



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 <u>deductible</u> ? | 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 <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> . |
| Are there other <u>deductibles</u> for specific services? | Yes. \$25 for Participating Providers \$50 for Non-Participating Providers for Pediatric Dental coverage. There are no other specific <u>deductibles</u> . | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services. |
| Is there an <u>out-of-pocket limit</u> on my expenses? | Yes. For Participating Providers \$6,350 person/ \$12,700 family For Non-Participating Providers \$12,700 person/ \$25,400 family | The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ? | Premiums, balance-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| 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 <i>specific</i> covered services, such as office visits. |
| Does this plan use a <u>network of providers</u> ? | Yes. For a list of <u>preferred providers</u> , see www.carefirst.com or call 1-855-258-6518. | If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> . |
| Do I need a referral to see a <u>specialist</u> ? | No. | You can see the <u>specialist</u> 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 <u>excluded services</u> . |

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 | 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 | | Limitations & Exceptions |
|--|--|--|---|--|
| | | Participating Provider | Non-Participating Provider | |
| 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 | | 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 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

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.

** 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.

OR

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.

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, kwijjigo 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.

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