CareFirst BlueChoice

BlueChoice Gold $0

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014
Coverage for: Individual | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,350** person/**$12,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay per date of service	Not Covered	None
	Specialist visit	$30 co-pay per date of service	Not Covered	None
	Other practitioner office visit	$30 co-pay per date of service for Acupuncture; $30 co-pay per date of service for Chiropractic	Not Covered	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	30% of Allowed Benefit	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% of Allowed Benefit	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Preferred Generic: 20% of Allowed Benefit Non-Preferred Generic: 20% of Allowed Benefit	Preferred Generic: 20% of Allowed Benefit Non-Preferred Generic: 20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	30% of Allowed Benefit	30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	50% of Allowed Benefit	50% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	50% of Allowed Benefit	50% of Allowed Benefit	Covers up to a 34-day supply

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% of Allowed Benefit	Not Covered	None
	Physician/surgeon fees	30% of Allowed Benefit per date of service	Not Covered	None
If you need immediate medical attention	Emergency room services	30% of Allowed Benefit	30% of Allowed Benefit	Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	30% of Allowed Benefit	30% of Allowed Benefit	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	30% of Allowed Benefit	30% of Allowed Benefit	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	30% of Allowed Benefit	Not Covered	Requires prior authorization
	Physician/surgeon fee	30% of Allowed Benefit per date of service	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay per date of service	Not Covered	None
	Mental/Behavioral health inpatient services	30% of Allowed Benefit	Not Covered	Requires prior authorization
	Substance use disorder outpatient services	$20 co-pay per date of service	Not Covered	None
	Substance use disorder inpatient services	30% of Allowed Benefit	Not Covered	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	$30 co-pay per date of service	Not Covered	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	30% of Allowed Benefit	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Requires prior authorization
	Rehabilitation services	$30 co-pay per date of service	Not Covered	Limited to 30 visits/condition/benefit period
	Habilitation services	$30 co-pay per date of service	Not Covered	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	30% of Allowed Benefit	Not Covered	Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	30% of Allowed Benefit	Not Covered	Prior authorization is required for specific services. Please see your contract.
	Hospice service	30% of Allowed Benefit	Not Covered	Requires prior authorization Outpatient Hospice Services: For Participating Providers: No Charge
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,830
- **Patient pays:** $1,710

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$1,560
Limits or exclusions	$150
Total	**$1,710**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,130
- **Patient pays:** $1,270

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$200
Coinsurance	$990
Limits or exclusions	$80
Total	**$1,270**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles.**	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,350** person/**$12,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Specialist visit	$30 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Other practitioner office visit	$30 co-pay per date of service for Acupuncture; $30 co-pay per date of service for Chiropractic	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have a test	Diagnostic test (x-ray, blood work)	30% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Imaging (CT/PET scans, MRIs)	30% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Preferred Generic: 20% of Allowed Benefit Non-Preferred Generic 20% of Allowed Benefit	Preferred Generic: 20% of Allowed Benefit Non-Preferred Generic 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34-day supply
	Preferred brand drugs	30% of Allowed Benefit	30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34-day supply
	Non-preferred brand drugs	50% of Allowed Benefit	50% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34-day supply
	Specialty drugs	50% of Allowed Benefit	50% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Physician/surgeon fees	30% of Allowed Benefit per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you need immediate medical attention	Emergency room services	30% of Allowed Benefit	30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	30% of Allowed Benefit	30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Urgent care	30% of Allowed Benefit	30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	30% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Physician/surgeon fee	30% of Allowed Benefit per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Mental/Behavioral health inpatient services	30% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Substance use disorder outpatient services	$20 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Substance use disorder inpatient services	30% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
If you are pregnant	Prenatal and postnatal care	$20 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Delivery and all inpatient services	30% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Rehabilitation services	$30 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 30 visits/benefit period
	Habilitation services	$30 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	30% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	30% of Allowed Benefit	Not Covered	Prior authorization is required for specific services. Please see your contract.
	Hospice service	30% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Outpatient Hospice Services: For Participating Providers: No Charge

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
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For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy**

does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

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This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,830
- **Patient pays:** $1,710

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$1,560
Limits or exclusions	$150
Total	**$1,710**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,320
- **Patient pays:** $2,080

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$990
Limits or exclusions	$1,090
Total	**$2,080**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

CareFirst BlueChoice

BlueChoice Gold $1000

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014
Coverage for: Individual | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** person/ **$2,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$3,750** person/ **$7,500** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at www.carefirst.com/sbcg.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay per date of service	Not Covered	None
	Specialist visit	Deductible, then $30 co-pay per date of service	Not Covered	None
	Other practitioner office visit	Deductible, then $30 co-pay per date of service for Acupuncture; Deductible, then $30 co-pay per date of service for Chiropractic	Not Covered	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 10% of Allowed Benefit	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Deductible, then 10% of Allowed Benefit	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Preferred Generic: $10 co-pay Non-Preferred Generic: 20% of Allowed Benefit	Preferred Generic: $10 co-pay Non-Preferred Generic: 20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Covers up to a 34-day supply

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 10% of Allowed Benefit	Not Covered	None
	Physician/surgeon fees	Deductible, then 10% of Allowed Benefit per date of service	Not Covered	None
If you need immediate medical attention	Emergency room services	Deductible, then 10% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	Deductible, then 10% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	$30 co-pay per date of service	$30 co-pay per date of service	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 10% of Allowed Benefit	Not Covered	Requires prior authorization
	Physician/surgeon fee	Deductible, then 10% of Allowed Benefit per date of service	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay per date of service	Not Covered	None
	Mental/Behavioral health inpatient services	Deductible, then 10% of Allowed Benefit	Not Covered	Requires prior authorization
	Substance use disorder outpatient services	$20 co-pay per date of service	Not Covered	None
	Substance use disorder inpatient services	Deductible, then 10% of Allowed Benefit	Not Covered	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then $20 co-pay per date of service	Not Covered	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	Deductible, then 10% of Allowed Benefit	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Not Covered	Requires prior authorization
	Rehabilitation services	Deductible, then $30 co-pay per date of service	Not Covered	Limited to 30 visits/condition/ benefit period
	Habilitation services	Deductible, then $30 co-pay per date of service	Not Covered	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then 10% of Allowed Benefit	Not Covered	Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	Deductible, then 10% of Allowed Benefit	Not Covered	Prior authorization is required for specific services. Please see your contract.
	Hospice service	Deductible, then 10% of Allowed Benefit	Not Covered	Requires prior authorization Outpatient Hospice Services: For Participating Providers: Deductible, then No Charge
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

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See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,950
- **Patient pays:** $1,590

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$20
Coinsurance	$420
Limits or exclusions	$150
Total	**$1,590**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,710
- **Patient pays:** $1,690

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,000
Copays	$500
Coinsurance	$110
Limits or exclusions	$80
Total	**$1,690**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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CareFirst BlueChoice

BlueChoice $1000 Ltd CSR

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014
Coverage for: Individual | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** person/ **$2,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$3,750** person/ **$7,500** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at www.carefirst.com/sbcg.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Specialist visit	Deductible, then $30 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Other practitioner office visit	Deductible, then $30 co-pay per date of service for Acupuncture; Deductible, then $30 co-pay per date of service for Chiropractic	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 10% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Imaging (CT/PET scans, MRIs)	Deductible, then 10% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Preferred Generic: $10 co-pay Non-Preferred Generic: 20% of Allowed Benefit	Preferred Generic: $10 co-pay Non-Preferred Generic: 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34-day supply
	Specialty drugs	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 10% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Physician/surgeon fees	Deductible, then 10% of Allowed	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you need immediate medical attention	Emergency room services	Deductible, then 10% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	Deductible, then 10% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Urgent care	$30 co-pay per date of service	$30 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 10% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Physician/surgeon fee	Deductible, then 10% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then $20 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Mental/Behavioral health inpatient services	Deductible, then 10% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Substance use disorder outpatient services	Deductible, then $20 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Substance use disorder inpatient services	Deductible, then 10% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then $20 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
	Delivery and all inpatient services	Deductible, then 10% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Rehabilitation services	Deductible, then $30 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 30 visits/condition/ benefit period
	Habilitation services	Deductible, then $30 co-pay per visit per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then 10% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	Deductible, then 10% of Allowed Benefit	Not Covered	Prior authorization is required for specified services. Please see your contract.
	Hospice service	Deductible, then 10% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Outpatient Hospice Services: For Participating Providers: Deductible, then No Charge

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	No member cost-sharing when services are rendered by an Indian Health Services Provider Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	No member cost-sharing when services are rendered by an Indian Health Services Provider Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,950
- **Patient pays:** $1,590

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$20
Coinsurance	$420
Limits or exclusions	$150
Total	**$1,590**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,710
- **Patient pays:** $1,690

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,000
Copays	$500
Coinsurance	$110
Limits or exclusions	$80
Total	**$1,690**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$4,000** person/ **$8,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,350** person/ **$12,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then $30 co-pay per date of service	Not Covered	None
	Specialist visit	Deductible, then $40 co-pay per date of service	Not Covered	None
	Other practitioner office visit	Deductible, then $40 co-pay per date of service for Acupuncture; Deductible, then $40 co-pay per date of service for Chiropractic	Not Covered	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 30% of Allowed Benefit	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Deductible, then 30% of Allowed Benefit	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Preferred Generic: Deductible, then 20% of Allowed Benefit Non-Preferred Generic: Deductible, then 20% of Allowed Benefit	Preferred Generic: Deductible, then 20% of Allowed Benefit Non-Preferred Generic: Deductible, then 20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 30% of Allowed Benefit	Not Covered	None
	Physician/surgeon fees	Deductible, then 30% of Allowed Benefit per date of service	Not Covered	None
If you need immediate medical attention	Emergency room services	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Co-pay waived if admitted Limited to emergency services
	Emergency medical transportation	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 30% of Allowed Benefit	Not Covered	Requires prior authorization
	Physician/surgeon fee	Deductible, then 30% of Allowed Benefit per date of service	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then $30 co-pay per date of service	Not Covered	None
	Mental/Behavioral health inpatient services	Deductible, then 30% of Allowed Benefit	Not Covered	Requires prior authorization
	Substance use disorder outpatient services	Deductible, then $30 co-pay per date of service	Not Covered	None
	Substance use disorder inpatient services	Deductible, then 30% of Allowed Benefit	Not Covered	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then $30 co-pay per date of service	Not Covered	For Participating Providers: Preventive Prenatal Care is provided at No Charge, and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	Deductible, then 30% of Allowed Benefit	Not Covered	None
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Not Covered	Requires prior authorization
	Rehabilitation services	Deductible, then $40 co-pay per date of service	Not Covered	Limited to 30 visits/condition/ benefit period
	Habilitation services	Deductible, then $40 co-pay per date of service	Not Covered	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then 30% of Allowed Benefit	Not Covered	Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	Deductible, then 30% of Allowed Benefit	Not Covered	Prior authorization is required for specific services. Please see your contract.
	Hospice service	Deductible, then 30% of Allowed Benefit	Not Covered	Requires prior authorization Outpatient Hospice Services: For Participating Providers: Deductible, then No Charge

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
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OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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Does this Coverage Provide Minimum Essential Coverage?

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Does this Coverage Meet the Minimum Value Standard?

