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.

### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>In-Network: $0; Out-Of-Network: $200 individual/$400 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 member(s) on the plan, each family member may need to meet their own individual deductible, OR all family members may combine to meet the overall family deductible before the plan begins to pay, depending upon plan coverage. Please refer to your contract for further details.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></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><strong>Are there other deductibles for specific services?</strong></td>
<td>There are no other specific deductibles.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>Medical and Prescription Drug combined (except EGWP Members): In-Network: $6,350 individual/$12,700 family; Medical for all Members: In-Network &amp; Out-Of-Network combined: $1,200 individual/$2,400 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><strong>What is not included in the out-of-pocket limit?</strong></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><strong>Will you pay less if you use a network provider?</strong></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><strong>Do you need a referral to see a specialist?</strong></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>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least)&lt;br&gt;Provider: $30 copay per visit Hospital Facility: $25 copay per visit&lt;br&gt;Out-of-Network Provider (You will pay the most)&lt;br&gt;Provider &amp; Hospital Facility: Deductible, then 20% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Network Provider (You will pay the least)&lt;br&gt;Provider: $30 copay per visit Hospital Facility: $25 copay per visit&lt;br&gt;Out-of-Network Provider (You will pay the most)&lt;br&gt;Provider &amp; Hospital Facility: Deductible, then 20% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Retail health clinic</td>
<td>Network Provider (You will pay the least)&lt;br&gt;Provider: $30 copay per visit Hospital Facility: $25 copay per visit&lt;br&gt;Out-of-Network Provider (You will pay the most)&lt;br&gt;Deductible, then 20% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>Network Provider (You will pay the least)&lt;br&gt;No Charge&lt;br&gt;Out-of-Network Provider (You will pay the most)&lt;br&gt;Deductible, then 20% of Allowed Benefit</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Network Provider (You will pay the least)&lt;br&gt;Lab Test: Non-Hospital &amp; Hospital: No Charge&lt;br&gt;X-Ray: Non-Hospital &amp; Hospital: No Charge&lt;br&gt;Out-of-Network Provider (You will pay the most)&lt;br&gt;Lab Tests: Non-Hospital: Deductible, then 20% of Allowed Benefit&lt;br&gt;Hospital: Paid As In-Network&lt;br&gt;X-Ray: Non-Hospital: Deductible, then 20% of Allowed Benefit&lt;br&gt;Hospital: Paid As In-Network</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Network Provider (You will pay the least)&lt;br&gt;Non-Hospital &amp; Hospital: No Charge&lt;br&gt;Out-of-Network Provider (You will pay the most)&lt;br&gt;Non-Hospital: Deductible, then 20% of Allowed Benefit&lt;br&gt;Hospital: Paid As In-Network</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Network Provider (You will pay the least)&lt;br&gt;$5 copay&lt;br&gt;Out-of-Network Provider (You will pay the most)&lt;br&gt;Paid As In-Network</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Network Provider (You will pay the least)&lt;br&gt;$20 copay&lt;br&gt;Out-of-Network Provider (You will pay the most)&lt;br&gt;Paid As In-Network</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Network Provider (You will pay the least)&lt;br&gt;$35 copay&lt;br&gt;Out-of-Network Provider (You will pay the most)&lt;br&gt;Paid As In-Network</td>
</tr>
<tr>
<td></td>
<td>Preferred Specialty drugs</td>
<td>Network Provider (You will pay the least)&lt;br&gt;$75 copay&lt;br&gt;Out-of-Network Provider (You will pay the most)&lt;br&gt;Not Covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred Specialty drugs</td>
<td>Network Provider (You will pay the least)&lt;br&gt;$75 copay&lt;br&gt;Out-of-Network Provider (You will pay the most)&lt;br&gt;Not Covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
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<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
</tr>
<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>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Hospital &amp; Hospital: No Charge</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Non-Hospital &amp; Hospital: No Charge</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td><strong>Emergency room care</strong></td>
<td>$85 copay per visit</td>
</tr>
<tr>
<td></td>
<td><strong>Emergency medical transportation</strong></td>
<td>No Charge</td>
</tr>
<tr>
<td></td>
<td><strong>Urgent care</strong></td>
<td>$30 copay per visit</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>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Charge</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Office Visit: $30 copay per visit Hospital Facility: No Charge</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No Charge</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>No Charge</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No Charge</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No Charge</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
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<td>--------------------------------------</td>
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<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
</tr>
<tr>
<td>If you need help recovering or have</td>
<td>Home health care</td>
<td>No Charge</td>
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<tr>
<td>other special health needs</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Office Visit: $30 copay per visit</td>
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<td></td>
<td></td>
<td>Hospital Facility: $25 copay per visit</td>
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<tr>
<td></td>
<td>Habilitation services</td>
<td>Office Visit: $30 copay per visit</td>
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<tr>
<td></td>
<td></td>
<td>Hospital Facility: $25 copay per visit</td>
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<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No Charge</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Durable medical equipment</td>
<td>No Charge</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No Charge</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td>If your child needs dental or eye</td>
<td>Children’s eye exam</td>
<td>Not Covered</td>
</tr>
<tr>
<td>care</td>
<td></td>
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<td></td>
<td>Children’s glasses</td>
<td>Not Covered</td>
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<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Excluded Services &amp; Other Covered</td>
<td>Cosmeti...</td>
<td></td>
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<tr>
<td>Services:</td>
<td>Long-term care</td>
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<td></td>
<td>Routine eye care</td>
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<td></td>
<td>Routine foot care</td>
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<td></td>
<td>Weight loss programs</td>
<td></td>
</tr>
<tr>
<td>Other Covered Services (Limitations</td>
<td>Abortion</td>
<td></td>
</tr>
<tr>
<td>may apply to these services. This</td>
<td>Acupuncture</td>
<td></td>
</tr>
<tr>
<td>isn’t a complete list. Please see</td>
<td>Bariatric surgery</td>
<td></td>
</tr>
<tr>
<td>your plan document.)</td>
<td>Chiropractic care</td>
<td></td>
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<tr>
<td></td>
<td>Coverage provided</td>
<td></td>
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<tr>
<td></td>
<td>outside the US</td>
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<tr>
<td></td>
<td><a href="http://www.carefirst.com">www.carefirst.com</a></td>
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<tr>
<td></td>
<td>Hearing aids</td>
<td></td>
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<td></td>
<td>Infertility treatment</td>
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<td></td>
<td>Non-emergency care</td>
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<td></td>
<td>when travelling</td>
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<td></td>
<td>outside the US</td>
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<td></td>
<td>Private-duty nursing</td>
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</tbody>
</table>

