The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.carefirst.com or call 1-800-535-2292. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-535-2292 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0.**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	This plan does not have a deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Medical: **$1,000**/individual; **$2,000**/family. Prescription Drug: **$5,500**/individual; **$9,600**/family.	The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family members on the plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, and penalties for failure to obtain preauthorization.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.carefirst.com or call 1-800-535-2292 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay/visit.	20% coinsurance plus charges above allowed amount.	None.
	Specialist visit			
	Preventive care/screening/ Immunization	No charge.	20% coinsurance plus charges above allowed amount.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge.	20% coinsurance plus charges above allowed amount.	In-network lab test benefits apply only to tests performed at LabCorp.
	Imaging (CT/PET scans, MRIs)	No charge.	20% coinsurance plus charges above allowed amount.	None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	Retail: $10 copay/prescription. Mail order: $15 copay/prescription.	Not covered.	Limit: Retail 30-day supply; Mail order: 90-day supply. No charge for ACA-required generic preventive drugs (e.g., FDA-approved generic contraceptives) or brand name preventive drugs if a generic is not medically appropriate. Preauthorization may be required for certain drugs or coverage may be denied.
	Preferred brand drugs	Retail: $20 copay/prescription. Mail order: $25 copay/ prescription.	Not covered.	
	Non-preferred brand drugs	Retail: $30 copay/prescription. Mail order: $35 copay/ prescription.	Not covered.	
	Specialty drugs	See above for copays.	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge.		None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees		20% coinsurance plus charges above allowed amount.	
If you need immediate medical attention	Emergency room care	$50 copay/visit.	$50 copay/visit.	Copay waived if admitted.
	Emergency medical transportation	No charge.	No charge.	None.
	Urgent care	$5 copay/visit.	No charge. Balance-billing charges may apply.	Unexpected, urgently required services only.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge.	$100 copay/admission then 20% coinsurance up to $1,500 out-of-pocket limit/admission then no charge. Balance-billing charges may apply.	Preauthorization required or coverage may be denied.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $5 copay/visit. Other outpatient: no charge.	20% coinsurance plus charges above allowed amount.	None.
	Inpatient services	No charge.	$100 copay/admission then 20% coinsurance up to $1,500 out-of-pocket limit/admission then no charge. Balance-billing charges may apply.	Preauthorization required or coverage may be denied.
If you are pregnant	Office visits	No charge.	20% coinsurance plus charges above allowed amount.	Maternity care may include tests and services described somewhere else in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services. Depending on the type of services, cost sharing may apply.
	Childbirth/delivery professional services	No charge.	$100 copay/admission then 20% coinsurance up to $1,500 out-of-pocket limit/admission, then no charge. Balance-billing charges may apply.	None.
	Childbirth/delivery facility services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge.	20% coinsurance plus charges above allowed amount.	Limited to 90 days/calendar year. Preauthorization required or coverage may be denied.
	Rehabilitation services	No charge.	20% coinsurance plus charges above allowed amount.	Physical, Speech and Occupational Therapy limited to combined 100 visits/calendar year. Preauthorization required after 10th visit or coverage may be denied.
	Habilitation services	No charge.	20% coinsurance plus charges above allowed amount.	Preauthorization required after first visit or coverage may be denied. Limited to individuals under age of 19.
	Skilled nursing care	No charge.	20% coinsurance plus charges above allowed amount.	Preauthorization required or coverage may be denied.
	Durable medical equipment	No charge.	20% coinsurance plus charges above allowed amount.	None.
	Hospice services	No charge.	20% coinsurance plus charges above allowed amount.	Respite care limited to 14 days/Hospice Eligibility Period. Bereavement counseling limited to 6 months or 15 visits. Preauthorization required or coverage may be denied.
If your child needs dental or eye care	Children's eye exam	$5 copay/exam.	You pay 100% and apply for reimbursement up to $38.	Separately administered by National Vision Administrators. Limit 1 exam/year.
	Children's glasses	$15 copay/pair lenses; no charge for frames up to $75 allowance.	You pay 100% and apply for reimbursement up to $41.50/pair lenses and $29.50/pair frames.	Separately administered by National Vision Administrators. Limit: 1 pair glasses/year.
	Children's dental check-up	PPO: no charge. HMO: $5 copay/exam.	PPO: no charge. HMO: not covered.	Separately administered by United Concordia. PPO: limit 2 exams/year.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery (Except for services related to mastectomy, cleft lip, or cleft palate).
- Long-term care.
- Routine foot care (Unless medically necessary).
- Weight loss programs (Except as required by ACA).

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion.
- Acupuncture.
- Bariatric surgery.
- Chiropractic care.
- Dental care (Adult) (Separately administered by United Concordia. Limit 2 exams/year).
- Hearing aids (Limit: 1 hearing aid per ear every 3 years).
- Infertility treatment (Preauthorization required).
- Non-emergency care when travelling outside the U.S. (See www.carefirst.com).
- Private-duty nursing.
- Routine eye care (Adult) (Separately administered by National Vision Administrators. Limit 1 pair glasses or contacts/12 months).

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, http://www.cciio.cms.gov, or call 1-877-267-2323 x61565. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 1-800-535-2292.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-535-2292.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-535-2292.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-535-2292.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-535-2292.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$5
Hospital (facility) copayment	$0
Other copayment	$0

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$90**

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

The plan's overall deductible	$0
Specialist copayment	$5
Hospital (facility) copayment	$0
Other copayment	$10

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$730**

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

The plan's overall deductible	$0
Specialist copayment	$5
Emergency room copayment	$50
Other copayment	$0

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$90**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.