CareFirst of Maryland, Inc.: State of Maryland PPO

Coverage Period: 01/01/2025 – 12/31/2025
Coverage for: Individual | Plan Type: PPO

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. 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.carefirst.com/sbcg or call 1-800-225-0131 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $0; Out-of-Network: $250 individual/$500 family	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.
Are there services covered before you meet your deductible?	Yes, all In-Network services, are provided without a deductible.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
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?	Medical: In-Network: $2,000 individual/$4,000 family; Out-of-Network: $3,250 individual/$6,500 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this 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, copayments for certain services, and penalties for failure to obtain pre-authorization for services.	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 https://member.carefirst.com/members/find-providers/provider-directory/search-providers.page or call 855-258-6518 for a list of 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.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	Provider: $15 copay per visit Hospital Facility: 10% of coinsurance	Provider & Hospital Facility: Deductible, then 30% of coinsurance	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Specialist visit	Provider: $30 copay per visit Hospital Facility: 10% of coinsurance	Provider & Hospital Facility: Deductible, then 30% of coinsurance	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Retail health clinic	$15 copay per visit	Deductible, then 30% of coinsurance	None
	Preventive care/screening/ immunization	No Charge	Deductible, then 30% of coinsurance	Some services may have limitations or exclusions based on your contract
If you have a test	Diagnostic test (x-ray, blood work)	Lab Test: Non-Hospital & Hospital: 10% of coinsurance X-Ray: Non-Hospital & Hospital: 10% of coinsurance	Lab Test: Non-Hospital & Hospital: Deductible, then 30% of coinsurance X-Ray: Non-Hospital & Hospital: Deductible, then 30% of coinsurance	None
	Imaging (CT/PET scans, MRIs)	Non-Hospital & Hospital: 10% of coinsurance	Non-Hospital & Hospital: Deductible, then 30% of coinsurance	None
If you need drugs to treat your illness or condition	Generic drugs	Not Covered	Not Covered	None
	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	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-Hospital & Hospital: 10% of coinsurance	Non-Hospital & Hospital: Deductible, then 30% of coinsurance	None
	Physician/surgeon fees	Non-Hospital & Hospital: 10% of coinsurance	Non-Hospital & Hospital: Deductible, then 30% of coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay per visit	Paid As In-Network	Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply; Copay waived if admitted
	Emergency medical transportation	10% of coinsurance	Deductible, then 30% of coinsurance	Non-Emergency Air Ambulance services shall be counted towards the Network out-of-pocket maximums, applicable under the plan or coverage
	Urgent care	$30 copay per visit	Deductible, then 30% of coinsurance	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	10% of coinsurance	Deductible, then 30% of coinsurance	Prior authorization is required
	Physician/surgeon fees	10% of coinsurance	Deductible, then 30% of coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $15 copay per visit Hospital Facility: 10% of coinsurance	Office Visit & Hospital Facility: Deductible, then 30% of coinsurance	For treatment at an Outpatient Hospital Facility, additional charges may apply
	Inpatient services	10% of coinsurance	Deductible, then 30% of coinsurance	Prior authorization is required; Additional professional charges may apply
If you are pregnant	Office visits	No Charge	Deductible, then 30% of coinsurance	For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
	Childbirth/delivery professional services	10% of coinsurance	Deductible, then 30% of coinsurance	None
	Childbirth/delivery facility services	10% of coinsurance	Deductible, then 30% of coinsurance	Additional professional charges may apply

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	10% of coinsurance	Deductible, then 30% of coinsurance	Prior authorization is required Benefits are limited to 120 days unlimited visits per benefit period; 40 home health aide visits
	Rehabilitation services	Provider & Hospital Facility: $30 copay per visit	Provider & Hospital Facility: Deductible, then 30% of coinsurance	Prior authorization is required for Physical and Occupational Therapies after the 20th visit; by-pass authorization requirement for visits only when surgery is performed on same day as facility Prior authorization is required for Speech Therapy after the 1st visit 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 50 visits combined per benefit period
	Habilitation services	Provider & Hospital Facility: $30 copay per visit	Provider & Hospital Facility: Deductible, then 30% of coinsurance	Prior authorization is required after the first visit Benefits are limited to Members under the age of 19 If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Skilled nursing care	10% of coinsurance	Deductible, then 30% of coinsurance	Prior authorization is required Benefits are limited to 180 days per benefit period
	Durable medical equipment	10% of coinsurance	Deductible, then 30% of coinsurance	None
	Hospice services	10% of coinsurance	Deductible, then 30% of coinsurance	Prior authorization is required Respite care: Benefits are limited to 14 days Bereavement: Benefits are limited to 6 months or 15 days

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge	Deductible, then 30% of coinsurance	Benefits are limited to 1 per benefit period
	Children's glasses	$70 copay	Deductible, then 30% of coinsurance	Benefits are limited to 1 per benefit period
	Children's dental check-up	Not Covered	Not Covered	None

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
- Dental care
- Long-term care
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when travelling outside the US
- Private-duty nursing
- 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: For group health coverage subject to ERISA, Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform; for non-federal governmental group health plans, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or http://www.cciio.cms.gov; or contact CareFirst at the number on the back of your ID card. Church plans are not covered by the Federal COBRA continuation rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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:
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 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 Copay	$0
Hospital Coinsurance	0%
Other Coinsurance	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	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

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 Copay	$30
Hospital Coinsurance	0%
Other Coinsurance	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	**$5,600**

In this example, Joe would pay:

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

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

The plan's overall deductible	$0
Specialist Copay	$0
Hospital (Facility) Copay	$150
Other Coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic tests (*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	$150
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$150**

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