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $3,030
- **Patient pays:** $4,510

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$4,000
Copays	$0
Coinsurance	$360
Limits or exclusions	$150
Total	**$4,510**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $1,030
- **Patient pays:** $4,370

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$4,000
Copays	$30
Coinsurance	$260
Limits or exclusions	$80
Total	**$4,370**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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CareFirst BlueChoice

BlueChoice HSA Bronze $4000 Ltd CSR

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014
Coverage for: Individual | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$4,000** person/ **$8,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,350** person/ **$12,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at www.carefirst.com/sbcg.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then $30 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Specialist visit	Deductible, then $40 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Other practitioner office visit	Deductible, then $40 co-pay per date of service for Acupuncture; Deductible, then $40 co-pay per date of service for Chiropractic	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members age 12 and older for Chiropractic. Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 30% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Imaging (CT/PET scans, MRIs)	Deductible, then 30% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Preferred Generic: Deductible, then 20% of Allowed Benefit Non-Preferred Generic: Deductible, then 20% of Allowed Benefit	Preferred Generic: Deductible, then 20% of Allowed Benefit Non-Preferred Generic: Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34-day supply
	Specialty drugs	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 30% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Physician/surgeon fees	Deductible, then 30% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you need immediate medical attention	Emergency room services	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Co-pay waived if admitted Limited to emergency services
	Emergency medical transportation	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Urgent care	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 30% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Physician/surgeon fee	Deductible, then 30% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then $30 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Mental/Behavioral health inpatient services	Deductible, then 30% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Substance use disorder outpatient services	Deductible, then $30 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Substance use disorder inpatient services	Deductible, then 30% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then $30 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	Deductible, then 30% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Rehabilitation services	Deductible, then $40 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 30 visits/condition/ benefit period
	Habilitation services	Deductible, then $40 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then 30% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	Deductible, then 30% of Allowed Benefit	Not Covered	Prior authorization is required for specified services. Please see your contract.
	Hospice service	Deductible, then 30% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Outpatient Hospice Services: For Participating Providers: Deductible, then No Charge

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $3,030
- **Patient pays:** $4,510

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$4,000
Copays	$0
Coinsurance	$360
Limits or exclusions	$150
Total	**$4,510**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $1,030
- **Patient pays:** $4,370

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$4,000
Copays	$30
Coinsurance	$260
Limits or exclusions	$80
Total	**$4,370**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$6,000** person/ **$12,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,000** person/ **$12,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then No Charge	Not Covered	None
	Specialist visit	Deductible, then No Charge	Not Covered	None
	Other practitioner office visit	Deductible, then No Charge for Acupuncture Deductible, then No Charge for Chiropractic	Not Covered	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Deductible, then No Charge	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Deductible, then No Charge	Deductible, then No Charge	Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then No Charge	Deductible, then No Charge	Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then No Charge	Deductible, then No Charge	Covers up to a 34-day supply
	Specialty drugs	Deductible, then No Charge	Deductible, then No Charge	Covers up to a 34-day supply

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then No Charge	Not Covered	None
	Physician/surgeon fees	Deductible, then No Charge	Not Covered	None
If you need immediate medical attention	Emergency room services	Deductible, then No Charge	Deductible, then No Charge	Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	Deductible, then No Charge	Deductible, then No Charge	Prior authorization is required for air ambulance services, except for Medically Necessary air ambulance services in an emergency
	Urgent care	Deductible, then No Charge	Deductible, then No Charge	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then No Charge	Not Covered	Requires prior authorization
	Physician/surgeon fee	Deductible, then No Charge	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then No Charge	Not Covered	None
	Mental/Behavioral health inpatient services	Deductible, then No Charge	Not Covered	Requires prior authorization
	Substance use disorder outpatient services	Deductible, then No Charge	Not Covered	None
	Substance use disorder inpatient services	Deductible, then No Charge	Not Covered	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then No Charge	Not Covered	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	Deductible, then No Charge	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Not Covered	Requires prior authorization
	Rehabilitation services	Deductible, then No Charge	Not Covered	Limited to 30 visits/ condition/benefit period
	Habilitation services	Deductible, then No Charge	Not Covered	Requires prior authorization Benefits available for Members age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then No Charge	Not Covered	Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	Deductible, then No Charge	Not Covered	Prior authorization is required for specific services. Please see your contract.
	Hospice service	Deductible, then No Charge	Not Covered	Requires prior authorization
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $2,190
- **Patient pays:** $5,350

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$5,200
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$5,350**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $50
- **Patient pays:** $5,350

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$5,270
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$5,350**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$6,000** person/ **$12,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,000** person/ **$12,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Specialist visit	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Other practitioner office visit	Deductible, then No Charge for Acupuncture; Deductible, then No Charge for Chiropractic	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Imaging (CT/PET scans, MRIs)	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Deductible, then No Charge	Deductible, then No Charge	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then No Charge	Deductible, then No Charge	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then No Charge	Deductible, then No Charge	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34-day supply
	Specialty drugs	Deductible, then No Charge	Deductible, then No Charge	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Physician/surgeon fees	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you need immediate medical attention	Emergency room services	Deductible, then No Charge	Deductible, then No Charge	No member cost-sharing when services are rendered by an Indian Health Services Provider. Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	Deductible, then No Charge	Deductible, then No Charge	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Urgent care	Deductible, then No Charge	Deductible, then No Charge	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Physician/surgeon fee	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Mental/Behavioral health inpatient services	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Substance use disorder outpatient services	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Substance use disorder inpatient services	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
	Delivery and all inpatient services	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Rehabilitation services	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 30 visits/ condition/benefit period
	Habilitation services	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 100 days/benefit period Prior authorization is required for specific services. Please see your contract.
	Durable medical equipment	Deductible, then No Charge	Not Covered	Prior authorization is required for specified services. Please see your contract.
	Hospice service	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

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- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $2,190
- **Patient pays:** $5,350

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$5,200
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$5,350**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $50
- **Patient pays:** $5,350

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$5,270
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$5,350**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$0**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	Not Covered	None
	Specialist visit	No Charge	Not Covered	None
	Other practitioner office visit	No Charge	Not Covered	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	No Charge	No Charge	Covers up to 34-day supply
	Preferred brand drugs	No Charge	No Charge	Covers up to 34-day supply
	Non-preferred brand drugs	No Charge	No Charge	Covers up to 34-day supply
	Specialty drugs	No Charge	No Charge	Covers up to 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room services	No Charge	No Charge	Co-pay waived if admitted Limited to Emergency Services

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
	Emergency medical transportation	No Charge	No Charge	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	No Charge	No Charge	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Requires prior authorization
	Physician/surgeon fee	No Charge	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	Not Covered	None
	Mental/Behavioral health inpatient services	No Charge	Not Covered	Requires prior authorization
	Substance use disorder outpatient services	No Charge	Not Covered	None
	Substance use disorder inpatient services	No Charge	Not Covered	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	No Charge	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Requires prior authorization
	Rehabilitation services	No Charge	Not Covered	Limited to 30 visits/ condition/benefit period
	Habilitation services	No Charge	Not Covered	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	No Charge	Not Covered	Requires prior authorization Limited to 100 days/benefit period
	Durable medical equipment	No Charge	Not Covered	Prior authorization is required for specified services. Please see your contract.
	Hospice service	No Charge	Not Covered	Requires prior authorization Outpatient Hospice Services: For Participating Providers: No Charge
If your child needs dental or eye care	Eye exam	No Charge	No Charge	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	No Charge for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	No Charge	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,540
- **Patient pays:** $0

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$0**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $5,400
- **Patient pays:** $0

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$0**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$900** person/ **$1,800** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$5,200** person/ **$10,400** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then $30 co-pay per date of service	Not Covered	None
	Specialist visit	Deductible, then $40 co-pay per date of service	Not Covered	None
	Other practitioner office visit	Deductible, then $40 co-pay per visit for Acupuncture; Deductible, then $40 co-pay per date of service for Chiropractic	Not Covered	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 20% of Allowed Benefit	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Deductible, then 20% of Allowed Benefit	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Covers up to a 34-day supply

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 20% of Allowed Benefit	Not Covered	None
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Not Covered	None
If you need immediate medical attention	Emergency room services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Not Covered	Requires prior authorization
	Physician/surgeon fee	Deductible, then 20% of Allowed Benefit	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then $30 co-pay per date of service	Not Covered	None
	Mental/Behavioral health inpatient services	Deductible, then 20% of Allowed Benefit	Not Covered	Requires prior authorization
	Substance use disorder outpatient services	Deductible, then $30 co-pay per date of service	Not Covered	None
	Substance use disorder inpatient services	Deductible, then 20% of Allowed Benefit	Not Covered	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then $30 co-pay per date of service	Not Covered	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	Deductible, then 20% of Allowed Benefit	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Not Covered	Requires prior authorization
	Rehabilitation services	Deductible, then $40 co-pay per date of service	Not Covered	Limited to 30 visits/condition/ benefit period
	Habilitation services	Deductible, then $40 co-pay per date of service	Not Covered	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Not Covered	Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Not Covered	Prior authorization is required for specific services. Please see your contract.
	Hospice service	Deductible, then 20% of Allowed Benefit	Not Covered	Requires prior authorization For Participating Providers: Outpatient Hospice Services: Deductible, then No Charge

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

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- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,630
- **Patient pays:** $1,910

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$900
Copays	$0
Coinsurance	$860
Limits or exclusions	$150
Total	**$1,910**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,470
- **Patient pays:** $1,930

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$900
Copays	$240
Coinsurance	$710
Limits or exclusions	$80
Total	**$1,930**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,250** person/ **$4,500** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at www.carefirst.com/sbcg.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 co-pay per date of service	Not Covered	None
	Specialist visit	$25 co-pay per date of service	Not Covered	None
	Other practitioner office visit	$25 co-pay per date of service for Acupuncture; $25 co-pay per date of service for Chiropractic	Not Covered	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	20% of Allowed Benefit	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% of Allowed Benefit	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Preferred Generic: 10% of Allowed Benefit Non-Preferred Generic: 10% of Allowed Benefit	Preferred Generic: 10% of Allowed Benefit Non-Preferred Generic: 10% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	30% of Allowed Benefit	Not Covered	Covers up to a 34-day supply
	Non-preferred brand drugs	50% of Allowed Benefit	Not Covered	Covers up to a 34-day supply
	Specialty drugs	50% of Allowed Benefit	Not Covered	Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% of Allowed Benefit	Not Covered	None
	Physician/surgeon fees	20% of Allowed Benefit	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need immediate medical attention	Emergency room services	20% of Allowed Benefit	20% of Allowed Benefit	Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	20% of Allowed Benefit	20% of Allowed Benefit	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	20% of Allowed Benefit	20% of Allowed Benefit	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of Allowed Benefit	Not Covered	Requires prior authorization
	Physician/surgeon fee	20% of Allowed Benefit per date of service	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$5 co-pay per date of service	Not Covered	None
	Mental/Behavioral health inpatient services	20% of Allowed Benefit	Not Covered	Requires prior authorization
	Substance use disorder outpatient services	$5 co-pay per date of service	Not Covered	None
	Substance use disorder inpatient services	20% of Allowed Benefit	Not Covered	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	$5 co-pay per date of service	Not Covered	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	20% of Allowed Benefit	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Requires prior authorization
	Rehabilitation services	$25 co-pay per date of service	Not Covered	Limited to 30 visits/condition/ benefit period
	Habilitation services	$25 co-pay per date of service	Not Covered	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	20% of Allowed Benefit	Not Covered	Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	20% of Allowed Benefit	Not Covered	Prior authorization is required for specified services. Please see your contract.
	Hospice service	20% of Allowed Benefit	Not Covered	Requires prior authorization For Participating Providers: Outpatient Hospice Services: No Charge
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,350
- **Patient pays:** $1,190

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$1,040
Limits or exclusions	$150
Total	**$1,190**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,700
- **Patient pays:** $700

