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 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 or call 410-767-4775 or 1-800-307-8283 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In Network: **None** Out of Network: **$250** Individual / **$500** Family	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you receive out-of-network. 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?	**No**	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 plan covers certain preventive services without cost-sharing. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ or www.dbm.maryland.gov/benefits.
Are there other deductibles for specific services?	**No**	
What is the out-of-pocket limit for this plan?	Coinsurance: In-network: **$1,000** Individual/**$2,000** Family; Out-of-network: **$3,000** Individual/ **$6,000** Family Copayment: In-network: **$1,000** Individual/**$2,000** Family; Out-of-network **None**	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?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	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 your plan's website address and phone number in the front cover of the Guide to Your Health Benefits 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	

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay	30% coinsurance	
	Specialist visit	$30 copay	30% coinsurance	
	Preventive care/screening/ immunization	$0 copay	30% coinsurance	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Coinsurance is waived for certain diagnostic tests. See the Guide to Your Health Benefits for details.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	$10 copay (1-45 day supply); $20 copay (46-90 day supply)		**Outpatient Prescription Drug coverage is not included in your medical plan.** 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 www.dbm.maryland/benefits for more details.
	Preferred brand drugs	$25 copay (1-45 day supply); $50 copay (46-90 day supply)		
	Non-preferred brand drugs	$40 copay (1-45 day supply); $80 copay (46-90 day supply)		
	Specialty drugs	Copay and drug supply limit varies by type of drug.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copay	$150 copay	
	Emergency medical transportation	No Cost	No Cost	
	Urgent care	$30 copay	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	

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 mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay for office visits	30% coinsurance	In Network non-office visits: 10% coinsurance
	Inpatient services	10% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	No Cost	30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Limited to 120 days per year.
	Rehabilitation services	$30 copay per day	30% coinsurance	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.
	Habilitation services	$30 copay per day	30% coinsurance	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.
	Skilled nursing care	10% coinsurance	30% coinsurance	Limited to 180 days per year.
	Durable medical equipment	10% coinsurance	30% coinsurance	Preauthorization is required if over $1,000.
	Hospice services	10% coinsurance	30% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	Routine Annual Visit: $0 copay Non-routine: $15 copay PCP/$30 copay Specialist	30% coinsurance	Limited to one routine eye exam per year.
	Children's glasses	No cost	30% coinsurance	In network limited to 100% of Allowed Benefit.
	Children's dental check-up	See Dental Coverage in		Dental covered separately through separate

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)	
		Guide to Your Health Benefits		enrollment in either Dental HMO or Dental PPO. Details at www.dbm.maryland.gov/benefits.

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 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， **请拨打这个号码** [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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

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

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]*	10%
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,000**

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]*	$30
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$90
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,090**

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]*	$150
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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$150
Coinsurance	$0
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$150**

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.