



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 1-800-628-8549 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.

Important Questions	Answers			Why This Matters:
	Option 1	Option 2	Option 3	
What is the overall deductible?	In-Network: \$125 individual/\$250 family	In-Network: \$250 individual/\$500 family	In-Network: \$500 individual/\$1,000 family	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 members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
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, Diagnostic testing, Outpatient surgery physician, Emergency room, Emergency medical transportation, Urgent care, Mental health office visit, Rehabilitation services,	Yes, all In-Network preventive care services, as well as the following (non-hospital facilities only, when applicable): Primary care, Specialist, Retail health, Diagnostic testing, Outpatient surgery physician, Emergency room, Emergency medical transportation, Urgent care, Mental health office visit, Rehabilitation services,	Yes, (non-hospital facilities only, when applicable): Diagnostic testing, Emergency room, Emergency medical transportation and Urgent care	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?	There are no other specific deductibles.	There are no other specific deductibles.	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: In-Network: \$500 individual/\$1,000 family	Medical In-Network: \$1,000 individual/\$2,000 family	Medical In-Network: \$1,500 individual/\$3,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

What is not included in the out-of-pocket limit?	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 out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. See www.carefirst.com or call 1-800-628-8549 for a list of Network providers.	Yes. See www.carefirst.com or call 1-800-628-8549 for a list of Network providers.	Yes. See www.carefirst.com or call 1-800-628-8549 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	No	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
		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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Provider: \$15 copay per visit Hospital Facility: Deductible, then 5% of Allowed Benefit	Provider: \$25 copay per visit Hospital Facility: Deductible, then 15% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 30% 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 5% of Allowed Benefit	Provider: \$50 copay per visit Hospital Facility: Deductible, then 15% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 30% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Retail health clinic	\$15 copay per visit	\$25 copay per visit	Deductible, then 30% of Allowed Benefit	None
	Preventive care/screening/immunization	No Charge	No Charge	Deductible, then 30% 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)	
If you have a test	Diagnostic test (x-ray, blood work)	Lab Tests: Non-Hospital: No Charge Hospital: Deductible, then 5% of Allowed Benefit X-Ray: Non-Hospital: No Charge Hospital: Deductible, then 5% of Allowed Benefit	Lab Tests: Non-Hospital: No Charge Hospital: Deductible, then 5% of Allowed Benefit X-Ray: Non-Hospital: No Charge Hospital: Deductible, then 5% of Allowed Benefit	Lab Tests: Non-Hospital: No Charge Hospital: Deductible, then 5% of Allowed Benefit X-Ray: Non-Hospital: No Charge Hospital: Deductible, then 5% of Allowed Benefit	BlueChoice Provider: In-Network Lab Test benefits apply only to tests performed at LabCorp.
	Imaging (CT/PET scans, MRIs)	Non-Hospital: No Charge Hospital: Deductible, then 5% of Allowed Benefit	Non-Hospital: No Charge Hospital: Deductible, then 5% of Allowed Benefit	Non-Hospital: No Charge Hospital: Deductible, then 5% of Allowed Benefit	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at	Generic drugs	Not Covered	Not Covered	Not Covered	CVS Caremark is your prescription drug provider. You can call them at 1-866-823-5181
	Preferred brand drugs	Not Covered	Not Covered	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	Not Covered	
	Preferred Specialty drugs	Not Covered	Not Covered	Not Covered	
	Non-preferred Specialty drugs	Not Covered	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-Hospital & Hospital: Deductible, then 5% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 15% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	None
	Physician/surgeon fees	Non-Hospital & Hospital: \$15 PCP/\$35 Specialist copay per visit	Non-Hospital & Hospital: \$50 copay per visit	Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	None

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)	
If you need immediate medical attention	Emergency room care	\$75 copay per visit	\$75 copay per visit	\$75 copay per visit	Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply. Copay waived if admitted BlueChoice Providers: Copay applies to Emergency Room only
	Emergency medical transportation	No Charge	No Charge	No Charge	None
	Urgent care	\$35 copay per visit	\$35 copay per visit	\$35 copay per visit	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 5% of Allowed Benefit	Deductible, then 15% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required
	Physician/surgeon fees	Deductible, then 5% of Allowed Benefit	Deductible, then 15% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$15 copay per visit Hospital Facility: Deductible, then 5% of Allowed Benefit	Office Visit: \$15 copay per visit Hospital Facility: Deductible, then 5% of Allowed Benefit	Office Visit & Hospital Facility: Deductible, then 30% of Allowed Benefit	For treatment at an Outpatient Hospital Facility, additional charges may apply
	Inpatient services	Deductible, then 5% of Allowed Benefit	Deductible, then 15% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required; Additional professional charges may apply
If you are pregnant	Office visits	No Charge	No Charge	Deductible, then 30% 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 5% of Allowed Benefit	Deductible, then 15% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Childbirth/delivery facility services	Deductible, then 5% of Allowed Benefit	Deductible, then 15% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Additional professional charges 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)	
If you need help recovering or have other special health needs	Home health care	Deductible, then 5% of Allowed Benefit	Deductible, then 5% of Allowed Benefit	Deductible, then 5% of Allowed Benefit	Prior authorization is required Benefits are limited to 90 days per Benefit Period. Benefits are limited to 40 Home Health Aid visits per benefit period.
	Rehabilitation services	Provider: \$35 copay per visit Hospital Facility: Deductible, then 5% of Allowed Benefit	Provider: \$50 copay per visit Hospital Facility: Deductible, then 5% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 30% 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 condition per benefit period
	Habilitation services	Provider: \$35 copay per visit Hospital Facility: Deductible, then 5% of Allowed Benefit	Provider: \$50 copay per visit Hospital Facility: Deductible, then 5% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 30% 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
	Skilled nursing care	Deductible, then 5% of Allowed Benefit	Deductible, then 15% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required PPO Providers: Benefits are limited to 120 days per benefit period
	Durable medical equipment	Deductible, then 5% of Allowed Benefit	Deductible, then 5% of Allowed Benefit	Deductible, then 5% of Allowed Benefit	PPO Providers: Must apply \$125 deductible
	Hospice services	Deductible, then 5% of Allowed Benefit	Deductible, then 5% of Allowed Benefit	Deductible, then 5% 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 whichever occurs first.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	Refer to your EyeMed vision plan
	Children's glasses	Not Covered	Not Covered	Not Covered	Refer to your EyeMed vision plan
	Children's dental check-up	Not Covered	Not Covered	Not Covered	Refer to your Cigna dental benefits plan

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 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
- Infertility treatment
- Non-emergency care when travelling outside the US
- 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**

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 [plan's](#) overall [deductible](#) \$125
- [Specialist](#) \$15
- [Hospital \(facility\)](#) 5%
- [Other](#) 5%

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	\$7540
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$125
Copayments	\$15
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$150
The total Peg would pay is	\$790

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

- The [plan's](#) overall [deductible](#) \$125
- [Specialist](#) \$35
- [Hospital \(facility\)](#) 5%
- [Other](#) 5%

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	\$160
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$125
Copayments	\$35
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$160

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

- The [plan's](#) overall [deductible](#) \$125
- [Specialist](#) \$35
- [Hospital \(facility\)](#) \$75
- [Other](#) 5%

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	\$895
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$125
Copayments	\$75
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$240