


**Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services**

**Coverage Period: 1/1/2020 – 12/31/2020**

**State of Maryland – CareFirst BlueCross BlueShield**

**Coverage for: Employee Only | Plan Type: EPO (SLEOLA)**

 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, go to DBM Health Benefits at [www.dbm.maryland.gov/benefits](http://www.dbm.maryland.gov/benefits) or call 410-767-4775 or 1-800-307-8283. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copay/copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary at [www.dbm.maryland.gov/benefits](http://www.dbm.maryland.gov/benefits) or call 410-767-4775 or 1-800-307-8283 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	In Network: <b>None</b>	You must pay all the costs up to the <a href="#">deductible</a> amount before this plan begins to pay for covered services you receive out-of-network. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	<b>No</b>	The deductible only applies to out of network services. All services received out of network are subject to the deductible except for emergency services. In network this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> or <a href="http://www.dbm.maryland.gov/benefits">www.dbm.maryland.gov/benefits</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	<b>No</b>	
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	Coinsurance: In-network: None Copayment: In-network: <b>\$1,000</b> Individual/ <b>\$2,000</b> Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Copayments</a> for certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See your plan's website address and phone number in the front cover of the Guide to Your Health Benefits for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	<b>No</b>	



All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met for out of network services, [deductibles](#) do not apply in-network.

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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a>	You must pay all charges billed by provider	Age and frequency schedules may apply.
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a>	You must pay all charges billed by provider	
	<a href="#">Preventive care/screening/</a> Immunization	\$0 <a href="#">copay</a>	You must pay all charges billed by provider	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Cost	You must pay all charges billed by provider	Coinsurance is waived for certain diagnostic tests. See the Guide to Your Health Benefits for details.
	Imaging (CT/PET scans, MRIs)	No Cost	You must pay all charges billed by provider	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.[insert].com</a>	Generic drugs	\$5 <a href="#">copay</a> (1-45 day supply); \$10 <a href="#">copay</a> (46-90 day supply)		<b>Outpatient Prescription Drug coverage is not included in your medical plan.</b> You elect this coverage separately from your medical plan. The plan is administered by CVS Caremark; you receive a separate ID card and pay a separate premium for prescription coverage.  See the State of Maryland's website at <a href="#">www.dbm.maryland/benefits</a> for more details.
	Preferred brand drugs	\$15 <a href="#">copay</a> (1-45 day supply); \$30 <a href="#">copay</a> (46-90 day supply)		
	Non-preferred brand drugs	\$25 <a href="#">copay</a> (1-45 day supply); \$50 <a href="#">copay</a> (46-90 day supply)		
	<a href="#">Specialty drugs</a>	<a href="#">Copay</a> and drug supply limit varies by type of drug.		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No Cost	You must pay all charges billed by provider	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced.
	Physician/surgeon fees	No Cost	You must pay all charges billed by provider	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a>	\$100 <a href="#">copay</a>	
	<a href="#">Emergency medical transportation</a>	No Cost	No Cost	
	<a href="#">Urgent care</a>	\$20 <a href="#">copay</a>	You must pay all charges billed by provider	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No Cost	You must pay all charges billed by provider	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced.
	Physician/surgeon fees	No Cost	You must pay all charges billed by provider	

\* For more information about limitations and exceptions, see the Guide to Your Health Benefits at [www.dbm.maryland.gov/benefits](#).

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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$15 copay for office visits	You must pay all charges billed by provider	In Network non-office visits: No Cost
	Inpatient services	No Cost	You must pay all charges billed by provider	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service.
<b>If you are pregnant</b>	Office visits	No Cost	You must pay all charges billed by provider	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Cost	You must pay all charges billed by provider	
	Childbirth/delivery facility services	No Cost	You must pay all charges billed by provider	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No Cost	You must pay all charges billed by provider	Limited to 120 days per year.
	<a href="#">Rehabilitation services</a>	\$25 <a href="#">copay</a> per day	You must pay all charges billed by provider	Limited to 50 combined days per plan year for Speech, Occupational, and Physical Therapy. One day may include multiple visits, but copay will only be applied on a per day basis. Occupational and physical therapy Must be preauthorized after 6th visit; speech therapy must be preauthorized from 1st visit.
	<a href="#">Habilitation services</a>	\$25 <a href="#">copay</a> per day	You must pay all charges billed by provider	No limit of treatment for children under 19 with congenital or genetic birth defects including autism, autism spectrum disorder, and cerebral palsy. Must be preauthorized by plan. Over age 19 members visits are limited to 50 combined visits for therapies.
	<a href="#">Skilled nursing care</a>	No cost	You must pay all charges billed by provider	Limited to 180 days per year.
	<a href="#">Durable medical equipment</a>	No cost	You must pay all charges billed by provider	<a href="#">Preauthorization</a> is required if over \$1,000.
	<a href="#">Hospice services</a>	No cost	You must pay all charges billed by provider	<a href="#">Preauthorization</a> is required.
<b>If your child needs dental or eye care</b>	Children's eye exam	Routine Annual Visit: \$0 <a href="#">copay</a> Non-routine: \$15 <a href="#">copay</a> PCP/\$25 <a href="#">copay</a> Specialist	20% <a href="#">coinsurance</a>	Limited to one routine eye exam per year.
	Children's glasses	No cost	You must pay all charges	In network limited to 100% of Allowed Benefit.

\* For more information about limitations and exceptions, see the Guide to Your Health Benefits at [www.dbm.maryland.gov/benefits](http://www.dbm.maryland.gov/benefits).

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)	
			billed by provider	
	Children's dental check-up	See Dental Coverage in Guide to Your Health Benefits		Dental covered separately through separate enrollment in either Dental HMO or Dental PPO. Details at <a href="http://www.dbm.maryland.gov/benefits">www.dbm.maryland.gov/benefits</a> .

### 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
- Long Term Care
- Routine Foot Care

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Acupuncture
- Chiropractic Care
- 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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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](http://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: [insert applicable contact information from instructions].

### 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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, ☒☒打☒个号☒ [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

—————*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 In- Network)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[cost sharing\]](#) 0%
- [Hospital \(facility\) \[cost sharing\]](#) 0%
- [Other \[cost sharing\]](#) 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$0</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[cost sharing\]](#) \$25
- [Hospital \(facility\) \[cost sharing\]](#) 0%
- [Other \[cost sharing\]](#) 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$75
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,075</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[cost sharing\]](#) \$0
- [Hospital \(facility\) \[cost sharing\]](#) \$100
- [Other \[cost sharing\]](#) N/A

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$
<b>The total Mia would pay is</b>	<b>\$100</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please see the Guide to Your Health Benefits at [www.dbm.maryland.gov/benefits](http://www.dbm.maryland.gov/benefits).