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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): Diné'ehgo shika at'ohwl 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.
The plan would be responsible for the other costs of these EXAMPLE covered services.

<table>
<thead>
<tr>
<th><strong>About these Coverage Examples:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>This is not a cost estimator.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Peg is Having a Baby</strong> (9 months of in-network pre-natal care and a hospital delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong> $0</td>
</tr>
<tr>
<td><strong>Specialist Copayment</strong> $30</td>
</tr>
<tr>
<td><strong>Hospital (facility) Copayment</strong> $0</td>
</tr>
<tr>
<td><strong>Other Copayment</strong> $0</td>
</tr>
</tbody>
</table>

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>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $10

**The total Peg would pay is** $10

<table>
<thead>
<tr>
<th><strong>Managing Joe’s type 2 Diabetes</strong> (a year of routine in-network care of a well-controlled condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong> $0</td>
</tr>
<tr>
<td><strong>Specialist Copayment</strong> $30</td>
</tr>
<tr>
<td><strong>Hospital (facility) Copayment</strong> $0</td>
</tr>
<tr>
<td><strong>Other Copayment</strong> $0</td>
</tr>
</tbody>
</table>

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>$525</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$525</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $0

**The total Joe would pay is** $525

<table>
<thead>
<tr>
<th><strong>Mia’s Simple Fracture</strong> (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong> $0</td>
</tr>
<tr>
<td><strong>Specialist Copayment</strong> $30</td>
</tr>
<tr>
<td><strong>Hospital (facility) Copayment</strong> $85</td>
</tr>
<tr>
<td><strong>Other Copayment</strong> $0</td>
</tr>
</tbody>
</table>

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>$270</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$270</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $0

**The total Mia would pay is** $270