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$50
Coinsurance	$570
Limits or exclusions	$80
Total	**$700**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,250** person/ **$4,500** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	Not Covered	None
	Specialist visit	$10 co-pay per date of service	Not Covered	None
	Other practitioner office visit	$10 co-pay per date of service for Acupuncture; $10 co-pay per date of service for Chiropractic	Not Covered	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	10% of Allowed Benefit	Not Covered	None
	Imaging (CT/PET scans, MRIs)	10% of Allowed Benefit	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	No Charge	No Charge	Covers up to a 34-day supply
	Preferred brand drugs	10% of Allowed Benefit	10% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	20% of Allowed Benefit	20% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	20% of Allowed Benefit	20% of Allowed Benefit	Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% of Allowed Benefit	Not Covered	None
	Physician/surgeon fees	10% of Allowed Benefit	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need immediate medical attention	Emergency room services	10% of Allowed Benefit	10% of Allowed Benefit	Co-pay waived if admitted Limited to emergency services
	Emergency medical transportation	10% of Allowed Benefit	10% of Allowed Benefit	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	10% of Allowed Benefit	10% of Allowed Benefit	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	10% of Allowed Benefit	Not Covered	Requires prior authorization
	Physician/surgeon fee	10% of Allowed Benefit	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% of Allowed Benefit	Not Covered	None
	Mental/Behavioral health inpatient services	10% of Allowed Benefit	Not Covered	Requires prior authorization
	Substance use disorder outpatient services	10% of Allowed Benefit	Not Covered	None
	Substance use disorder inpatient services	10% of Allowed Benefit	Not Covered	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	$10 co-pay per date of service	Not Covered	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	10% of Allowed Benefit	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Requires prior authorization
	Rehabilitation services	$10 co-pay per date of service	Not Covered	Limited to 30 visits/condition/ benefit period
	Habilitation services	$10 co-pay per date of service	Not Covered	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	10% of Allowed Benefit	Not Covered	Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	10% of Allowed Benefit	Not Covered	Prior authorization is required for specified services. Please see your contract.
	Hospice service	10% of Allowed Benefit	Not Covered	Requires prior authorization For Participating Providers: For Outpatient Service: No Charge
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
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For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
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OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,870
- **Patient pays:** $670

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$520
Limits or exclusions	$150
Total	**$670**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $5,180
- **Patient pays:** $220

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$140
Limits or exclusions	$80
Total	**$220**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

CareFirst BlueChoice

BlueChoice HSA Silver Ltd CSR

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014
Coverage for: Individual | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,300** person/**$2,600** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,350** person/**$12,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at www.carefirst.com/sbcg.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then $30 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Specialist visit	Deductible, then $40 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Other practitioner office visit	Deductible, then$40 co-pay per date of service for Acupuncture; Deductible, then$40 co-pay per date of service for Chiropractic	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Imaging (CT/PET scans, MRIs)	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you need immediate medical attention	Emergency room services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to unexpected, and urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Physician/surgeon fee	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then $30 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Mental/Behavioral health inpatient services	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Substance use disorder outpatient services	Deductible, then $30 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Substance use disorder inpatient services	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then $30 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Rehabilitation services	Deductible, then $40 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 30 visits/condition/ benefit period.
	Habilitation services	Deductible, then $40 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Not Covered	Prior authorization is required for specific services. Please see your contract.
	Hospice service	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization For Participating Providers: Outpatient Hospice Services: Deductible, then No Charge

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,310
- **Patient pays:** $2,230

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,300
Copays	$0
Coinsurance	$780
Limits or exclusions	$150
Total	**$2,230**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,170
- **Patient pays:** $2,230

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,300
Copays	$150
Coinsurance	$700
Limits or exclusions	$80
Total	**$2,230**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

CareFirst BlueChoice

BlueChoice HSA Silver $1300

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014
Coverage for: Individual | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,300** person/**$2,600** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,350** person/**$12,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at www.carefirst.com/sbcg.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then $30 co-pay per date of service	Not Covered	None
	Specialist visit	Deductible, then $40 co-pay per date of service	Not Covered	None
	Other practitioner office visit	Deductible, then$40 co-pay per date of service for Acupuncture; Deductible, then$40 co-pay per date of service for Chiropractic	Not Covered	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 20% of Allowed Benefit	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Deductible, then 20% of Allowed Benefit	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Covers up to a 34-day supply

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 20% of Allowed Benefit	Not Covered	None
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Not Covered	None
If you need immediate medical attention	Emergency room services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Limited to unexpected, and urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Not Covered	Requires prior authorization
	Physician/surgeon fee	Deductible, then 20% of Allowed Benefit	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then $30 co-pay per date for service	Not Covered	None
	Mental/Behavioral health inpatient services	Deductible, then 20% of Allowed Benefit	Not Covered	Requires prior authorization
	Substance use disorder outpatient services	Deductible, then $30 co-pay per date for service	Not Covered	None
	Substance use disorder inpatient services	Deductible, then 20% of Allowed Benefit	Not Covered	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then $30 co-pay per date for service	Not Covered	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	Deductible, then 20% of Allowed Benefit	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Not Covered	Requires prior authorization
	Rehabilitation services	Deductible, then $40 co-pay per date of service	Not Covered	Limited to 30 visits/condition/ benefit period
	Habilitation services	Deductible, then $40 co-pay per date of service	Not Covered	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Not Covered	Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Not Covered	Prior authorization is required for specific services. Please see your contract.
	Hospice service	Deductible, then 20% of Allowed Benefit	Not Covered	Requires prior authorization For Participating Providers: Outpatient Hospice Services: Deductible, then No Charge
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
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For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,310
- **Patient pays:** $2,230

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,300
Copays	$0
Coinsurance	$780
Limits or exclusions	$150
Total	**$2,230**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,170
- **Patient pays:** $2,230

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,300
Copays	$150
Coinsurance	$700
Limits or exclusions	$80
Total	**$2,230**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

CareFirst BlueChoice

BlueChoice Plus Bronze $5500

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014
Coverage for: Individual | **Plan Type:** POS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Participating Providers **$5,500** person/ **$11,000** family For Non-Participating Providers $**6,350** person/ **$12,700** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental Coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,350** person/ **$12,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 co-pay per date of service	Deductible, then 40% of Allowed Benefit	None
	Specialist visit	Deductible, then $45 co-pay per date of service	Deductible, then 40% of Allowed Benefit	None
	Other practitioner office visit	Deductible, then $45 co-pay per date of service for Acupuncture; Deductible, then $45 co-pay per date of service Chiropractic	Deductible, then 40% of Allowed Benefit for Acupuncture; Deductible, then 40% of Allowed benefit for Chiropractic	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Deductible, then No Charge	None
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 20% of Allowed Benefit	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
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Preferred Generic: $10 co-pay Non-Preferred Generic: Deductible, then 20% of Allowed Benefit	Preferred Generic: $10 co-pay Non-Preferred Generic: Deductible, then 20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Covers up to a 34-day supply

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Specialty drugs	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Covers up to a 34-day supply
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	Emergency room services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for air ambulance services, except for Medically Necessary air ambulance services in an emergency
	Urgent care	$45 co-pay per date of service	$45 co-pay per date of service	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization
	Physician/surgeon fee	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 co-pay per date of service	Deductible, then 40% of Allowed Benefit	None
	Mental/Behavioral health inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization
	Substance use disorder outpatient services	$35 co-pay per date of service	Deductible, then 40% of Allowed Benefit	None
	Substance use disorder inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then $35 co-pay per date of service	Deductible, then 40% of Allowed Benefit	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Delivery and all inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Deductible, then 40% of Allowed Benefit	Requires prior authorization
	Rehabilitation services	Deductible, then $45 co-pay per date of service	Deductible, then 40% of Allowed Benefit	Limited to 30 visits/condition/ benefit period
	Habilitation services	Deductible, then $45 co-pay per date of service	Deductible, then 40% of Allowed Benefit	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for specified services. Please see your contract
	Hospice service	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization Outpatient Hospice Services: For Participating Providers Deductible, then No Charge
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

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- You commit fraud
- The insurer stops offering services in the State
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OR

**** Group health coverage–**

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Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

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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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $2,190
- **Patient pays:** $5,350

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$5,200
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$5,350**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $50
- **Patient pays:** $5,350

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$5,270
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$5,350**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Participating Providers **$5,500** person/ **$11,000** family For Non-Participating Providers $**6,350** person/ **$12,700** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental Coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,350** person/ **$12,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 co-pay per date of service	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Specialist visit	Deductible, then $45 co-pay per date of service	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Other practitioner office visit	Deductible, then $45 co-pay per date of service for Acupuncture; Deductible, then $45 co-pay per date of service Chiropractic	Deductible, then 40% of Allowed Benefit for Acupuncture; Deductible, then 40% of Allowed benefit for Chiropractic	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Deductible, then No Charge	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Imaging (CT/PET scans, MRIs)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Preferred Generic: $10 co-pay Non-Preferred Generic: Deductible, then 20% of Allowed Benefit	Preferred Generic: $10 co-pay Non-Preferred Generic: Deductible, then 20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you need immediate medical attention	Emergency room services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for air ambulance services, except for Medically Necessary air ambulance services in an emergency
	Urgent care	$45 co-pay per date of service	$45 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to unexpected, urgently required services

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Physician/surgeon fee	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then $35 co-pay per date of service	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Mental/Behavioral health inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Substance use disorder outpatient services	Deductible, then $35 co-pay per date of service	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Substance use disorder inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
If you are pregnant	Prenatal and postnatal care	$35 co-pay per date of service	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Rehabilitation services	Deductible, then $45 co-pay per date of service	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 30 visits/condition/ benefit period.
	Habilitation services	Deductible, then $45 co-pay per date of service	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 100 days/benefit period.
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for specific services. Please see your contract.
	Hospice service	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Outpatient Hospice Services: For Participating Providers: Deductible, then No Charge

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $2,190
- **Patient pays:** $5,350

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$5,200
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$5,350**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $50
- **Patient pays:** $5,350

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$5,270
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$5,350**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$0**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	Not Covered	None
	Specialist visit	No Charge	Not Covered	None
	Other practitioner office visit	No Charge for Acupuncture, No Charge for Chiropractic	Not Covered	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	No Charge	No Charge	Covers up to 34-day supply
	Preferred brand drugs	No Charge	No Charge	Covers up to 34-day supply
	Non-preferred brand drugs	No Charge	No Charge	Covers up to 34-day supply
	Specialty drugs	No Charge	No Charge	Covers up to 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room services	No Charge	No Charge	Limited to emergency services

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
	Emergency medical transportation	No Charge	No Charge	Prior authorization is required for air ambulance services, except for Medically Necessary air ambulance services in an emergency
	Urgent care	No Charge	No Charge	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Requires prior authorization
	Physician/surgeon fee	No Charge	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	Not Covered	None
	Mental/Behavioral health inpatient services	No Charge	Not Covered	Requires prior authorization
	Substance use disorder outpatient services	No Charge	Not Covered	None
	Substance use disorder inpatient services	No Charge	Not Covered	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	For Participating providers: Preventive Prenatal Care is provided at No Charge, and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	No Charge	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Requires prior authorization
	Rehabilitation services	No Charge	Not Covered	Limited to 30 visits/ condition/benefit period
	Habilitation services	No Charge	Not Covered	Requires prior authorization
	Skilled nursing care	No Charge	Not Covered	Requires prior authorization Limited to 100 days/benefit period
	Durable medical equipment	No Charge	Not Covered	Prior authorization is required for specified services. Please see your contract.
	Hospice service	No Charge	Not Covered	Requires prior authorization
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to 1 visit/benefit period
	Glasses	No Charge for frames/lenses	Not Covered	None
	Dental check-up	No Charge	Not Covered	Limited to members up to age of 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

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**** Group health coverage–**

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For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,540
- **Patient pays:** $0

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$0**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $5,400
- **Patient pays:** $0

