CareFirst BlueChoice

BlueChoice Plus Bronze 5500

Coverage Period: 01/01/2016 - 12/31/2016

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

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 content.carefirst.com/sbc/contracts/ATNMBN5CRXXMBN5L.pdf 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: **$8,000** person/**$16,000** family. Deductible does not apply to some services, including all In-Network Preventive care.	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 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. For Pediatric Dental: **$25** for Participating Providers; **$50** for Non-Participating Providers. For Prescription Drug: **$150** per person. 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. Medical and Prescription Drug combined: **$6,850** person/**$13,700** family for Participating Providers; **$10,000** person/**$20,000** family for Non-Participating Providers.	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 does not 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 3 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. See www.carefirst.com or call **1-855-258-6518** for a list of participating providers.	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 3 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.

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.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 9. See your policy or plan document for additional information about **excluded services**.

- **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 $25 co-pay per visit	Deductible, then $70 co-pay per visit	For treatment at a Hospital Facility, an additional charge may apply: Participating Provider: Deductible, then $100 co-pay per visit Non-Participating Provider: Deductible, then $200 co-pay per visit; Participating Providers: Office visits 1&2, Deductible does not apply
	Specialist visit	Deductible, then $50 co-pay per visit	Deductible, then $70 co-pay per visit	For treatment at a Hospital Facility, an additional charge may apply: Participating Provider: Deductible, then $100 co-pay per visit Non-Participating Provider: Deductible, then $200 co-pay per visit
	Other practitioner office visit	Acupuncture: Deductible, then $50 co-pay per visit Chiropractic: Deductible, then $50 co-pay per visit	Acupuncture: Deductible, then $70 co-pay per visit Chiropractic: Deductible, then $70 co-pay per visit	For treatment at a Hospital Facility, an additional charge may apply: Participating Provider: Deductible, then $100 co-pay per visit Non-Participating Provider: Deductible, then $200 co-pay per visit; Limited to 20 visits/condition/benefit period for Chiropractic
	Preventive care/screening/ immunization	No Charge	Deductible, then No Charge	Some services may have limitations or exclusions based on your contract

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have a test	Diagnostic test (x-ray, blood work)	LabTests: $25 co-pay per visit X-Ray: $100 co-pay per visit	LabTests: Deductible, then $75 co-pay per visit X-Ray: Deductible, then $150 co-pay per visit	For services provided at a Hospital Facility, prior authorization is required, and the following costs apply: Lab Tests: Participating Provider: Deductible, then $100 co-pay per visit Non-Participating Provider: Deductible, then $200 co-pay per visit X-rays: Participating Provider: Deductible, then $150 co-pay per visit Non-Participating Provider: Deductible, then $200 co-pay per visit
	Imaging (CT/PET scans, MRIs)	Deductible, then $500 co-pay per visit	Deductible, then $550 co-pay per visit	For services provided at a Hospital Facility, prior authorization is required, and the following costs apply: Participating Provider: Deductible, then $750 co-pay per visit Non-Participating Provider: Deductible, then $800 co-pay per visit
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.carefirst.com/rx**	Generic drugs	Preferred Preventive: No Charge (30-day supply) No Charge (90-day supply) Generic Drugs: $10 co-pay (30-day supply) $20 co-pay (90-day supply)	Preferred Preventive: Paid As In-Network Generic Drugs: Paid As In-Network	Prior authorization may be required for certain drugs
	Preferred brand drugs	Deductible, then $75 co-pay (30-day supply) Deductible, then $150 co-pay (90-day supply)	Paid As In-Network	Prior authorization may be required for certain drugs
	Non-preferred brand drugs	Deductible, then $150 co-pay (30-day supply) Deductible, then $300 co-pay (90-day supply)	Paid As In-Network	Prior authorization may be required for certain drugs

