Lidl US, LLC & Lidl Operations, LLC
BlueChoice Advantage HSA $1600

Coverage Period: 01/01/2024 – 12/31/2024
Coverage for: Individual | **Plan Type:** POS-HSA

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	Answers	Why This Matters:
What is the overall deductible?	In-Network: $1,600 individual/$3,200 family; Out-of-Network: $4,200 individual/$8,400 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 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.
Are there services covered before you meet your deductible?	Yes, all In-Network preventive care 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?	Prescription drug and medical combined.	You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical and Prescription Drug combined: In-Network: $4,500 individual/$9,000 family; Out-of-Network: $9,000 individual/$18,000 family.	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.
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 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.

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 & Hospital Facility: Deductible, then 20% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 30% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Specialist visit	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 30% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Retail health clinic	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Preventive care/screening/ immunization	No Charge	Deductible, then 30% of Allowed Benefit	Some services may have limitations or exclusions based on your contract
If you have a test	Diagnostic test (x-ray, blood work)	Lab Tests: Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit X-Ray: Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	Lab Tests: Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit X-Ray: Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	In-Network Lab Test benefits apply only to tests performed at LabCorp.
	Imaging (CT/PET scans, MRIs)	Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com rxgroup	Generic drugs	Deductible, then 20% of Allowed Benefit	Paid As In-Network	For all prescription drugs: Prior authorization may be required for certain drugs; No Charge for preventive drugs or contraceptives; Copay applies to up to 30-day supply; Up to 90-day supply of maintenance drugs is 1 copay; Specialty Drugs:
	Preferred brand drugs	Deductible, then 20% of Allowed Benefit	Paid As In-Network	
	Non-preferred brand drugs	Deductible, then 20% of Allowed Benefit	Paid As In-Network	
	Preferred Specialty drugs	Deductible, then 20% of Allowed Benefit	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)	
	Non-preferred Specialty drugs	Deductible, then 20% of Allowed Benefit	Not Covered	Participating Providers: covered when purchased through the Exclusive Specialty Pharmacy Network Non-Participating Providers: Not Covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	None
	Physician/surgeon fees	Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	None
If you need immediate medical attention	Emergency room care	Deductible, then 20% of Allowed Benefit	Paid As In-Network	Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Paid As In-Network	None
	Urgent care	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit & Hospital Facility: Deductible, then 20% of Allowed Benefit	Office Visit & Hospital Facility: Deductible, then 30% of Allowed Benefit	For treatment at an Outpatient Hospital Facility, additional charges may apply
	Inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required; Additional professional charges may apply
If you are pregnant	Office visits	No Charge	Deductible, then 30% 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 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Childbirth/delivery facility services	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	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	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required Benefits are limited to 100 days per benefit period
	Rehabilitation services	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 30% of Allowed Benefit	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 60 visits per benefit period combined with Pulmonary, Cognitive and Cardiac Rehabilitation
	Habilitation services	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 30% of Allowed Benefit	Prior authorization is required If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required Benefits are limited to 100 days per benefit period combined with inpatient rehabilitation
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Hospice services	Inpatient and Outpatient Facility: Deductible, then 20% of Allowed Benefit	Inpatient and Outpatient Facility: Deductible, then 30% of Allowed Benefit	Prior authorization is required Hospice Maximum: Benefits are limited to 180 lifetime days inpatient/outpatient combined. 30 days inpatient per lifetime Bereavement: Services must be rendered within 90 days following the death of a covered Member. Maximum 3 visits Family Counseling: Applies to the 180-day Hospice Maximum Respite Care: Benefits are limited to 14 days
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.)		
• Acupuncture	• Infertility treatment	• Routine eye care
• Cosmetic surgery	• Long-term care	• Routine foot care
• Dental care (Adult)	• Private-duty nursing	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion	• Chiropractic care	• Hearing aids
• Bariatric surgery	• Coverage provided outside the US. See www.carefirst.com	• Non-emergency care when travelling outside the US

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:
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** **$1,600**
- **Specialist *Coinsurance*** **20%**
- **Hospital (facility) *Coinsurance*** **20%**
- **Other *Coinsurance*** **20%**

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	$1,600
Copayments	$0
Coinsurance	$1,680
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$3,290**

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

- **The plan's overall deductible** **$1,600**
- **Specialist *Coinsurance*** **20%**
- **Hospital (facility) *Coinsurance*** **20%**
- **Other *Coinsurance*** **20%**

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	$1,600
Copayments	$0
Coinsurance	$766
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,366**

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

- **The plan's overall deductible** **$1,600**
- **Specialist *Coinsurance*** **20%**
- **Hospital (facility) *Coinsurance*** **20%**
- **Other *Coinsurance*** **20%**

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	$1,600
Copayments	$0
Coinsurance	$240
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,840**

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