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$0**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$6,350** person/ **$12,700** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,350** person/ **$12,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then No Charge	Not Covered	None
	Specialist visit	Deductible, then No Charge	Not Covered	None
	Other practitioner office visit	Deductible, then No Charge for Acupuncture; Deductible, then No Charge for Chiropractic	Not Covered	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Deductible, then No Charge	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Deductible, then No Charge	Deductible, then No Charge	Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then No Charge	Deductible, then No Charge	Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then No Charge	Deductible, then No Charge	Covers up to a 34-day supply
	Specialty drugs	Deductible, then No Charge	Deductible, then No Charge	Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then No Charge	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Physician/surgeon fees	Deductible, then No Charge	Not Covered	None
If you need immediate medical attention	Emergency room services	Deductible, then No Charge	Deductible, then No Charge	Co-pay waived if admitted Limited to emergency services
	Emergency medical transportation	Deductible, then No Charge	Deductible, then No Charge	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	Deductible, then No Charge	Deductible, then No Charge	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then No Charge	Not Covered	Requires prior authorization
	Physician/surgeon fee	Deductible, then No Charge	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then No Charge	Not Covered	Requires prior authorization
	Mental/Behavioral health inpatient services	Deductible, then No Charge	Not Covered	Requires prior authorization
	Substance use disorder outpatient services	Deductible, then No Charge	Not Covered	Requires prior authorization
	Substance use disorder inpatient services	Deductible, then No Charge	Not Covered	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then No Charge	Not Covered	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	Deductible, then No Charge	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Not Covered	Requires prior authorization
	Rehabilitation services	Deductible, then No Charge	Not Covered	Limited to 30 visits/condition/ benefit period
	Habilitation services	Deductible, then No Charge	Not Covered	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then No Charge	Not Covered	Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	Deductible, then No Charge	Not Covered	Prior authorization is required for specific services. Please see your contract
	Hospice service	Deductible, then No Charge	Not Covered	Requires prior authorization
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $2,190
- **Patient pays:** $5,350

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$5,200
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$5,350**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $50
- **Patient pays:** $5,350

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$4,260
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$4,340**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Participating Providers **$3,500** person/ **$7,000** family For Non-Participating Providers **$7,000** person/ **$14,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For Participating Providers **$6,350** person/ **$12,700** family For Non-Participating Providers **$12,700** person/ **$25,400** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then $30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	None
	Specialist visit	Deductible, then $40 co-pay per date of service	Deductible, then 20% of Allowed Benefit	None
	Other practitioner office visit	Deductible, then $40 co-pay per date of service for Acupuncture; Deductible, then $40 co-pay per date of service for Chiropractic	Deductible, then 20% of Allowed Benefit for Acupuncture; Deductible, then 20% of Allowed Benefit for Chiropractic	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Deductible, then No Charge	None
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 20% of Allowed Benefit	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
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Covers up to a 34-day supply

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
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	Emergency room services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization
	Physician/surgeon fee	Deductible, then 20% of Allowed Benefit per date of service	Deductible, then 40% of Allowed Benefit per date of service	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then $30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	None
	Mental/Behavioral health inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization
	Substance use disorder outpatient services	Deductible, then $30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	None
	Substance use disorder inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then $30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Deductible, then 20% of Allowed Benefit	Requires prior authorization
	Rehabilitation services	Deductible, then $40 co-pay per visit	Deductible, then 20% of Allowed Benefit	Limited to 30 visits/condition/ benefit period
	Habilitation services	Deductible, then $40 co-pay per visit	Deductible, then 20% of Allowed Benefit	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for specific services. Please see your contract.
	Hospice service	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization For Outpatient Hospice Services: For Participating Providers: Deductible, then No Charge For Non-Participating Providers: Deductible, then 20% of Allowed Benefit
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $3,550
- **Patient pays:** $3,990

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,500
Copays	$0
Coinsurance	$340
Limits or exclusions	$150
Total	**$3,990**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $1,460
- **Patient pays:** $3,940

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$3,500
Copays	$30
Coinsurance	$330
Limits or exclusions	$80
Total	**$3,940**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Participating Providers **$3,500** person/ **$7,000** family For Non-Participating Providers **$7,000** person/ **$14,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For Participating Providers **$6,350** person/ **$12,700** family For Non-Participating Providers **$12,700** person/ **$25,400** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then $30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	None
	Specialist visit	Deductible, then $40 co-pay per date of service	Deductible, then 20% of Allowed Benefit	None
	Other practitioner office visit	Deductible, then $40 co-pay per date of service for Acupuncture; Deductible, then $40 co-pay per date of service for Chiropractic	Deductible, then 20% of Allowed Benefit for Acupuncture; Deductible, then 20% of Allowed Benefit for Chiropractic	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Deductible, then No Charge	None
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 20% of Allowed Benefit	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
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Covers up to a 34-day supply

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
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	Emergency room services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization
	Physician/surgeon fee	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then $30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	None
	Mental/Behavioral health inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization
	Substance use disorder outpatient services	Deductible, then $30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	None
	Substance use disorder inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then $30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Deductible, then 20% of Allowed Benefit	Requires prior authorization
	Rehabilitation services	Deductible, then $40 co-pay per visit	Deductible, then 20% of Allowed Benefit	Limited to 30 visits/condition/ benefit period.
	Habilitation services	Deductible, then $40 co-pay per visit	Deductible, then 20% of Allowed Benefit	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for specific services. Please see your contract.
	Hospice service	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization Outpatient Hospice Services: For Participating Providers: Deductible, then No Charge For Non-Participating Providers: Deductible, then 20% of Allowed Benefit
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

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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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $3,550
- **Patient pays:** $3,990

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,500
Copays	$0
Coinsurance	$340
Limits or exclusions	$150
Total	**$3,990**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $1,460
- **Patient pays:** $3,940

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$3,500
Copays	$30
Coinsurance	$330
Limits or exclusions	$80
Total	**$3,940**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Participating Providers **$3,500** person/ **$7,000** family For Non-Participating Providers **$7,000** person/ **$14,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For Participating Providers **$6,350** person/ **$12,700** family For Non-Participating Providers **$12,700** person/ **$25,400** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.
CareFirst SBC ID: SBC20130917MANBPHMMN5CRXCMMN50N012014

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then $30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Specialist visit	Deductible, then $40 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Other practitioner office visit	Deductible, then $40 co-pay per date of service for Acupuncture; Deductible, then $40 co-pay per date of service for Chiropractic	Deductible, then 20% of Allowed Benefit for Acupuncture; Deductible, then 20% of Allowed Benefit for Chiropractic	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Deductible, then No Charge	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Imaging (CT/PET scans, MRIs)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you need immediate medical attention	Emergency room services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to Emergency Services
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Physician/surgeon fee	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then $30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Mental/Behavioral health inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Substance use disorder outpatient services	Deductible, then $30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Substance use disorder inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then $30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Rehabilitation services	Deductible, then $40 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 30 visits/condition/ benefit period.
	Habilitation services	Deductible, then $40 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for specific services. Please see your contract.
	Hospice service	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization For Outpatient Hospice Services: For Participating Providers: Deductible, then No Charge For Non-Participating Providers: Deductible, then 20% of Allowed Benefit

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If your child needs dental or eye care	Eye exam	No Charge	Plan pays $40 reimbursement	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 1 visit/benefit period
	Glasses	No Charge for frames/lenses	Allowances available for eyeglasses/lenses	Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $3,550
- **Patient pays:** $3,990

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,500
Copays	$0
Coinsurance	$340
Limits or exclusions	$150
Total	**$3,990**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $1,460
- **Patient pays:** $3,940

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$3,500
Copays	$30
Coinsurance	$330
Limits or exclusions	$80
Total	**$3,940**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Participating Providers **$3,500** person/ **$7,000** family For Non-Participating Providers **$7,000** person/ **$14,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For Participating Providers **$6,350** person/ **$12,700** family For Non-Participating Providers **$12,700** person/ **$25,400** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.
CareFirst SBC ID: SBC20130917MANBPHMMN5CRXCMMN50N012014

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then $30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Specialist visit	Deductible, then $40 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Other practitioner office visit	Deductible, then $40 co-pay per date of service for Acupuncture; Deductible, then $40 co-pay per date of service for Chiropractic	Deductible, then 20% of Allowed Benefit for Acupuncture; Deductible, then 20% of Allowed Benefit for Chiropractic	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Deductible, then No Charge	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Imaging (CT/PET scans, MRIs)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you need immediate medical attention	Emergency room services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to Emergency Services
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Physician/surgeon fee	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then $30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Mental/Behavioral health inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Substance use disorder outpatient services	Deductible, then $30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Substance use disorder inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then $30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Rehabilitation services	Deductible, then $40 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 30 visits/condition/ benefit period.
	Habilitation services	Deductible, then $40 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for specific services. Please see your contract.
	Hospice service	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization For Outpatient Hospice Services: For Participating Providers: Deductible, then No Charge For Non-Participating Providers: Deductible, then 20% of Allowed Benefit

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If your child needs dental or eye care	Eye exam	No Charge	Plan pays $40 reimbursement	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 1 visit/benefit period
	Glasses	No Charge for frames/lenses	Allowances available for eyeglasses/lenses	Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
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- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

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**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

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OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $3,550
- **Patient pays:** $3,990

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,500
Copays	$0
Coinsurance	$340
Limits or exclusions	$150
Total	**$3,990**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $1,460
- **Patient pays:** $3,940

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$3,500
Copays	$30
Coinsurance	$330
Limits or exclusions	$80
Total	**$3,940**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$0**	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	No Charge	None
	Specialist visit	No Charge	No Charge	None
	Other practitioner office visit	No Charge for Acupuncture and Chiropractic	No Charge	Limited to 20 visits/condition/ benefit period for Chiropractic.
	Preventive care/screening/immunization	No Charge	No Charge	None
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	No Charge	None
	Imaging (CT/PET scans, MRIs)	No Charge	No Charge	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	No Charge	No Charge	Covers up to 34-day supply
	Preferred brand drugs	No Charge	No Charge	Covers up to 34-day supply
	Non-preferred brand drugs	No Charge	No Charge	Covers up to 34-day supply
	Specialty drugs	No Charge	No Charge	Covers up to 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	No Charge	None
	Physician/surgeon fees	No Charge	No Charge	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need immediate medical attention	Emergency room services	No Charge	No Charge	Co-pay waived if admitted Limited to emergency services
	Emergency medical transportation	No Charge	No Charge	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	No Charge	No Charge	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	No Charge	Requires prior authorization
	Physician/surgeon fee	No Charge	No Charge	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	No Charge	None
	Mental/Behavioral health inpatient services	No Charge	No Charge	Requires prior authorization
	Substance use disorder outpatient services	No Charge	No Charge	None
	Substance use disorder inpatient services	No Charge	No Charge	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	No Charge	No Charge	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	No Charge	No Charge	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Requires prior authorization
	Rehabilitation services	No Charge	No Charge	Limited to 30 visits/ condition/benefit period
	Habilitation services	No Charge	No Charge	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	No Charge	No Charge	Limited to 100 days/benefit period
	Durable medical equipment	No Charge	No Charge	Prior authorization is required for specific services. Please see your contract.
	Hospice service	No Charge	No Charge	None
If your child needs dental or eye care	Eye exam	No Charge	No Charge	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	No Charge for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	No Charge	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

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- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

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Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,540
- **Patient pays:** $0

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$0**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $5,400
- **Patient pays:** $0

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$0**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$0**	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	No Charge	None
	Specialist visit	No Charge	No Charge	None
	Other practitioner office visit	No Charge for Acupuncture and Chiropractic	No Charge	Limited to 20 visits/condition/ benefit period for Chiropractic.
	Preventive care/screening/immunization	No Charge	No Charge	None
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	No Charge	None
	Imaging (CT/PET scans, MRIs)	No Charge	No Charge	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	No Charge	No Charge	Covers up to 34-day supply
	Preferred brand drugs	No Charge	No Charge	Covers up to 34-day supply
	Non-preferred brand drugs	No Charge	No Charge	Covers up to 34-day supply
	Specialty drugs	No Charge	No Charge	Covers up to 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	No Charge	None
	Physician/surgeon fees	No Charge	No Charge	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need immediate medical attention	Emergency room services	No Charge	No Charge	Co-pay waived if admitted Limited to emergency services
	Emergency medical transportation	No Charge	No Charge	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	No Charge	No Charge	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	No Charge	Requires prior authorization
	Physician/surgeon fee	No Charge	No Charge	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	No Charge	None
	Mental/Behavioral health inpatient services	No Charge	No Charge	Requires prior authorization
	Substance use disorder outpatient services	No Charge	No Charge	None
	Substance use disorder inpatient services	No Charge	No Charge	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	No Charge	No Charge	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	No Charge	No Charge	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Requires prior authorization
	Rehabilitation services	No Charge	No Charge	Limited to 30 visits/ condition/benefit period
	Habilitation services	No Charge	No Charge	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	No Charge	No Charge	Limited to 100 days/benefit period
	Durable medical equipment	No Charge	No Charge	Prior authorization is required for specific services. Please see your contract.
	Hospice service	No Charge	No Charge	None
If your child needs dental or eye care	Eye exam	No Charge	No Charge	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	No Charge for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	No Charge	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

