



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:
	Option 1	Option 2	Option 3	
<b>What is the overall <a href="#">deductible</a>?</b>	\$50 individual/\$100 family	\$50 individual/\$100 family	\$250 individual/\$500 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.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes, all In-Network preventive care services, as well as the following (non-hospital facilities only, when applicable): Prescription drugs	Yes, all In-Network preventive care services, as well as the following (non-hospital facilities only, when applicable): Prescription drugs	Not applicable to Out-of-Network services	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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	There are no other specific deductibles.	There are no other specific deductibles.	There are no other specific deductibles.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	Medical: \$1,200 individual/\$2,400 family; Prescription Drug: \$5,400 individual/\$10,800 family	Medical: \$1,200 individual/\$2,400 family; Prescription Drug: \$5,400 individual/\$10,800 family	Medical: \$1,200 individual/\$2,400 family; Prescription Drug: \$5,400 individual/\$10,800 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.

<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	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.	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.	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> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.carefirst.com">www.carefirst.com</a> or call 855-258-6518 for a list of Network providers.	Yes. See <a href="http://www.carefirst.com">www.carefirst.com</a> or call 855-258-6518 for a list of Network providers.	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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No	No	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
		Preferred Network Provider (You will pay the least)	Non-Preferred Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's office</a> or clinic</b>	Primary care visit to treat an injury or illness	Provider: Deductible, then \$15 copay per visit Hospital Facility: Deductible, then No Charge	Provider: Deductible, then \$20 copay per visit Hospital Facility: Deductible, then No Charge	Provider & Hospital Facility: Deductible, then 20% 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 \$20 copay per visit Hospital Facility: Deductible, then No Charge	Provider: Deductible, then \$25 copay per visit Hospital Facility: Deductible, then No Charge	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Retail health clinic	Deductible, then \$15 copay per visit	Deductible, then \$20 copay per visit	Deductible, then 20% of Allowed Benefit	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge	No Charge	Deductible, then 20% 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
		Preferred Network Provider (You will pay the least)	Non-Preferred Network Provider (You will pay more)	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 Test: Non-Hospital & Hospital: Deductible, then No Charge X-Ray: Non-Hospital & Hospital: Deductible, then No Charge	Lab Test: Non-Hospital & Hospital: Deductible, then No Charge X-Ray: Non-Hospital & Hospital: Deductible, then No Charge	Lab Test: Non-Hospital & Hospital: Deductible, then 20% of Allowed benefit X-Ray: Non-Hospital & Hospital: Deductible, then 20% of Allowed benefit	In-Network Lab Test benefits apply only to tests performed at LabCorp.
	Imaging (CT/PET scans, MRIs)	Non-Hospital & Hospital: Deductible, then No Charge	Non-Hospital & Hospital: Deductible, then No Charge	Non-Hospital & Hospital: Deductible, then 20% 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	\$15 copay	\$15 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 1 copay.
	Preferred brand drugs	\$30 copay	\$30 copay	Paid As In-Network	
	Non-preferred brand drugs	\$45 copay	\$45 copay	Paid As In-Network	
	Preferred <a href="#">Specialty drugs</a>	\$15/\$30/\$45 copay	\$15/\$30/\$45 copay	Paid As In-Network	
	Non-preferred <a href="#">Specialty drugs</a>	\$15/\$30/\$45 copay	\$15/\$30/\$45 copay	Paid As In-Network	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Non-Hospital & Hospital: Deductible, then No Charge	Non-Hospital & Hospital: Deductible, then No Charge	Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	None
	Physician/surgeon fees	Non-Hospital & Hospital: Deductible, then No Charge	Non-Hospital & Hospital: Deductible, then No Charge	Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Deductible, then \$75 copay per visit	Deductible, then \$75 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 No Charge	Deductible, then No Charge	Paid As In-Network	None
	<a href="#">Urgent care</a>	Deductible, then \$20 copay per visit	Deductible, then \$25 copay per visit	Deductible, then 20% of Allowed Benefit	Limited to unexpected, urgently required services

