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>$0</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</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: $2,000 individual/$6,000 family/$1,300 individual complimentary to Medicare.</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>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provider: $10 copay per visit Hospital Facility: No Charge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provider: $15 copay per visit Hospital Facility: No Charge</td>
</tr>
<tr>
<td></td>
<td>Retail health clinic</td>
<td>$10 copay per visit</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/ immunization</td>
<td>No Charge</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Lab Tests: Non-Hospital &amp; Hospital: No Charge X-Ray: Non-Hospital &amp; Hospital: No Charge</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Non-Hospital &amp; Hospital: No Charge</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Preferred Specialty drugs</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred Specialty drugs</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Non-Hospital &amp; Hospital: No Charge</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Non-Hospital &amp; Hospital: $10 PCP copay/$15 Specialist copay per visit</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>$85 copay per visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

*Some services may have limitations or exclusions based on your contract.*

*In-Network Lab Test benefits apply only to tests performed at LabCorp.*

*Refer to the SilverScript benefits.*

*Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply; Copay waived if admitted.*
<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></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><strong>Urgent care</strong></td>
<td>Paid As In-Network</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Facility fee (e.g., hospital room)</strong></td>
<td><strong>Not Covered</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Physician/surgeon fees</strong></td>
<td><strong>Not Covered</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Outpatient services</strong></td>
<td><strong>Not Covered</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Inpatient services</strong></td>
<td><strong>Not Covered</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Office visits</strong></td>
<td><strong>Not Covered</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Childbirth/delivery professional services</strong></td>
<td><strong>Not Covered</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Childbirth/delivery facility services</strong></td>
<td><strong>Not Covered</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Home health care</strong></td>
<td><strong>Not Covered</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td><strong>Not Covered</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Habilitation services</strong></td>
<td><strong>Not Covered</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td><strong>Not Covered</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Durable medical equipment</strong></td>
<td><strong>Not Covered</strong></td>
</tr>
</tbody>
</table>

**Urgent care**

- Facility fee (e.g., hospital room): No Charge
- Physician/surgeon fees: No Charge

**Outpatient services**

- Office Visit: $10 copay per visit
- Hospital Facility: No Charge

**Inpatient services**

- No Charge

**Office visits**

- No Charge

**Childbirth/delivery professional services**

- No Charge

**Childbirth/delivery facility services**

- No Charge

**Home health care**

- No Charge

**Rehabilitation services**

- Office Visit: $15 copay per visit
- Hospital Facility: No Charge

**Habilitation services**

- Office Visit: $15 copay per visit
- Hospital Facility: No Charge

**Skilled nursing care**

- No Charge

**Durable medical equipment**

- No Charge

**Common Medical Event**

- **Urgent care**
- **Facility fee (e.g., hospital room)**
- **Physician/surgeon fees**
- **Outpatient services**
- **Inpatient services**
- **Office visits**
- **Childbirth/delivery professional services**
- **Childbirth/delivery facility services**
- **Home health care**
- **Rehabilitation services**
- **Habilitation services**
- **Skilled nursing care**
- **Durable medical equipment**

**Services You May Need**

- **Urgent care**
- **Facility fee (e.g., hospital room)**
- **Physician/surgeon fees**
- **Outpatient services**
- **Inpatient services**
- **Office visits**
- **Childbirth/delivery professional services**
- **Childbirth/delivery facility services**
- **Home health care**
- **Rehabilitation services**
- **Habilitation services**
- **Skilled nursing care**
- **Durable medical equipment**

**What You Will Pay**

- **Network Provider (You will pay the least)**
- **Out-of-Network Provider (You will pay the most)**

**Limitations, Exceptions, & Other Important Information**

- Limited to unexpected, urgently required services
- Prior authorization is required
- None
- For treatment at an Outpatient Hospital Facility, additional charges may apply
- Prior authorization is required; Additional professional charges may apply
- For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
- None
- Additional professional charges may apply
- Prior authorization is required
- If a service is rendered at a Hospital Facility, the additional Facility charge may apply
- Benefits for Speech, Physical, and Occupational Therapies are limited to 30 days combined per condition per benefit period
- Prior authorization is required after the first visit
- Benefits are limited to Members under the age of 19
- Prior authorization is required
- None
<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></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>Hospice services</td>
<td></td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td></td>
<td></td>
<td>Prior authorization is required</td>
</tr>
<tr>
<td></td>
<td>Children’s eye exam</td>
<td>$10 copay per visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Discount program available to all Members</td>
<td>Benefits are limited to 1 visit/benefit period</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Benefits are limited to 1 set of glasses/lenses per benefit period</td>
</tr>
</tbody>
</table>

**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
- Coverage provided outside the US. See [www.carefirst.com](http://www.carefirst.com)
- Dental care (Adult)
- Long-term care
- Non-emergency care when travelling outside the US
- Private-duty nursing
- Routine foot care
- Weight loss programs

**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
- Hearing aids
- Infertility treatment
- Routine eye care
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
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-855-258-6518.]
[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, kwijigo 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The <strong>plan’s overall deductible</strong> $0</td>
<td>- The <strong>plan’s overall deductible</strong> $0</td>
<td>- The <strong>plan’s overall deductible</strong> $0</td>
</tr>
<tr>
<td>- <strong>Specialist Copayment</strong> $0</td>
<td>- <strong>Specialist Copayment</strong> $0</td>
<td>- <strong>Specialist Copayment</strong> $0</td>
</tr>
<tr>
<td>- <strong>Hospital (facility) Copayment</strong> $0</td>
<td>- <strong>Hospital (facility) Copayment</strong> $0</td>
<td>- <strong>Hospital (facility) Copayment</strong> $0</td>
</tr>
<tr>
<td>- <strong>Other Copayment</strong> $0</td>
<td>- <strong>Other Copayment</strong> $0</td>
<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** $0

In this example, Peg would pay:
- **Deductibles** $0
- **Copayments** $0
- **Coinsurance** $0

What isn’t covered
- Limits or exclusions $0

The total Peg would pay is $0

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** $0

In this example, Joe would pay:
- **Deductibles** $0
- **Copayments** $0
- **Coinsurance** $0

What isn’t covered
- Limits or exclusions $0

The total Joe would pay is $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** $0

In this example, Mia would pay:
- **Deductibles** $0
- **Copayments** $0
- **Coinsurance** $0

What isn’t covered
- Limits or exclusions $0

The total Mia would pay is $0

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