Anne Arundel County Public Schools
BC Triple Option Retirees Over 65

Coverage Period: 01/01/2020 – 12/31/2020
Coverage for: Individual| **Plan Type: HMO**

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:
	Option 1	Option 2	Option 3	
What is the overall deductible?	$0	In-Network: $200 individual/$400 family	Out-of-Network: $300 individual/$600 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 services, are provided without a deductible.	Yes, all In-Network preventive care services, as well as the following (non-hospital facilities only, when applicable): Primary care, Specialist, Retail health, Diagnostic testing, Emergency room, Emergency medical transportation, Urgent care, Mental health outpatient services, Home health care, Rehabilitation services, and Hospice services	Emergency room, Emergency medical transportation, Home health care, and Hospice 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.	There are no other specific deductibles.	There are no other specific deductibles.	You don't have to meet deductibles for specific services.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	Non-Preferred Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
What is the out-of-pocket limit for this plan?	Medical: In-Network: $2,000 individual/$6,000 family/$1,300 individual complimentary to Medicare.	Medical: In-Network, (combined with out of network) $2,000 individual/$4,000 family	Medical: Out-of-Network, (combined with in network): $2,000 individual/$4,000 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.	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.	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.	Yes. See www.carefirst.com or call 855-258-6518 for a list of Network providers.	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	No	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
		Preferred Network Provider (You will pay the least)	Non-Preferred Network Provider (You will pay more)	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: No Charge	Provider: $20 copay per visit Hospital Facility: Deductible, then 10% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Specialist visit	Provider: $15 copay per visit Hospital Facility: No Charge	Provider: $20 copay per visit Hospital Facility: Deductible, then 10% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Retail health clinic	$15 copay per visit	$20 copay per visit	Deductible, then 20% of Allowed Benefit	None
	Preventive care/screening/ immunization	No Charge	No Charge	Deductible, then 20% 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 Test: Non-Hospital & Hospital: No Charge X-Ray: Non-Hospital & Hospital: No Charge	Lab Test: Non-Hospital: $20 copay per visit Hospital: No Charge X-Ray: Non-Hospital: $20 copay per visit Hospital: No Charge	Lab Test: Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit X-Ray: Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	In-Network Lab Test benefits apply only to tests performed at LabCorp.
	Imaging (CT/PET scans, MRIs)	Non-Hospital & Hospital: No Charge	Non-Hospital: $20 copay per visit Hospital: No Charge	Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	None
	Generic drugs	Not Covered	Not Covered	Not Covered	Refer to the SilverScript benefits.
	Preferred brand drugs	Not Covered	Not Covered	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	Non-Preferred Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Preferred Specialty drugs	Not Covered	Not Covered	Not Covered	
	Non-preferred Specialty drugs	Not Covered	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-Hospital & Hospital: No Charge	Non-Hospital: Deductible, then 10% of Allowed Benefit Hospital: $20 copay per visit	Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	None
	Physician/surgeon fees	Non-Hospital & Hospital: $15 copay per visit	Non-Hospital & Hospital: $20 copay per visit	Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	None
If you need immediate medical attention	Emergency room care	$85 copay per visit	$85 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	No Charge	No Charge	No Charge	None
	Urgent care	$15 copay per visit	$20 copay per visit	Deductible, then 20% of Allowed Benefit	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Prior authorization is required
	Physician/surgeon fees	No Charge	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	Non-Preferred Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $15 copay per visit Hospital Facility: No Charge	Office Visit: $15 copay per visit Hospital Facility: No Charge	Office Visit & Hospital Facility: Deductible, then 20% of Allowed Benefit	For treatment at an Outpatient Hospital Facility, additional charges may apply
	Inpatient services	No Charge	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Prior authorization is required; Additional professional charges may apply
If you are pregnant	Office visits	No Charge	No Charge	Deductible, then 20% 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	No Charge	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	None
	Childbirth/delivery facility services	No Charge	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Additional professional charges may apply
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	No Charge	Prior authorization is required Level 2 & 3 – Benefits are limited to 90 days per benefit period
	Rehabilitation services	Provider: $15 copay per visit Hospital Facility: No Charge	Provider: $20 copay per visit Hospital Facility: No Charge	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply Level 1: Benefits for Speech, Physical, and Occupational Therapies are limited to 30 days combined per condition per benefit period Level 2 & 3: Benefits for Speech, Physical, and Occupational Therapies are limited to 100 visits combined per benefit period
	Habilitation services	Provider: $15 copay per visit Hospital Facility: No Charge	Provider: $20 copay per visit Hospital Facility: No Charge	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	Non-Preferred Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	No Charge	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Prior authorization is required
	Durable medical equipment	No Charge	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	None
	Hospice services	No Charge	No Charge	No Charge	Prior authorization is required Hospice Maximum: Inpatient benefits are limited to 180 days per lifetime Respite Care: Benefits are limited to 14 days during the Hospice eligibility period Bereavement: Benefits are limited to a maximum of 6 months following the Member's death or 15 visits, whichever occurs first
If your child needs dental or eye care	Children's eye exam	$10 copay per visit	Not Covered	Not Covered	Benefits are limited to 1 visit/benefit period
	Children's glasses	Discount program available to all Members	Not Covered	Not Covered	Benefits are limited to 1 set of glasses/ lenses per benefit period
	Children's dental check-up	Not Covered	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)
- Long-term care
- Private-duty nursing
- 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.)

- Abortion
- Acupuncture
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the US. See www.carefirst.com
- Hearing aids
- Infertility treatment (Level 2 & 3)
- Non-emergency care when travelling outside the US
- 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: 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**
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 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** **$**
- **Specialist** **$**
- **Hospital (facility)** **%**
- **Other** **%**

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	**$**

In this example, Peg would pay:

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

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

- **The plan's overall deductible** **$**
- **Specialist** **$**
- **Hospital (facility)** **%**
- **Other** **%**

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	**$**

In this example, Joe would pay:

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

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

- **The plan's overall deductible** **$**
- **Specialist** **$**
- **Hospital (facility)** **%**
- **Other** **%**

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	**$**

In this example, Mia would pay:

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

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