CareFirst BlueChoice

# BlueChoice Silver CSR 87%

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

**Coverage Period: 01/01/2015 - 12/31/2015**

**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?** | For Participating Providers: **$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. For Participating Providers: **$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 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 | $5 co-pay per visit | Not Covered | If a service is rendered on a hospital campus, there could be 2 bills - one from your practitioner and one from the facility |
| | Specialist visit | $25 co-pay per visit | Not Covered | If a service is rendered on a hospital campus, there could be 2 bills - one from your practitioner and one from the facility |
| | Other practitioner office visit | $25 co-pay per visit for Acupuncture<br>$25 co-pay per visit for Chiropractic | Not Covered | If a service is rendered on a hospital campus, there could be 2 bills - one from your practitioner and one from the facility;<br>Limited to 20 visits/condition/ benefit period for Chiropractic |
| | Preventive care/screening/immunization | No Charge | Not Covered | Some services may have limitations or exclusions based on your contract |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Lab Tests: 20% of Allowed Benefit<br>X-Ray: 20% of Allowed Benefit | Not Covered | If a service is rendered on a hospital campus, there could be 2 bills - one from your practitioner and one from the facility |
| | Imaging (CT/PET scans, MRIs) | 20% of Allowed Benefit | Not Covered | If a service is rendered on a hospital campus, there could be 2 bills - one from your practitioner and one from the facility |

| 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**<br><br>More information about **prescription drug coverage** is available at **www.carefirst.com** | Generic drugs | Preferred Preventive:<br>No Charge<br>(34-day supply)<br>No Charge<br>(90-day supply)<br>Generic Drugs:<br>15% of Allowed Benefit<br>(34-day supply)<br>15% of Allowed Benefit<br>(90-day supply) | Paid As In-Network | None |
| | Preferred brand drugs | 30% of Allowed Benefit<br>(34-day supply)<br>30% of Allowed Benefit<br>(90-day supply) | Paid As In-Network | Prior authorization is required to receive brand name oral contraceptives with no deductible, coinsurance or copay |
| | Non-preferred brand drugs | 50% of Allowed Benefit<br>(34-day supply)<br>50% of Allowed Benefit<br>(90-day supply) | Paid As In-Network | Prior authorization is required to receive brand name oral contraceptives with no deductible, coinsurance or copay |
| | Specialty drugs | 50% of Allowed Benefit<br>(34-day supply)<br>50% of Allowed Benefit<br>(90-day supply) | Paid As In-Network | None |
| **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 | Paid As In-Network | Limited to Emergency Services or unexpected, urgently required services |
| | Emergency medical transportation | 20% of Allowed Benefit | Paid As In-Network | Prior authorization is required for air ambulance services, except for Medically Necessary air ambulance services in an emergency |
| | Urgent care | 20% of Allowed Benefit | Paid As In-Network | 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 | Not Covered | None |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | Office Visits:<br>$5 co-pay per visit<br>Outpatient Hospital Facility:<br>20% of Allowed Benefit | Not Covered | None |
| | Mental/Behavioral health inpatient services | 20% of Allowed Benefit | Not Covered | Requires prior authorization |
| | Substance use disorder outpatient services | Office Visits:<br>$5 co-pay per visit<br>Outpatient Hospital Facility:<br>20% of Allowed Benefit | 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 | No Charge | Not Covered | Some services may have limitations or exclusions based on your contract |
| | 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 visit | Not Covered | If a service is rendered on a hospital campus, there could be 2 bills - one from your practitioner and one from the facility; Limited to 30 visits/condition/ benefit period |
| | Habilitation services | $25 co-pay per visit | Not Covered | Requires prior authorization; If a service is rendered on a hospital campus, there could be 2 bills - one from your practitioner and one from the facility; 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 | Requires prior authorization; Limited to 100 days/benefit period |
| | Durable medical equipment | 20% of Allowed Benefit | Not Covered | Prior authorization is required for specified services. Please see your contract. |
| | Hospice service | Inpatient Care: 20% of Allowed Benefit Outpatient Care: 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<br>• Dental care (Adult)<br>• Long-term care | • Most coverage provided outside the United States<br>• Non-emergency care when traveling outside the U.S. | • Private-duty nursing<br>• Routine foot care<br>• 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<br>• Bariatric surgery | • Chiropractic care<br>• Hearing aids (Pediatric) | • Infertility treatment<br>• 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:** $6,461
- **Patient pays:** $1,079

**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 | $1,049 |
| Limits or exclusions | $30 |
| **Total** | **$1,079** |

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,658
- **Patient pays:** $742

**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 | $40 |
| Coinsurance | $702 |
| Limits or exclusions | $0 |
| **Total** | **$742** |

# 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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