)
- Private-duty nursing

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, kwiijigo 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 plan's overall deductible $1,500
- Specialist *Copayment* $35
- Hospital (facility) *Coinsurance* 30%
- Other *Copayment* $35

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	$1,500
Copayments	$0
Coinsurance	$2,550
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$4,060**

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

- The plan's overall deductible $1,500
- Specialist *Copayment* $35
- Hospital (facility) *Coinsurance* 30%
- Other *Coinsurance* 30%

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	$1,500
Copayments	$870
Coinsurance	$87
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,457**

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

- The plan's overall deductible $1,500
- Specialist *Copayment* $35
- Hospital (facility) *Coinsurance* 30%
- Other *Copayment* $35

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	$1,500
Copayments	$290
Coinsurance	$87
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,877**

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