CareFirst PPO – Sodexo, Inc.

Coverage Period: 01/01/2022 – 12/31/2022
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 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.healthcare.gov/sbc-glossary/ or call 1-866-399-9450 to request a copy. If you want more detail about your coverage and costs, you can get the complete terms in the Summary Plan Description at **www.SodexoBenefitsCenter.com** or by calling **1-855-668-5040**.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $1,250 You Only/$2,500 family; Out-of-Network: $2,500 You Only/$5,000 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 preventive care services, as well as the following: Prescription Drug, primary care visits, specialist visits, urgent care, hospice, therapy services	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?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $8,700 You Only/ $17,400 family; Out-of-Network: $17,400 You Only/$34,800 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 www.carefirst.com or call 866-399-9450 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.

* For more information about limitations and exceptions, see the plan or policy document at **www.SodexoBenefitsCenter.com**

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: $30 copay per visit Hospital Facility: Deductible, then 30% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 50% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Specialist visit	Provider: $40 copay per visit Hospital Facility: Deductible, then 30% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 50% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Retail health clinic	$30 copay per visit	Deductible, then 50% of Allowed Benefit	None
	Preventive care/screening/ immunization	No Charge	No deductible, copay or coinsurance	Some services may have limitations or exclusions based on your plan
If you have a test	Diagnostic test (x-ray, blood work)	Lab Tests: Non-Hospital: $30 PCP copay/$40 Specialist copay Independent Lab: No Charge Hospital: Deductible, then 30% of Allowed Benefit X-Ray: Non-Hospital: $30 PCP copay/$40 Specialist copay Hospital: Deductible, then 30% of Allowed Benefit	Lab Tests: Non-Hospital, Independent Lab & Hospital: Deductible, then 50% of Allowed Benefit X-Ray: Non-Hospital & Hospital: Deductible, then 50% of Allowed Benefit	None
	Imaging (CT/PET scans, MRIs)	Lab Tests: Non-Hospital: $30 PCP copay/$40 Specialist copay Independent Lab: No Charge Hospital: Deductible, then 30% of Allowed Benefit X-Ray: Non-Hospital: $30 PCP copay/$40 Specialist copay Hospital: Deductible, then 30% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 50% of Allowed Benefit	None

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 drugs to treat your illness or condition	Generic drugs	$10 copay (retail) $20 copay (mail)	Not covered	Retail is limited to 30-day supply. Mail order is limited to 90-day supply. After 3 prescription fills of maintenance medications at retail pharmacy, a 100% penalty applies if mail order or 90 day fill at a participating Smart90 retail pharmacy is not pursued. Mandatory generic rules apply for non-specialty drugs. Some specialty medications require member to use mail order at first fill or a 100% penalty will apply In accordance with formulary guidelines, certain drugs may not be covered. More information can be found at express-scripts.com/sodexo
	Brand name formulary drugs	10% coinsurance (retail) $50 min/$125 max 10% coinsurance (mail) $100 min/$250 max	Not covered	
	Brand name non-formulary drugs	30% coinsurance (retail) $75 min/$175 max 30% coinsurance (mail) $150 min/$350 max	Not covered	
	Specialty drugs	Same as brand name formulary and non-formulary as applicable	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 50% of Allowed Benefit	None
	Physician/surgeon fees	Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 50% of Allowed Benefit	None
Orthopedic Surgery	Orthopedic Surgery (CareFirst)	Total hip and knee replacement, Total joint replacement, Spinal fusion surgery: No Coverage* Other orthopedic procedures: Deductible, then 30% of Allowed Benefit	Total hip and knee replacement, Total joint replacement, Spinal fusion surgery: No Coverage* Other orthopedic procedures: Deductible, then 50% of Allowed Benefit	*Carrum Health providers must be used for these surgeries
	Orthopedic Surgery Benefit (*Carrum Health)	If eligible, covers all medical costs incurred and related to	Not Covered	Certain orthopedic and spinal procedures are covered at 100% (deductible and coinsurance waived) when received through the Carrum

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)	
		the surgery without deductible or coinsurance		Health surgery benefit. Contact Carrum Health at 888-855-7806 or visit carrum.me/sodexo for more information
If you need immediate medical attention	Emergency room care	Deductible, then $150 copay per visit, then 30% of Allowed Benefit	Paid As In-Network	To be used for unexpected, urgently required services; Additional professional charges may apply; Copay waived if admitted
	Emergency medical transportation	Deductible, then 30% of Allowed Benefit	Paid As In-Network	None
	Urgent care	$30 copay per visit	Paid As In-Network	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then $250 per admission copay, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Prior authorization is required
	Physician/surgeon fees	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $30 copay per visit Hospital Facility: Deductible, then 30% of Allowed Benefit	Office Visit & Hospital Facility: Deductible, then 50% of Allowed Benefit	For treatment at an Outpatient Hospital Facility, additional charges may apply
	Inpatient services	Deductible, then $250 per admission copay, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Prior authorization is required; Additional professional charges may apply
If you are pregnant	Office visits	No Charge	Deductible, then 50% of Allowed Benefit	For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
	Childbirth/delivery professional services	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	None
	Childbirth/delivery facility services	Deductible, then $250 per admission copay, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Additional professional charges may apply
If you need help recovering or have	Home health care	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Prior authorization is required Benefits are limited to 120 days per benefit period

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)	
other special health needs	Rehabilitation services	Office Visit or Outpatient Hospital/Facility: $15 copay per visit (physical, speech, occupational), $40 copay per visit (other therapies); Outpatient Hospital: Deductible, then 30% of Allowed Benefit.	Deductible, then 50% of Allowed Benefit	None
	Habilitation services	Office or Outpatient Hospital/Facility: $15 copay per visit (physical, speech, occupational), $40 copay per visit (other therapies); Outpatient Hospital: Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	There is not a habilitative mandate for children.
	Skilled nursing care	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Prior authorization is required Benefits are limited to 60 days per benefit period
	Durable medical equipment	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	None
	Hospice services	30% of Allowed Benefit No deductible	30% of Allowed Benefit No deductible	Prior authorization is required Respite Care: Benefits are limited to 14 days annually Bereavement & Family Counseling: Not subject to any limitations.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	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 (Adult) • Hearing aids	• Infertility treatment • Long-term care • Routine eye care	• Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion • Acupuncture • Bariatric surgery (through Carrum Health)	• Chiropractic care- (limited to 30 visits) • Hinge Health (virtual physical therapy) • Non-emergency care when travelling outside the US	• Private-duty nursing

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, https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/, 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 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, contact: Department of Labor Employee Benefits Security Administration, https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/, 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.]

* For more information about limitations and exceptions, see the plan or policy document at **www.SodexoBenefitsCenter.com**

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

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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 $1,250
- Specialist *Copayment* $40
- Hospital (facility) *Coinsurance* 30%
- Other *Coinsurance* 30%

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	$1,250
Copayments	$300
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,910**

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

- The plan's overall deductible $1,250
- Specialist *Copayment* $40
- Hospital (facility) *Coinsurance* 30%
- Other *Coinsurance* 30%

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	$900
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

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

- The plan's overall deductible $1,250
- Specialist *Copayment* $40
- Hospital (facility) *Coinsurance* 30%
- Other *Copayment* $15

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	$1,250
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,650**

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