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- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,540
- **Patient pays:** $0

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$0**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $5,400
- **Patient pays:** $0

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$0**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Participating Providers **$0** For Non-Participating Providers **$1,000** person/ **$2,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For Participating Providers **$1,800** person/ **$3,600** family For Non-Participating Providers **$3,600** person/ **$7,200** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay per date of service	Deductible, then 20% of Allowed Benefit	None
	Specialist visit	$30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	None
	Other practitioner office visit	$30 co-pay per date of service for Acupuncture; $30 co-pay per date of service for Chiropractic	Deductible, then 20% of Allowed Benefit for Acupuncture; Deductible, then 20% of Allowed Benefit for Chiropractic	Limited to 20 visits/condition/ benefit period for Chiropractic.
	Preventive care/screening/immunization	No Charge	Deductible, then No Charge	None
If you have a test	Diagnostic test (x-ray, blood work)	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Imaging (CT/PET scans, MRIs)	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	20% of Allowed Benefit	20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	30% of Allowed Benefit	30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	50% of Allowed Benefit	50% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	50% of Allowed Benefit	50% of Allowed Benefit	Covers up to a 34-day supply

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Physician/surgeon fees	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
If you need immediate medical attention	Emergency room services	10% of Allowed Benefit	10% of Allowed Benefit	Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	10% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Requires prior authorization
	Physician/surgeon fee	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay per date of service	Deductible, then 20% of Allowed Benefit	None
	Mental/Behavioral health inpatient services	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Requires prior authorization
	Substance use disorder outpatient services	$20 co-pay per date of service	Deductible, then 20% of Allowed Benefit	None
	Substance use disorder inpatient services	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	$20 co-pay per date of service	Deductible, then 20% of Allowed Benefit	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	No Charge	Deductible, then 20% of Allowed Benefit	Requires prior authorization
	Rehabilitation services	$30 co-pay per visit	Deductible, then 20% of Allowed Benefit	Limited to 30 visits/condition/ benefit period
	Habilitation services	$30 co-pay per visit	Deductible, then 20% of Allowed Benefit	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required for specific services. Please see your contract.
	Hospice service	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Requires prior authorization Outpatient Hospice Services: For Participating Providers: No Charge For Non-Participating Providers: Deductible, then 20% of Allowed Benefit
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
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OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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

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See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,870
- **Patient pays:** $670

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$520
Limits or exclusions	$150
Total	**$670**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,410
- **Patient pays:** $990

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$200
Coinsurance	$710
Limits or exclusions	$80
Total	**$990**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Participating Providers **$0** For Non-Participating Providers **$1,000** person/ **$2,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For Participating Providers **$1,800** person/ **$3,600** family For Non-Participating Providers **$3,600** person/ **$7,200** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay per date of service	Deductible, then 20% of Allowed Benefit	None
	Specialist visit	$30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	None
	Other practitioner office visit	$30 co-pay per date of service for Acupuncture; $30 co-pay per date of service for Chiropractic	Deductible, then 20% of Allowed Benefit for Acupuncture; Deductible, then 20% of Allowed Benefit for Chiropractic	Limited to 20 visits/condition/ benefit period for Chiropractic.
	Preventive care/screening/immunization	No Charge	Deductible, then No Charge	None
If you have a test	Diagnostic test (x-ray, blood work)	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Imaging (CT/PET scans, MRIs)	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	20% of Allowed Benefit	20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	30% of Allowed Benefit	30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	50% of Allowed Benefit	50% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	50% of Allowed Benefit	50% of Allowed Benefit	Covers up to a 34-day supply

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Physician/surgeon fees	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
If you need immediate medical attention	Emergency room services	10% of Allowed Benefit	10% of Allowed Benefit	Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	10% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Requires prior authorization
	Physician/surgeon fee	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay per date of service	Deductible, then 20% of Allowed Benefit	None
	Mental/Behavioral health inpatient services	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Requires prior authorization
	Substance use disorder outpatient services	$20 co-pay per date of service	Deductible, then 20% of Allowed Benefit	None
	Substance use disorder inpatient services	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	$20 co-pay per date of service	Deductible, then 20% of Allowed Benefit	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	No Charge	Deductible, then 20% of Allowed Benefit	Requires prior authorization
	Rehabilitation services	$30 co-pay per visit	Deductible, then 20% of Allowed Benefit	Limited to 30 visits/condition/ benefit period
	Habilitation services	$30 co-pay per visit	Deductible, then 20% of Allowed Benefit	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required for specific services. Please see your contract.
	Hospice service	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Requires prior authorization Outpatient Hospice Services: For Participating Providers: No Charge For Non-Participating Providers: Deductible, then 20% of Allowed Benefit
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,870
- **Patient pays:** $670

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$520
Limits or exclusions	$150
Total	**$670**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,410
- **Patient pays:** $990

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$200
Coinsurance	$710
Limits or exclusions	$80
Total	**$990**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Participating Providers **$0** For Non-Participating Providers **$1,000** person/ **$2,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For Participating Providers **$1,800** person/ **$3,600** family For Non-Participating Providers **$3,600** person/ **$7,200** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Specialist visit	$30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Other practitioner office visit	$30 co-pay per date of service for Acupuncture; $30 co-pay per date of service for Chiropractic	Deductible, then 20% of Allowed Benefit for Acupuncture; Deductible, then 20% of Allowed Benefit for Chiropractic	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Deductible, then No Charge	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have a test	Diagnostic test (x-ray, blood work)	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Imaging (CT/PET scans, MRIs)	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	20% of Allowed Benefit	20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	30% of Allowed Benefit	30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	50% of Allowed Benefit	50% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	50% of Allowed Benefit	50% of Allowed Benefit	Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Physician/surgeon fees	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you need immediate medical attention	Emergency room services	10% of Allowed Benefit	10% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Co-pay waived if admitted Limited to emergency services
	Emergency medical transportation	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
	Physician/surgeon fee	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Mental/Behavioral health inpatient services	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Substance use disorder outpatient services	$20 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Substance use disorder inpatient services	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
If you are pregnant	Prenatal and postnatal care	$20 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	No Charge	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Rehabilitation services	$30 co-pay per visit	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 30 visits/condition/ benefit period
	Habilitation services	$30 co-pay per visit	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Prior authorization is required for some services. Please see your contract.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Hospice service	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Outpatient Hospice Services: For Participating Providers: No Charge For Non-Participating Providers: Deductible, then 20% of Allowed Benefit
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Most coverage provided outside the United States
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
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For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

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OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

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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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,870
- **Patient pays:** $670

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$520
Limits or exclusions	$150
Total	**$670**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,410
- **Patient pays:** $990

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$200
Coinsurance	$710
Limits or exclusions	$80
Total	**$990**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Participating Providers **$0** For Non-Participating Providers **$1,000** person/ **$2,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For Participating Providers **$1,800** person/ **$3,600** family For Non-Participating Providers **$3,600** person/ **$7,200** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Specialist visit	$30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Other practitioner office visit	$30 co-pay per date of service for Acupuncture; $30 co-pay per date of service for Chiropractic	Deductible, then 20% of Allowed Benefit for Acupuncture; Deductible, then 20% of Allowed Benefit for Chiropractic	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 20 visits/condition/ benefit period for Chiropractic.
	Preventive care/screening/immunization	No Charge	Deductible, then No Charge	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have a test	Diagnostic test (x-ray, blood work)	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Imaging (CT/PET scans, MRIs)	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	20% of Allowed Benefit	20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	30% of Allowed Benefit	30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	50% of Allowed Benefit	50% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	50% of Allowed Benefit	50% of Allowed Benefit	Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Physician/surgeon fees	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you need immediate medical attention	Emergency room services	10% of Allowed Benefit	10% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Physician/surgeon fee	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Mental/Behavioral health inpatient services	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Substance use disorder outpatient services	$20 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Substance use disorder inpatient services	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
If you are pregnant	Prenatal and postnatal care	$20 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Rehabilitation services	$30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 30 visits/condition/ benefit period
	Habilitation services	$30 co-pay per date of service	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required for specific services. Please see your contract.
	Hospice service	10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Outpatient Hospice Services: For Participating Providers: No Charge For Non-Participating Providers: Deductible, then 20% of Allowed Benefit

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,870
- **Patient pays:** $670

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$520
Limits or exclusions	$150
Total	**$670**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,410
- **Patient pays:** $990

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$200
Coinsurance	$710
Limits or exclusions	$80
Total	**$990**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

CareFirst BlueChoice **HealthyBlue Gold $1500**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Individual | **Plan Type:** POS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Participating Providers **$1,500** person/ **$3,000** family For Non-Participating Providers **$2,500** person/ **$5,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. **$400** person for Prescription Drug. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For Participating Providers **$3,250** person/ **$6,500** family For Non-Participating Providers **$3,250** person/ **$6,500** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	Deductible, then $40 co-pay per date of service	None
	Specialist visit	$40 co-pay per visit	Deductible, then $40 co-pay per date of service	None
	Other practitioner office visit	$40 co-pay per date of service for Acupuncture; $40 co-pay per date of service for Chiropractic	Deductible, then $40 co-pay per date of service for Acupuncture; Deductible, then $40 co-pay per date of service for Chiropractic	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Deductible, then No Charge	None
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Deductible, then No Charge	None
	Imaging (CT/PET scans, MRIs)	No Charge	Deductible, then No Charge	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Deductible, then No Charge	Deductible, then No Charge	Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then $45 co-pay	Deductible, then $45 co-pay	Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then $200 co-pay	Deductible, then $200 co-pay	Covers up to a 34-day supply
	Specialty drugs	Deductible, then $200 co-pay	Deductible, then $200 co-pay	Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then $40 co-pay per visit	Deductible, then $125 co-pay per visit	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
	Physician/surgeon fees	Deductible, then $40 co-pay per date of service	Deductible, then $125 co-pay per date of service	None
If you need immediate medical attention	Emergency room services	$200 co-pay per visit	$200 co-pay per visit	Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	$50 co-pay per date of service	$50 co-pay per date of service	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	$50 co-pay per date of service	$50 co-pay per date of service	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then $450 co-pay per day	Deductible, then $700 co-pay per day	Requires prior authorization
	Physician/surgeon fee	Deductible, then $40 co-pay per date of service	Deductible, then $125 co-pay per date of service	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then No Charge	Deductible, then $40 co-pay per date of service	None
	Mental/Behavioral health inpatient services	Deductible, then $450 co-pay per day	Deductible, then $700 co-pay per day	Requires prior authorization
	Substance use disorder outpatient services	Deductible, then No Charge	Deductible, then $40 co-pay per date of service	None
	Substance use disorder inpatient services	Deductible, then $450 co-pay per day	Deductible, then $700 co-pay per day	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then No Charge	Deductible, then $40 co-pay per date of service	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	Deductible, then $450 co-pay per day	Deductible, then $700 co-pay per day	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Deductible, then $125 co-pay per visit	Requires prior authorization
	Rehabilitation services	$40 co-pay per date of service	Deductible, then $40 co-pay per date of service	Limited to 30 visits/condition/ benefit period.
	Habilitation services	$40 co-pay per date of service	Deductible, then $40 co-pay per date of service	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period.
	Skilled nursing care	Deductible, then $40 co-pay	Deductible, then $125 co-pay	Limited to 100 days/benefit period.
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for specific services. Please see your contract.
	Hospice service	Deductible, then $40 co-pay	Deductible, then $125 co-pay	Requires prior authorization Outpatient Hospice Services: For Participating Providers: Deductible, then No Charge
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
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For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,440
- **Patient pays:** $2,100

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$450
Coinsurance	$0
Limits or exclusions	$150
Total	$2,100

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,050
- **Patient pays:** $1,350