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
	Specialty drugs	Deductible, then $150 co-pay (30-day supply) Deductible, then $300 co-pay (90-day supply)	Not Covered	Prior authorization may be required for certain drugs; For Participating Providers: Specialty Drugs are only covered when purchased through the Exclusive Specialty Pharmacy Network For Non-Participating Providers: Specialty Drugs are not covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Surgery Center/Non-Hospital: Deductible, then $300 co-pay per visit Hospital: Deductible, then $450 co-pay per visit	Surgery Center/Non-Hospital: Deductible, then $400 co-pay per visit Hospital: Deductible, then $550 co-pay per visit	For services provided at a Hospital Facility, prior authorization is required
	Physician/surgeon fees	Deductible, then $50 co-pay per visit	Deductible, then $70 co-pay per visit	For services provided at a Hospital Facility, prior authorization is required
If you need immediate medical attention	Emergency room services	Deductible, then $300 co-pay per visit	Paid As In-Network	Co-pay waived if admitted; Limited to Emergency Services or unexpected, urgently required services
	Emergency medical transportation	Deductible, then $50 co-pay per visit	Paid As In-Network	Prior authorization is required for air ambulance services, except when Medically Necessary in an emergency
	Urgent care	$75 co-pay per visit	Paid As In-Network	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then $500 co-pay per day	Deductible, then $600 co-pay per day	Prior authorization is required
	Physician/surgeon fee	Deductible, then $50 co-pay per visit	Deductible, then $70 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	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visits: Deductible, then $25 co-pay per visit Hospital Facility: Deductible, then $50 co-pay per visit	Deductible, then $70 co-pay per visit	For treatment at a Hospital Facility, an additional professional charge applies: Participating Provider: Deductible, then $50 co-pay per visit Non-Participating Provider: Deductible, then $70 co-pay per visit; Participating Providers: Office visits 1&2, Deductible does not apply
	Mental/Behavioral health inpatient services	Deductible, then $500 co-pay per day	Deductible, then $600 co-pay per day	Prior authorization is required
	Substance use disorder outpatient services	Office Visits: Deductible, then $25 co-pay per visit Hospital Facility: Deductible, then $50 co-pay per visit	Deductible, then $70 co-pay per visit	For treatment at a Hospital Facility, an additional professional charge applies: Participating Provider: Deductible, then $50 co-pay per visit Non-Participating Provider: Deductible, then $70 co-pay per visit; Participating Providers: Office visits 1&2, Deductible does not apply
	Substance use disorder inpatient services	Deductible, then $500 co-pay per day	Deductible, then $600 co-pay per day	Prior authorization is required
If you are pregnant	Prenatal and postnatal care	No Charge	Deductible, then $70 co-pay per visit	For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
	Delivery and all inpatient services	Deductible, then $500 co-pay per day	Deductible, then $600 co-pay per day	Additional professional charges may apply
If you need help recovering or have other special health needs	Home health care	No Charge	Deductible, then $70 co-pay per visit	Prior authorization is required

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
	Rehabilitation services	Deductible, then $50 co-pay per visit	Deductible, then $70 co-pay per visit	For treatment at a Hospital Facility, prior authorization is required, and the following costs may apply: Participating Provider: Deductible, then $100 co-pay per visit Non-Participating Provider: Deductible, then $200 co-pay per visit; Limited to 30 visits/therapy type/condition/benefit period
	Habilitation services	Deductible, then $50 co-pay per visit	Deductible, then $70 co-pay per visit	Prior authorization is required; For treatment at a Hospital Facility, an additional charge may apply: Participating Provider: Deductible, then $100 co-pay per visit Non-Participating Provider: Deductible, then $200 co-pay per visit; Benefits available for Member age 19 and older are limited to 30 visits/therapy type/condition/benefit period
	Skilled nursing care	Deductible, then $100 co-pay per admission	Deductible, then $200 co-pay per admission	Prior authorization is required; 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	Inpatient Care: No Charge Outpatient Care: No Charge	Inpatient Care: Deductible, then $70 co-pay per admission Outpatient Care: Deductible, then $70 co-pay per visit	Prior authorization is required
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

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
	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; Limited to 2 visits/benefit period

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

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	• Hearing aids	• Termination of pregnancy, except in limited circumstances
• Bariatric surgery	• Infertility treatment	
• Chiropractic care	• 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, kwiijiho 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:** $2,270
- **Patient pays:** $5,270

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	$5,225
Copays	$15
Coinsurance	$0
Limits or exclusions	$30
Total	**$5,270**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,670
- **Patient pays:** $2,730

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	$2,330
Copays	$400
Coinsurance	$0
Limits or exclusions	$0
Total	**$2,730**

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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