Cecil County Public Schools
PPO Core

Coverage Period: 9/1/2020 – 8/30/2021

Coverage for: Individual, Parent & Child, Individual & Spouse, Parent & Children, and Family| 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.carefirst.com/sbcg or call 1-877-691-5856 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 providers $500 Individual / $1,500 Family. Out-of-network providers $1,000 Individual / $3,000 Family.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The deductible starts over January 1. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Coinsurance and copayments do not count toward deductible. Does not apply to preventative care. Does not apply to prescription drug.
Are there services covered before you meet your deductible?	Yes, all In-Network preventive care is covered before you meet your deductible.	This plan covers certain preventative care 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 do not have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers
What is the out-of-pocket limit for this plan?	Medical: In-Network providers $2,500 Individual / $5,000 Family. Out-of-Network providers $2,500 Individual/ $5,000 Family. Prescription: $3,600 Individual / $7,200 Family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
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 877-691-5856 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 of you use an out-of-network provider, and you might receive a bill from a provider for the cost of your visit if you receive services from an out-of-network provider (a balance bill). 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	$20 copay/visit after deductible	30% coinsurance after deductible	----------None----------
	Specialist visit	$20 copay/visit after deductible	30% coinsurance after deductible	----------None----------
	Retail health clinic	Deductible, then $20 copay per visit	Deductible, then 30% of Allowed Benefit	None
	Preventive care/screening/ immunization	No Charge for covered services	Deductible, then 30% of Allowed Benefit	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Maximum tests per year may apply.
If you have a test	Diagnostic test (x-ray, blood work)	$15 copay/visit after deductible	30% coinsurance after deductible	----------None----------
	Imaging (CT/PET scans, MRIs)	$75 copay/visit after deductible	30% coinsurance after deductible	----------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	$5 copay retail / $10 copay for 90 day maintenance drug mail order	Not Covered	None
	Preferred brand drugs	$25 copay retail / $50 copay for 90 day maintenance drug mail order	Not Covered	
	Non-preferred brand drugs	$50 copay retail / $100 copay for 90 day maintenance drug mail order	Not Covered	
	Preferred Specialty drugs	$5 copay retail for generic; $25 copay retail for preferred brand	Not Covered	
	Non-preferred Specialty drugs	$50 copay Non-preferred brand retail $100 copay Non-preferred brand mail order	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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$35 copay/visit after deductible	30% coinsurance after deductible	----------None----------
	Physician/surgeon fees	$20 copay/visit for PCP and specialist after deductible $25 copay/visit for practitioner at hospital after deductible	30% coinsurance after deductible	----------None----------
If you need immediate medical attention	Emergency room care	$100 copay/visit after deductible	$100 copay/visit after deductible	Copay waived if admitted.
	Emergency medical transportation	$0 copay after deductible	$0 copay after deductible	----------None----------
	Urgent care	$35 copay after deductible	$35 copay after deductible	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	30% coinsurance after deductible	Prior authorization is required
	Physician/surgeon fees	$20 copay PCP and Specialist after deductible; $25 copay Practitioner at hospital after deductible	30% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: Deductible, then $20 copay per visit Hospital Facility: Deductible, then $25 copay per visit	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 10% 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 for covered services	30% coinsurance after deductible	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) that may be subject to the deductible, coinsurance, and/or copay.
	Childbirth/delivery professional services	10% coinsurance after deductible	30% coinsurance after deductible	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)	
	Childbirth/delivery facility services	10% coinsurance after deductible	30% coinsurance after deductible	Additional professional charges may apply
If you need help recovering or have other special health needs	Home health care	$35 copay facility; $25 copay practitioner at facility after deductible; $20 practitioner in office after deductible	30% coinsurance after deductible	Physical Therapy is limited to 100 visits per plan year.
	Rehabilitation services	$35 copay facility; $25 copay practitioner at facility after deductible; $20 practitioner in office after deductible	30% coinsurance after deductible	Preauthorization required after initial visit.
	Habilitation services	10% coinsurance after deductible	30% coinsurance after deductible	----------None----------
	Skilled nursing care	10% coinsurance after deductible	30% coinsurance after deductible	----------None----------
	Durable medical equipment	10% coinsurance after deductible	30% coinsurance after deductible	Treatment plan required.
	Hospice services	$35 copay facility; $25 copay practitioner at facility after deductible; $20 practitioner in office after deductible	30% coinsurance after deductible	Physical Therapy is limited to 100 visits per plan year.
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)
- Long-term care
- Routine eye care
- 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	• 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, 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	$500
Specialist *copayment*	$20
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	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	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$140
Coinsurance	$210
What isn't covered	
Limits or exclusions	$150
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)

The plan's overall deductible	$500
Specialist *copayment*	$20
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	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	**$4,100**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$360
Coinsurance	$130
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$1,070**

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

The plan's overall deductible	$500
Specialist *copayment*	$20
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	10%

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	**$9,850**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$50
The total Mia would pay is	**$1,050**

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