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,270
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,350**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

CareFirst BlueChoice

HealthyBlue Gold $1500 Ltd CSR

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014
Coverage for: Individual | **Plan Type:** POS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Participating Providers **$1,500** person/ **$3,000** family For Non-Participating Providers **$2,500** person/ **$5,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. **$400** person for Prescription Drug. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$3,250** person/ **$6,500** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	Deductible, then $40 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Specialist visit	$40 co-pay per visit	Deductible, then $40 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Other practitioner office visit	$40 co-pay per date of service for Acupuncture; $40 co-pay per date of service for Chiropractic	Deductible, then $40 co-pay per date of service for Acupuncture; Deductible, then $40 co-pay per date of service for Chiropractic	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 20 visits/condition/ benefit period for Chiropractic.
	Preventive care/screening/immunization	No Charge	Deductible, then No Charge	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Deductible, then No Charge	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Imaging (CT/PET scans, MRIs)	No Charge	Deductible, then No Charge	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Deductible, then No Charge	Deductible, then No Charge	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34-day supply.
	Preferred brand drugs	Deductible, then $45 co-pay	Deductible, then $45 co-pay	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34-day supply.
	Non-preferred brand drugs	Deductible, then $200 co-pay	Deductible, then $200 co-pay	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34-day supply.
	Specialty drugs	Deductible, then $200 co-pay	Deductible, then $200 co-pay	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then $40 co-pay per visit	Deductible, then $125 co-pay per visit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Physician/surgeon fees	Deductible, then $40 co-pay per date of service	Deductible, then $125 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you need immediate medical attention	Emergency room services	$200 co-pay per visit	$200 co-pay per visit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	$50 co-pay per date of service	$50 co-pay per date of service	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	$50 co-pay per date of service	$50 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to unexpected, urgently required services

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then $450 co-pay per day	Deductible, then $700 co-pay per day	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Physician/surgeon fee	Deductible, then $40 co-pay per date of service	Deductible, then $125 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	Deductible, then $40 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Mental/Behavioral health inpatient services	Deductible, then $450 co-pay per day	Deductible, then $700 co-pay per day	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Substance use disorder outpatient services	No Charge	Deductible, then $40 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Substance use disorder inpatient services	Deductible, then $450 co-pay per day	Deductible, then $700 co-pay per day	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then No Charge	Deductible, then $40 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider. For Participating Providers: Preventive Prenatal Care is provided at No Charge, and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	Deductible, then $450 co-pay per day	Deductible, then $700 co-pay per day	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Deductible, then $125 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Rehabilitation services	$40 co-pay per date of service	Deductible, then $40 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 30 visits/condition/ benefit period.
	Habilitation services	$40 co-pay per date of service	Deductible, then $40 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period.
	Skilled nursing care	Deductible, then $40 co-pay per admission	Deductible, then $125 co-pay per admission	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 100 days/benefit period.
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for specific services. Please see your contract.
	Hospice service	Deductible, then $40 co-pay per admission	Deductible, then $125 co-pay per admission	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Outpatient Hospice Services: For Participating Providers: Deductible, then No Charge

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
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For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

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OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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- DC – 1-877-685-6391 or www.disb.dc.gov
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For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

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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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,440
- **Patient pays:** $2,100

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$450
Coinsurance	$0
Limits or exclusions	$150
Total	$2,100

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,620
- **Patient pays:** $1,780

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Copays	$0
Coinsurance	$200
Limits or exclusions	$80
Total	**$1,780**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Participating Providers **$0** For Non-Participating Providers **$1,000** person/ **$2,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For Participating Providers **$2,000** person/ **$4,000** family For Non-Participating Providers **$4,000** person/ **$8,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	Deductible, then $30 co-pay per date of service	None
	Specialist visit	$30 co-pay per date of service	Deductible, then $30 co-pay per date of service	None
	Other practitioner office visit	$30 co-pay per date of service for Acupuncture; $30 co-pay per date of service for Chiropractic	Deductible, then $30 co-pay per date of service for Acupuncture; Deductible, then $30 co-pay per date of service for Chiropractic	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Deductible, then No Charge	None
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Deductible, then No Charge	None
	Imaging (CT/PET scans, MRIs)	No Charge	Deductible, then No Charge	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	No Charge	No Charge	Covers up to a 34-day supply
	Preferred brand drugs	$45 co-pay	$45 co-pay	Covers up to a 34-day supply
	Non-preferred brand drugs	$100 co-pay	$100 co-pay	Covers up to a 34-day supply
	Specialty drugs	$200 co-pay	$200 co-pay	Covers up to a 34-day supply

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$30 co-pay per visit	Deductible, then $100 co-pay per visit	None
	Physician/surgeon fees	$30 co-pay per date of service	Deductible, then $100 co-pay per date of service	None
If you need immediate medical attention	Emergency room services	$200 co-pay per date of service	$200 co-pay per date of service	Co-pay waived if admitted Limited to emergency services
	Emergency medical transportation	$50 co-pay per service	$50 co-pay per service	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	$50 co-pay per date of service	$50 co-pay per date of service	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 co-pay per day	Deductible, then $400 co-pay per day	Requires prior authorization
	Physician/surgeon fee	$30 co-pay per date of service	Deductible, then $100 co-pay per date of service	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then No Charge	Deductible, then $30 co-pay per date of service	None
	Mental/Behavioral health inpatient services	$150 co-pay per day	Deductible, then $400 co-pay per day	Requires prior authorization
	Substance use disorder outpatient services	Deductible, then No Charge	Deductible, then $30 co-pay per date of service	None
	Substance use disorder inpatient services	$150 co-pay per day	Deductible, then $400 co-pay per day	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	$30 co-pay per date of service	Deductible, then $30 co-pay per date of service	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	$150 co-pay per day	Deductible, then $400 co-pay per day	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Deductible, then $100 co-pay per visit	Requires prior authorization
	Rehabilitation services	$30 co-pay per date of service	Deductible, then $30 co-pay per date of service	Limited to 30 visits/condition/ benefit period
	Habilitation services	$30 co-pay per date of service	Deductible, then $30 co-pay per date of service	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	$30 co-pay per admission	Deductible, then $100 co-pay per admission	Requires prior authorization Limited to 100 days/benefit period
	Durable medical equipment	20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for specific services. Please see your contract.
	Hospice service	$30 co-pay per admission	Deductible, then $100 co-pay per admission	Requires prior authorization Outpatient Hospice Services: For Participating Providers: No Charge For Non-Participating Providers: Deductible, then $100/visit
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,240
- **Patient pays:** $300

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$150
Coinsurance	$0
Limits or exclusions	$150
Total	**$300**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $5,070
- **Patient pays:** $330

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$250
Limits or exclusions	$80
Total	**$330**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Participating Providers **$0** For Non-Participating Providers **$1,000** person/ **$2,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For Participating Providers **$2,000** person/ **$4,000** family For Non-Participating Providers **$4,000** person/ **$8,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	Deductible, then $30 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider
	Specialist visit	$30 co-pay per date of service	Deductible, then $30 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider
	Other practitioner office visit	$30 co-pay per date of service for Acupuncture; $30 co-pay per date of service for Chiropractic	Deductible, then $30 co-pay per visit for Acupuncture; Deductible, then $30 co-pay per date of service for Chiropractic	No member cost-sharing when services are rendered by an Indian Health Services Provider Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Deductible, then No Charge	No member cost-sharing when services are rendered by an Indian Health Services Provider
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Deductible, then No Charge	No member cost-sharing when services are rendered by an Indian Health Services Provider
	Imaging (CT/PET scans, MRIs)	No Charge	Deductible, then No Charge	No member cost-sharing when services are rendered by an Indian Health Services Provider

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	No Charge	No Charge	No member cost-sharing when services are rendered by an Indian Health Services Provider Covers up to a 34-day supply
	Preferred brand drugs	$45 co-pay	$45 co-pay	No member cost-sharing when services are rendered by an Indian Health Services Provider Covers up to a 34-day supply
	Non-preferred brand drugs	$100 co-pay	$100 co-pay	No member cost-sharing when services are rendered by an Indian Health Services Provider Covers up to a 34-day supply
	Specialty drugs	$200 co-pay	$200 co-pay	No member cost-sharing when services are rendered by an Indian Health Services Provider Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$30 co-pay per visit	Deductible, then $100 co-pay per visit	No member cost-sharing when services are rendered by an Indian Health Services Provider
	Physician/surgeon fees	$30 co-pay per date of service	Deductible, then $100 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider
If you need immediate medical attention	Emergency room services	$200 co-pay per visit	$200 co-pay per visit	No member cost-sharing when services are rendered by an Indian Health Services Provider Co-pay waived if admitted Limited to emergency services
	Emergency medical transportation	$50 co-pay per service	$50 co-pay per service	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Urgent care	$50 co-pay per date of service	$50 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 co-pay per day	Deductible, then $400 co-pay per day	No member cost-sharing when services are rendered by an Indian Health Services Provider Requires prior authorization
	Physician/surgeon fee	$30 co-pay per date of service	Deductible, then $100 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	Deductible, then $30 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider
	Mental/Behavioral health inpatient services	$150 co-pay per day	Deductible, then $400 co-pay per day	No member cost-sharing when services are rendered by an Indian Health Services Provider Requires prior authorization
	Substance use disorder outpatient services	No Charge	Deductible, then $30 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider
	Substance use disorder inpatient services	$150 co-pay per day	Deductible, then $400 co-pay per day	No member cost-sharing when services are rendered by an Indian Health Services Provider Requires prior authorization
If you are pregnant	Prenatal and postnatal care	$30 co-pay per date of service	Deductible, then $30 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Delivery and all inpatient services	$150 co-pay per day	Deductible, then $400 co-pay per day	No member cost-sharing when services are rendered by an Indian Health Services Provider
If you need help recovering or have other special health needs	Home health care	No Charge	Deductible, then $100 co-pay per visit	No member cost-sharing when services are rendered by an Indian Health Services Provider Requires prior authorization
	Rehabilitation services	$30 co-pay per date of service	Deductible, then $30 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider Limited to 30 visits/condition/ benefit period
	Habilitation services	$30 co-pay per date of service	Deductible, then $30 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	$30 co-pay per admission	Deductible, then $100 co-pay per admission	No member cost-sharing when services are rendered by an Indian Health Services Provider Requires prior authorization Limited to 100 days/benefit period
	Durable medical equipment	20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider Prior authorization is required for specific service. Please see your contract.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Hospice service	$30 co-pay per admission	Deductible, then $100 co-pay per admission	No member cost-sharing when services are rendered by an Indian Health Services Provider Requires prior authorization Outpatient Hospice Services: For Participating Providers: No Charge For Non-Participating Providers: Deductible, then $100/visit
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	No member cost-sharing when services are rendered by an Indian Health Services Provider Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	No member cost-sharing when services are rendered by an Indian Health Services Provider Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,240
- **Patient pays:** $300

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$150
Coinsurance	$0
Limits or exclusions	$150
Total	**$300**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $5,070
- **Patient pays:** $330

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$250
Limits or exclusions	$80
Total	**$330**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Participating Providers **$1,600** person/**$3,200** family For Non-Particpating Providers **$3,500** person/**$7,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. **$400** person for Prescription Drug coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$5,200** person/**$10,400** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay per date of service	Deductible, then 40% of Allowed Benefit	None
	Specialist visit	Deductible, then $40 co-pay per date of service	Deductible, then 40% of Allowed Benefit	None
	Other practitioner office visit	Deductible, then $40 co-pay per date of service for Acupuncture; Deductible, then $40 co-pay per date of service for Chiropractic	Deductible, then 40% of Allowed Benefit for Acupuncture; Deductible, then 40% of Allowed Benefit for Chiropractic	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Deductible, then 40% of Allowed Benefit	None
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 20% of Allowed Benefit	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
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Preferred Generic: $10 co-pay Non-Preferred Generic: Deductible, then 20% of Allowed Benefit	Preferred Generic: $10 co-pay Non-Preferred Generic: Deductible, then 20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Covers up to a 34-day supply