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	Non-Preferred Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Deductible, then No Charge	Deductible, then No Charge	Deductible, then 20% of Allowed Benefit	Prior authorization is required
	Physician/surgeon fees	Deductible, then No Charge	Deductible, then No Charge	Deductible, then 20% of Allowed Benefit	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office Visits: Deductible, then \$15 copay per visit Hospital Facility: Deductible, then No Charge	Office Visits: Deductible, then \$20 copay per visit Hospital Facility: Deductible, then No Charge	Office Visits & Hospital Facility: Deductible, then 20% of Allowed Benefit	For treatment at an Outpatient Hospital Facility, additional charges may apply
	Inpatient services	Deductible, then No Charge	Deductible, then No Charge	Deductible, then 20% of Allowed Benefit	Prior authorization is required; Additional professional charges may apply
<b>If you are pregnant</b>	Office visits	No Charge	No Charge	Deductible, then 20% 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 No Charge	Deductible, then No Charge	Deductible, then 20% of Allowed Benefit	None
	Childbirth/delivery facility services	Deductible, then No Charge	Deductible, then No Charge	Deductible, then 20% 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 No Charge	Deductible, then No Charge	Deductible, then 20% of Allowed Benefit	Prior authorization is required Benefits are limited to 90 days per benefit period
	<a href="#">Rehabilitation services</a>	Provider & Hospital Facility: Deductible, then \$20 copay per visit	Provider: Deductible, then \$25 copay per visit Hospital Facility: Deductible, then \$30 copay per visit	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply Benefits for Speech, Physical and Occupational Therapies are limited to 100 days combined per benefit period.
	<a href="#">Habilitation services</a>	Provider & Hospital Facility: Deductible, then \$20 copay per visit	Provider: Deductible, then \$25 copay per visit Hospital Facility: Deductible, then \$30 copay per visit	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	Prior authorization is required after the first visit Benefits are limited to Members under the age of 19 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
		Preferred Network Provider (You will pay the least)	Non-Preferred Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Skilled nursing care</a>	Deductible, then No Charge	Deductible, then No Charge	Deductible, then 20% of Allowed Benefit	Prior authorization is required
	<a href="#">Durable medical equipment</a>	Deductible, then No Charge	Deductible, then No Charge	Deductible, then 20% of Allowed Benefit	None
	<a href="#">Hospice services</a>	Deductible, then No Charge	Deductible, then No Charge	Deductible, then 20% of Allowed Benefit	Prior authorization is required Respite Care: Benefits are limited to 14 days during the Hospice Eligibility Period Bereavement: Benefits are limited to 6 months or 15 visits.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$10 copay per visit	Not Covered	Not Covered	Benefits are limited to 1 visit per benefit period
	Children's glasses	Discount program available to all Members	Not Covered	Not Covered	Benefits are limited to 1 set of glasses/lenses per benefit period
	Children's dental check-up	Not Covered	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.)

- Abortion
- Acupuncture
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the US. See [www.carefirst.com](http://www.carefirst.com)
- Hearing aids
- Infertility treatment
- Non-emergency care when travelling outside the US
- Private-duty nursing
- Routine eye care (level one)

**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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$50
■ <a href="#">Specialist Copayment</a>	\$20
■ Hospital (facility) <a href="#">Copayment</a>	\$0
■ 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>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$50
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$60</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>	\$50
■ <a href="#">Specialist Copayment</a>	\$20
■ Hospital (facility) <a href="#">Copayment</a>	\$0
■ Other <a href="#">Copayment</a>	\$0

#### 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:

Cost Sharing	
Deductibles	\$50
Copayments	\$575
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$625</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>	\$50
■ <a href="#">Specialist Copayment</a>	\$20
■ Hospital (facility) <a href="#">Copayment</a>	\$75
■ 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>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$50
Copayments	\$205
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$255</b>

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