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 general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can see the Glossary at www.carefirst.com/sbcg or call 1-855-258-6518 to request a copy. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.carefirst.com.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>In-Network: $0; Out-of-Network: $300 individual/$600 family</td>
<td>Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes, all In-Network services, are provided without a deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>There are no other specific deductibles.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Medical: In-Network: $1,000 individual/$2,000 family; Out-of-Network: $1,000 individual/$2,000 family</td>
<td>The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family member(s) on the plan, each family member may need to meet their own out-of-pocket limits, OR all family members may combine to meet the overall family out-of-pocket limit, depending upon plan coverage. Please refer to your contract for further details.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, health care this plan doesn’t cover, copayments for certain services, and penalties for failure to obtain pre-authorization for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.carefirst.com">www.carefirst.com</a> or call 855-258-6518 for a list of Network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
</tbody>
</table>
| If you visit a health care provider’s office or clinic | Primary care visit to treat an injury or illness | Provider: $15 copay per visit  
Hospital Facility: No Charge | Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit  
|                                          | Specialist visit                                           | Provider: $25 copay per visit  
Hospital Facility: No Charge | Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit  
|                                          | Retail health clinic                                       | $15 copay per visit                         | Deductible, then 20% of Allowed Benefit  
|                                          | Preventive care/screening/immunization                    | No Charge                                    | Well Child care: 20% of Allowed Benefit  
|                                          |                                                           |                                               | Adult Routine Physical: Not Covered  
| If you have a test                      | Diagnostic test (x-ray, blood work)                       | Lab Tests: Non-Hospital & Hospital: No Charge  
X-Ray: Non-Hospital & Hospital: No Charge | Lab Tests: Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit  
X-Ray: Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit  
|                                          | Imaging (CT/PET scans, MRIs)                              | Non-Hospital & Hospital: No Charge           | Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit  
| If you need drugs to treat your illness or condition | Generic drugs                                             | Not Covered                                  | Not Covered  
|                                          | Preferred brand drugs                                     | Not Covered                                  | Not Covered  
|                                          | Non-preferred brand drugs                                 | Not Covered                                  | Not Covered  
|                                          | Preferred Specialty drugs                                 | Not Covered                                  | Not Covered  
|                                          | Non-preferred Specialty drugs                             | Not Covered                                  | Not Covered  

If you have a test

- **Diagnostic test** (x-ray, blood work)
- **Imaging** (CT/PET scans, MRIs)

If you need drugs to treat your illness or condition

- **Generic drugs**
- **Preferred brand drugs**
- **Non-preferred brand drugs**
- **Preferred Specialty drugs**
- **Non-preferred Specialty drugs**
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Hospital: $25 copay per visit</td>
<td>Non-Hospital &amp; Hospital: Deductible, then 20% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Non-Hospital &amp; Hospital: No Charge</td>
<td>Non-Hospital &amp; Hospital: Deductible, then 20% of Allowed Benefit</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td><strong>Emergency room care</strong></td>
<td>$150 copay per visit</td>
<td>Paid As In Network</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 copay per visit</td>
<td>20% of Allowed Benefit</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>No Charge</td>
<td>Deductible, then 20% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Charge</td>
<td>Deductible, then 20% of Allowed Benefit</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Office Visits: $15 copay per visit</td>
<td>Office Visit &amp; Hospital Facility: Deductible, then 20% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital Facility: No Charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No Charge</td>
<td>Deductible, then 20% of Allowed Benefit</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>No Charge</td>
<td>Deductible, then 20% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No Charge</td>
<td>Deductible, then 20% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No Charge</td>
<td>Deductible, then 20% of Allowed Benefit</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No Charge</td>
<td>Deductible, then 20% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>Office Visit: $25 copay per visit Hospital Facility: No Charge</td>
<td>Office Visit &amp; Hospital Facility: Deductible, then 20% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Office Visit: $25 copay per visit Hospital Facility: No Charge</td>
<td>Office Visit &amp; Hospital Facility: Deductible, then 20% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Office Visit: $25 copay per visit Hospital Facility: No Charge</td>
<td>Office Visit &amp; Hospital Facility: Deductible, then 20% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No Charge</td>
<td>Deductible, then 20% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No Charge</td>
<td>Deductible, then 20% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No Charge</td>
<td>Deductible, then 20% of Allowed Benefit</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cosmetic surgery</td>
</tr>
<tr>
<td>Dental care (Adult)</td>
</tr>
<tr>
<td>Long-term care</td>
</tr>
<tr>
<td>Private-duty nursing</td>
</tr>
<tr>
<td>Routine eye care</td>
</tr>
<tr>
<td>Routine foot care</td>
</tr>
<tr>
<td>Weight loss programs</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
</tr>
<tr>
<td>Acupuncture</td>
</tr>
<tr>
<td>Bariatric surgery</td>
</tr>
<tr>
<td>Chiropractic care</td>
</tr>
<tr>
<td>Coverage provided outside the US. See <a href="http://www.carefirst.com">www.carefirst.com</a></td>
</tr>
<tr>
<td>Hearing aids</td>
</tr>
<tr>
<td>Infertility treatment</td>
</tr>
<tr>
<td>Non-emergency care when travelling outside the US</td>
</tr>
</tbody>
</table>

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 Labor Employee Benefits Security Administration, http://www.dol.gov/ebsa/healthreform, or call 1-866-444-EBSA (3272); or 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor Employee Benefits Security Administration, http://www.dol.gov/ebsa/healthreform, or call 1-866-444-EBSA (3272); or 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.

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:

Navajo (Dine): Dinek’ehgo shika a't'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 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: $____
- Specialist [cost sharing]: $____
- Hospital (facility) [cost sharing]: %
- Other [cost sharing]: %

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions: $____

The total Peg would pay is: $____

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

- The plan’s overall deductible: $____
- Specialist [cost sharing]: $____
- Hospital (facility) [cost sharing]: %
- Other [cost sharing]: %

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions: $____

The total Joe would pay is: $____

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

- The plan’s overall deductible: $____
- Specialist [cost sharing]: $____
- Hospital (facility) [cost sharing]: %
- Other [cost sharing]: %

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions: $____

The total Mia would pay is: $____