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Specialty drugs	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Covers up to a 34-day supply
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	Emergency room services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for air ambulance services, except for Medically Necessary air ambulance services in an emergency
	Urgent care	$40 co-pay per date of service	$40 co-pay per date of service	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization
	Physician/surgeon fee	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay per date of service	Deductible, then 40% of Allowed Benefit	None
	Mental/Behavioral health inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization
	Substance use disorder outpatient services	$20 co-pay per date of service	Deductible, then 40% of Allowed Benefit	None
	Substance use disorder inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	$20 co-pay per date of service	Deductible, then 40% of Allowed Benefit	For Participating Providers: Preventive Prenatal Care is provided at No Charge, and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Deductible, then 40% of Allowed Benefit	Requires prior authorization
	Rehabilitation services	Deductible, then $40 co-pay per date of service	Deductible, then 40% of Allowed Benefit	Limited to 30 visits/condition/ benefit period
	Habilitation services	Deductible, then $40 co-pay per date of service	Deductible, then 40% of Allowed Benefit	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period.
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization Limited to 100 days/benefit period.
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for specified services. Please see your contract.
	Hospice service	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization Outpatient Hospice Services: For Participating Providers: Deductible, then No Charge
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

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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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,060
- **Patient pays:** $2,480

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,620
Copays	$0
Coinsurance	$710
Limits or exclusions	$150
Total	**$2,480**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,780
- **Patient pays:** $2,620

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Copays	$420
Coinsurance	$120
Limits or exclusions	$80
Total	**$2,620**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

CareFirst BlueChoice

BlueChoice Plus Silver 87% CSR

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014
Coverage for: Individual | **Plan Type:** POS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Participating Providers **$0** For Non-Participating Providers **$1,000** person/**$2,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,250** person/**$4,500** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 co-pay per date of service	Deductible, then 40% of Allowed Benefit	None
	Specialist visit	$25 co-pay per date of service	Deductible, then 40% of Allowed Benefit	None
	Other practitioner office visit	$25 co-pay per date of service for Acupuncture; $25 co-pay per date of service for Chiropractic	Deductible, then 40% of Allowed Benefit for Acupuncture; Deductible, then 40% of Allowed Benefit for Chiropractic	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Deductible, then No Charge	None
If you have a test	Diagnostic test (x-ray, blood work)	20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
	Imaging (CT/PET scans, MRIs)	20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Preferred Generic: No Charge Non-Preferred Generic: 10% of Allowed Benefit	Preferred Generic: No Charge Non-Preferred Generic: 10% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	30% of Allowed Benefit	30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	40% of Allowed Benefit	40% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	40% of Allowed Benefit	40% of Allowed Benefit	Covers up to a 34-day supply

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
	Physician/surgeon fees	20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
If you need immediate medical attention	Emergency room services	20% of Allowed Benefit	20% of Allowed Benefit	Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	$25 co-pay per visit	$25 co-pay per visit	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization
	Physician/surgeon fee	20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 co-pay per date of service	Deductible, then 40% of Allowed Benefit	None
	Mental/Behavioral health inpatient services	20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization
	Substance use disorder outpatient services	$10 co-pay per date of service	Deductible, then 40% of Allowed Benefit	None
	Substance use disorder inpatient services	20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	$10 co-pay per date of service	Deductible, then 40% of Allowed Benefit	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Deductible, then 40% of Allowed Benefit	Requires prior authorization
	Rehabilitation services	$25 co-pay per date of service	Deductible, then 40% of Allowed Benefit	Limited to 30 visits/condition/ benefit period
	Habilitation services	$25 co-pay per date of service	Deductible, then 40% of Allowed Benefit	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for specific services. Please see your contract.
	Hospice service	20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization For Participating Providers: Outpatient Hospice Services: No Charge
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,360
- **Patient pays:** $1,180

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$1,030
Limits or exclusions	$150
Total	**$1,180**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,940
- **Patient pays:** $460

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$100
Coinsurance	$280
Limits or exclusions	$80
Total	**$460**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Participating Providers **$0** For Non-Participating Providers **$100** person/**$200** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,250** person/**$4,500** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	Deductible, then 20% of Allowed Benefit	None
	Specialist visit	$5 co-pay per date of service	Deductible, then 20% of Allowed Benefit	None
	Other practitioner office visit	$5 co-pay per date of service for Acupuncture; $5 co-pay per date of service for Chiropractic	Deductible, then 20% of Allowed Benefit for Acupuncture; Deductible, then 20% of Allowed Benefit for Chiropractic	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Deductible, then No Charge	None
If you have a test	Diagnostic test (x-ray, blood work)	10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	None
	Imaging (CT/PET scans, MRIs)	10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	No Charge	No Charge	Covers up to a 34-day supply
	Preferred brand drugs	10% of Allowed Benefit	10% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	20% of Allowe Benefit	20% of Allowe Benefit	Covers up to a 34-day supply
	Specialty drugs	20% of Allowed Benefit	20% of Allowed Benefit	Covers up to a 34-day supply

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	None
	Physician/surgeon fees	10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	None
If you need immediate medical attention	Emergency room services	10% of Allowed Benefit	10% of Allowed Benefit	Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Prior authorization is required for air ambulance services, except for Medically Necessary air ambulance services in an emergency
	Urgent care	$5 co-pay per visit	$5 co-pay per visit	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Requires prior authorization
	Physician/surgeon fee	10% of Allowed Benefit per date of service	Deductible, then 20% of Allowed Benefit	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	Deductible, then 20% of Allowed Benefit	None
	Mental/Behavioral health inpatient services	10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Requires prior authorization
	Substance use disorder outpatient services	No Charge	Deductible, then 20% of Allowed Benefit	None
	Substance use disorder inpatient services	10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	No Charge	Deductible, then 20% of Allowed Benefit	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Deductible, then 20% of Allowed Benefit	Requires prior authorization
	Rehabilitation services	$5 co-pay per date of service	Deductible, then 20% of Allowed Benefit	Limited to 30 visits/condition/ benefit period
	Habilitation services	$5 co-pay per date of service	Deductible, then 20% of Allowed Benefit	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Prior authorization is required for specified services. Please see your contract.
	Hospice service	10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Requires prior authorization Outpatient Hospices Services: For Participating Providers: No Charge
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
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- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

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**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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Does this Coverage Provide Minimum Essential Coverage?

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

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See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,870
- **Patient pays:** $670

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$520
Limits or exclusions	$150
Total	**$670**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $5,180
- **Patient pays:** $220

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$140
Limits or exclusions	$80
Total	**$220**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Participating Providers: **$2,500** person/**$5,000** family For Non-Participating Providers: **$5,000** person/**$10,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. **$400** person for Prescription Drug coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,350** person/**$12,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay per date of service	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Specialist visit	Deductible, then $40 co-pay per date of service	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Other practitioner office visit	Deductible, then $40 co-pay per date of service for Acupuncture; Deductible, then $40 co-pay per date of service for Chiropractic	Deductible, then 40% of Allowed Benefit for Acupuncture; Deductible, then 40% of Allowed Benefit for Chiropractic	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 20 visits/condition/ benefit period for Chiropractic.
	Preventive care/screening/immunization	No Charge	Deductible, then No Charge	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Imaging (CT/PET scans, MRIs)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Preferred Generic: $10 co-pay Non-Preferred Generic: Deductible, then 20% of Allowed Benefit	Preferred Generic: $10 co-pay Non-Preferred Generic: Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34 day supply
	Preferred brand drugs	Deducitble, then 30% of Allowed Benefit	Deducitble, then 30% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34 day supply
	Non-preferred brand drugs	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34 day supply
	Specialty drugs	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Covers up to a 34 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit per date of service	Deductible, then 40% of Allowed Benefit per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you need immediate medical attention	Emergency room services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for air ambulance services, except for Medically Necessary air ambulance services in an emergency

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Urgent care	Deductible, then $40 co-pay per date of service	Deductible, then $40 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Physician/surgeon fee	Deductible, then 20% of Allowed Benefit per date of service	Deductible, then 40% of Allowed Benefit date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay per date of service	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Mental/Behavioral health inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Substance use disorder outpatient services	$20 co-pay per date of service	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Substance use disorder inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then $20 co-pay per date of service	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Delivery and all inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Rehabilitation services	Deductible, then $40 co-pay per date of service	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 30 visits/condition/ benefit period.
	Habilitation services	Deductible, then $40 co-pay per date of service	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Benefits available for Members age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 100 days/benefit period. Requires prior authorization
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for specified services. Please see your contract.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Hospice service	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Outpatient Hospice Services: For Participating Providers: Deductible, then No Charge
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	No member cost-sharing when services are rendered by an Indian Health Services Provider Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	No member cost-sharing when services are rendered by an Indian Health Services Provider Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $4,350
- **Patient pays:** $3,200

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,520
Copays	$0
Coinsurance	$530
Limits or exclusions	$150
Total	**$3,200**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,140
- **Patient pays:** $3,260

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,820
Copays	$360
Coinsurance	$0
Limits or exclusions	$80
Total	**$3,260**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Participating Providers **$2,500** person/**$5,000** family For Non-Participating Providers **$5,000** person/**$10,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. **$400** person for Prescription Drug coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,350** person/**$12,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay per date of service	Deductible, then 40% of Allowed Benefit	None
	Specialist visit	Deductible, then $40 co-pay per date of service	Deductible, then 40% of Allowed Benefit	None
	Other practitioner office visit	Deductible, then $40 co-pay per date of service for Acupuncture; Deductible, then $40 co-pay per date of service for Chiropractic	Deductible, then 40% of Allowed Benefit for Acupuncture; Deductible, then 40% of Allowed Benefit for Chiropractic	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Deductible, then No Charge	None
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 20% of Allowed Benefit	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
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Preferred Generic: $10 co-pay Non-Preferred Generic: Deductible, then 20% of Allowed Benefit	Preferred Generic: $10 co-pay Non-Preferred Generic: Deductible, then 20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Covers up to a 34-day supply

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Specialty drugs	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Covers up to a 34-day supply
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 per date of service	Deductible, then 40% of Allowed Benefit	None
If you need immediate medical attention	Emergency room services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for air ambulance services, except for Medically Necessary air ambulance services in an emergency
	Urgent care	Deductible, then $40 co-pay per date of service	Deductible, then $40 co-pay per date of service	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization
	Physician/surgeon fee	Deductible, then 20% of Allowed Benefit per date of service	Deductible, then 40% of Allowed Benefit	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay per date of service	Deductible, then 20% of Allowed Benefit	None
	Mental/Behavioral health inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization
	Substance use disorder outpatient services	$20 co-pay per date of service	Deductible, then 20% of Allowed Benefit	None
	Substance use disorder inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then $20 co-pay per date of service	Deductible, then 40% of Allowed Benefit	For Participating Providers: Preventive Prenatal Care is provided at No Charge, and includes 1 Postnatal visit/delivery

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Delivery and all inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Deductible, then 40% of Allowed Benefit	Requires prior authorization
	Rehabilitation services	Deductible, then $40 co-pay per date of service	Deductible, then 40% of Allowed Benefit	Limited to 30 visits/condition/ benefit period
	Habilitation services	Deductible, then $40 co-pay per date of service	Deductible, then 40% of Allowed Benefit	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for specified services. Please see your contract.
	Hospice service	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Requires prior authorization Outpatient Hospice Services: For Participating Providers: Deductible, then No Charge
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $4,350
- **Patient pays:** $3,200

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,520
Copays	$0
Coinsurance	$530
Limits or exclusions	$150
Total	**$3,200**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,140
- **Patient pays:** $3,260

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,820
Copays	$360
Coinsurance	$0
Limits or exclusions	$80
Total	**$3,260**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,400** person/**$2,800** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$5,200** person/**$10,400** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-pay per date of service	Not Covered	None
	Specialist visit	Deductible, then $40 co-pay per date of service	Not Covered	None
	Other practitioner office visit	Deductible, then $40 co-pay per date of service for Acupuncture Deductible, then $40 co-pay per date of service for Chiropractic	Not Covered	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 20% of Allowed Benefit	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Deductible, then 20% of Allowed Benefit	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Preferred Generic: $10 co-pay Non-Preferred Generic: Deductible, then 20% of Allowed Benefit	Preferred Generic: $10 co-pay Non-Preferred Generic: Deductible, then 20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 20% of Allowed Benefit	Not Covered	None
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Not Covered	None
If you need immediate medical attention	Emergency room services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	$40 co-pay per date of service	$40 co-pay per date of service	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Not Covered	Requires prior authorization
	Physician/surgeon fee	Deductible, then 20% of Allowed Benefit	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 co-pay per date of service	Not Covered	None
	Mental/Behavioral health inpatient services	Deductible, then 20% of Allowed Benefit	Not Covered	Requires prior authorization
	Substance use disorder outpatient services	$30 co-pay per date of service	Not Covered	None
	Substance use disorder inpatient services	Deductible, then 20% of Allowed Benefit	Not Covered	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	$40 co-pay per date of service	Not Covered	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	Deductible, then 20% of Allowed Benefit	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Not Covered	Requires prior authorization
	Rehabilitation services	Deductible, then $40 co-pay per date of service	Not Covered	Limited to 30 visits/condition/ benefit period.
	Habilitation services	Deductible, then $40 co-pay per date of service	Not Covered	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Not Covered	Limited to 100 days/benefit period. Requires prior authorization
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Not Covered	Prior authorization is required for specific services. Please see your contract.
	Hospice service	Deductible, then 20% of Allowed Benefit	Not Covered	Requires prior authorization Outpatient Hospice Services: For Participating Providers: Deductible, then No Charge
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
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OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

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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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,220
- **Patient pays:** $2,320

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,400
Copays	$20
Coinsurance	$750
Limits or exclusions	$150
Total	**$2,320**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,210
- **Patient pays:** $2,190

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,400
Copays	$500
Coinsurance	$210
Limits or exclusions	$80
Total	**$2,190**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,250** person/**$4,500** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 co-pay per date of service	Not Covered	None
	Specialist visit	$20 co-pay per date of service	Not Covered	None
	Other practitioner office visit	$20 co-pay per date of service for Acupuncture; $20 co-pay per date of service for Chiropractic	Not Covered	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	20% of Allowed Benefit	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% of Allowed Benefit	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Preferred Generic: $5 co-pay Non-Preferred Generic: 20% of Allowed Benefit	Preferred Generic: $5 co-pay Non-Preferred Generic: 20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	30% of Allowed Benefit	30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	40% of Allowed Benefit	40% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	40% of Allowed Benefit	40% of Allowed Benefit	Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% of Allowed Benefit	Not Covered	None
	Physician/surgeon fees	20% of Allowed Benefit per date of service	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% of Allowed Benefit	20% of Allowed Benefit	Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	20% of Allowed Benefit	20% of Allowed Benefit	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	$20 co-pay per date of service	$20 co-pay per date of service	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of Allowed Benefit	Not Covered	Requires prior authorization
	Physician/surgeon fee	20% of Allowed Benefit per date of service	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 co-pay per date of service	Not Covered	None
	Mental/Behavioral health inpatient services	20% of Allowed Benefit	Not Covered	Requires prior authorization
	Substance use disorder outpatient services	$10 co-pay per date of service	Not Covered	None
	Substance use disorder inpatient services	20% of Allowed Benefit	Not Covered	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	$10 co-pay per date of service	Not Covered	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	20% of Allowed Benefit	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Requires prior authorization
	Rehabilitation services	$20 co-pay per date of service	Not Covered	Limited to 30 visits/condition/ benefit period
	Habilitation services	$20 co-pay per date of service	Not Covered	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	20% of Allowed Benefit	Not Covered	Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	20% of Allowed Benefit	Not Covered	Prior authorization is required for specific services. Please see your contract.
	Hospice service	20% of Allowed Benefit	Not Covered	Requires prior authorization For Participating Providers: Outpatient Hospice Services: No Charge
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupunture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

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For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,350
- **Patient pays:** $1,190

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$10
Coinsurance	$1,030
Limits or exclusions	$150
Total	**$1,190**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,740
- **Patient pays:** $660

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$300
Coinsurance	$280
Limits or exclusions	$80
Total	**$660**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,250** person/**$4,500** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	Not Covered	None
	Specialist visit	$10 co-pay per date of service	Not Covered	None
	Other practitioner office visit	$10 co-pay per date of service for Acupuncture; $10 co-pay per date of service for Chiropractic	Not Covered	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	10% of Allowed Benefit	Not Covered	None
	Imaging (CT/PET scans, MRIs)	10% of Allowed Benefit	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	No Charge	No Charge	Covers up to a 34-day supply
	Preferred brand drugs	10% of Allowed Benefit	10% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	20% of Allowed Benefit	20% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	20% of Allowed Benefit	20% of Allowed Benefit	Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% of Allowed Benefit	Not Covered	None
	Physician/surgeon fees	10% of Allowed Benefit	Not Covered	None
If you need immediate medical attention	Emergency room services	10% of Allowed Benefit	10% of Allowed Benefit	Co-pay waived if admitted Limited to Emergency Services

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Emergency medical transportation	10% of Allowed Benefit	10% of Allowed Benefit	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	$10 co-pay per date of service	$10 co-pay per date of service	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	10% of Allowed Benefit	Not Covered	Requires prior authorization
	Physician/surgeon fee	10% of Allowed Benefit per date of service	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	Not Covered	None
	Mental/Behavioral health inpatient services	10% of Allowed Benefit	Not Covered	Requires prior authorization
	Substance use disorder outpatient services	No Charge	Not Covered	None
	Substance use disorder inpatient services	10% of Allowed Benefit	Not Covered	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	10% of Allowed Benefit	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Requires prior authorization
	Rehabilitation services	$10 co-pay per date of service	Not Covered	Limited to 30 visits/condition/ benefit period
	Habilitation services	$10 co-pay per date of service	Not Covered	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	10% of Allowed Benefit	Not Covered	Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	10% of Allowed Benefit	Not Covered	Prior authorization is required for specific services. Please see your contract.
	Hospice service	10% of Allowed Benefit	Not Covered	Requires prior authorization Outpatient Hospice Services: For Participating Providers: No Charge
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupunture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

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For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
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Language Access Services:

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,870
- **Patient pays:** $670

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$520
Limits or exclusions	$150
Total	**$670**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $5,180
- **Patient pays:** $220

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$140
Limits or exclusions	$80
Total	**$220**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** person/**$4,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,350** person/**$12,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses..
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Specialist visit	Deductible, then $40 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Other practitioner office visit	Deductible, then $40 co-pay per date of service for Acupuncture; Deductible, then $40 co-pay per date of service for Chiropractic	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Imaging (CT/PET scans, MRIs)	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Preferred Generic: $10 co-pay Non-Preferred Generic: Deducitble, then 20% of Allowed Benefit	Preferred Generic: $10 co-pay Non-Preferred Generic: Deducitble, then 20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Covers up to a 34-day supply
	Specialty drugs	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you need immediate medical attention	Emergency room services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Urgent care	$40 co-pay per date of service	$40 co-pay per date of service	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Physician/surgeon fee	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then $30 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Mental/Behavioral health inpatient services	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Substance use disorder outpatient services	Deductible, then $30 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.
	Substance use disorder inpatient services	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then $30 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization
	Rehabilitation services	Deductible, then $40 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 30 visits/condition/ benefit period
	Habilitation services	Deductible, then $40 co-pay per date of service	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Not Covered	Prior authorization is required for specified services. Please see your contract.
	Hospice service	Deductible, then 20% of Allowed Benefit	Not Covered	No member cost-sharing when services are rendered by an Indian Health Services Provider. Requires prior authorization For Participating Providers: Outpatient Hospice Services: Deductible, then No Charge

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19 Limited to 1 visit/benefit period
	Glasses	No Charge for glasses/lenses	Allowances available for glasses/lenses	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19 Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	No member cost-sharing when services are rendered by an Indian Health Services Provider. Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
-
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $4,740
- **Patient pays:** $2,800

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$20
Coinsurance	$630
Limits or exclusions	$150
Total	**$2,800**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,690
- **Patient pays:** $2,710

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Copays	$440
Coinsurance	$190
Limits or exclusions	$80
Total	**$2,710**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-855-258-6518.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** person/**$4,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$25** for Participating Providers **$50** for Non-Participating Providers for Pediatric Dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,350** person/**$12,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses..
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.carefirst.com** or call **1-855-258-6518**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.
CareFirst SBC ID: SBC20130919MANBHAMCN6ARXCMCN6AN012014

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-pay per date of service	Not Covered	None
	Specialist visit	Deductible, then $40 co-pay per date of service	Not Covered	None
	Other practitioner office visit	Deductible, then $40 co-pay per date of service for Acupuncture; Deductible, then $40 co-pay per date of service for Chiropractic	Not Covered	Limited to 20 visits/condition/ benefit period for Chiropractic
	Preventive care/screening/immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 20% of Allowed Benefit	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Deductible, then 20% of Allowed Benefit	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com	Generic drugs	Preferred Generic: $10 co-pay Non-Preferred Generic: Deductible, then 20% of Allowed Benefit	Preferred Generic: $10 co-pay Non-Preferred Generic: Deductible, then 20% of Allowed Benefit	Covers up to a 34-day supply
	Preferred brand drugs	Deductible, then 30% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Covers up to a 34-day supply
	Non-preferred brand drugs	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Covers up to a 34-day supply

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
	Specialty drugs	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Covers up to a 34-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 20% of Allowed Benefit	Not Covered	None
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit per date of service	Not Covered	None
If you need immediate medical attention	Emergency room services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Co-pay waived if admitted Limited to Emergency Services
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Prior authorization is required for air ambulance services except for Medically Necessary air ambulance services in an emergency
	Urgent care	$40 co-pay per date of service	$40 co-pay per date of service	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Not Covered	Requires prior authorization
	Physician/surgeon fee	Deductible, then 20% of Allowed Benefit per date of service	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 co-pay per date of service	Not Covered	None
	Mental/Behavioral health inpatient services	Deductible, then 20% of Allowed Benefit	Not Covered	Requires prior authorization
	Substance use disorder outpatient services	$30 co-pay per date of service	Not Covered	None
	Substance use disorder inpatient services	Deductible, then 20% of Allowed Benefit	Not Covered	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	Deductible, then $30 co-pay per date of service	Not Covered	For Participating Providers: Preventive Prenatal Care is provided at No Charge and includes 1 Postnatal visit/delivery
	Delivery and all inpatient services	Deductible, then 20% of Allowed Benefit	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Not Covered	Requires prior authorization
	Rehabilitation services	Deductible, then $40 co-pay per date of service	Not Covered	Limited to 30 visits/condition/ benefit period
	Habilitation services	Deductible, then $40 co-pay per date of service	Not Covered	Requires prior authorization Benefits available for Member age 19 and older are limited to 30 visits/condition/benefit period
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Not Covered	Limited to 100 days/benefit period Requires prior authorization
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Not Covered	Prior authorization is required for specified services. Please see your contract.
	Hospice service	Deductible, then 20% of Allowed Benefit	Not Covered	Requires prior authorization Outpatient Hospice Services: For Participating Providers: Deductible, then No Charge
If your child needs dental or eye care	Eye exam	No Charge	Plan pays $40 reimbursement	Limited to 1 visit/benefit period
	Glasses	No Charge for frames/lenses	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of $40	Limited to 1 set of glasses/lenses per benefit period
	Dental check-up	No Charge	20% of Allowed Benefit	Limited to members up to age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Pediatric)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $4,740
- **Patient pays:** $2,800

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$20
Coinsurance	$630
Limits or exclusions	$150
Total	**$2,800**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,690
- **Patient pays:** $2,710

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Copays	$440
Coinsurance	$190
Limits or exclusions	$80
Total	**$2,710**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.