The Maryland School for the Blind
ACHIEVING INDEPENDENCE

2020-2021 HEALTH BENEFITS

MEDICAL

Please see your Summary of Benefits and Coverage (SBC) for full details on your benefits.

The Maryland School for the Blind offers medical benefits through *Kaiser Permanente* effective 9/1/20. Employees will have access to Kaiser's *Signature Network* of physicians and hospitals. Through Kaiser, you have the choice of 3 comprehensive medical plans.

SUMMARY OF SERVICES	1 HMO HSA PLAN	2 DHMO PLUS PLAN	
	Signature Network	***Signature Network***	***Out-of-Network*** *(up to 10 Primary Care Provider/ Specialist visits per plan year)*
Deductible (Ded) *(Individual/Family)*	$1,500 / $3,000	$500 / $1,000	N/A
Plan Year Out-of-Pocket Maximum	$3,500 / $7,000	$3,000 / $6,000	N/A
Co-Insurance *(Plan pays/You pay)*	90% / 10%	100%	N/A
Physician/Specialist Visits	Ded., then Co-Ins.	$20 / $30 Copay	$40 / $50 Copay (10 visit limit)
Emergency Room[1]	Ded., then Co-Ins.	$100 Copay	$100 Copay
Urgent Care	Ded., then Co-Ins.	$30 Copay	Not Covered
Referral Required	Yes	Yes	No
PCP Required	Yes	Yes	No
PRESCRIPTION DRUGS[2] Generic / Preferred / Non-Preferred			
Local Pharmacy *(30-day supply)*	Kaiser: Ded., then $15 / $35 / $60 Non-Kaiser In-Network: Ded., then $25 / $45 / $80	Kaiser: $10 / $30 / $50 Non-Kaiser In-Network: $30 / $50 / $75	$30 / $50 / $70 (5 fill/refill limit)
Mail Order *(90-day supply)*	Kaiser: Ded., then $45 /$105 / $180 Non-Kaiser In-Network: Ded., then $75 / $135 / $240	Kaiser: $20 / $60 / $100 Non-Kaiser In-Network: $60 / $100 / $150	Not Covered

SUMMARY OF SERVICES	3 FLEX PLAN - PHCS		
	Signature Network	***PHCS Network***	***Out-of-Network***
Deductible (Ded) *(Individual/Family)*	None	$500 / $1,000	$1,000 / $2,000
Plan Year Out-of-Pocket Maximum	$2,250 / $4,500	$3,000 / $6,000	$6,000 / $12,000
Co-Insurance *(Plan pays/You pay)*	100%	90% / 10%	70% / 30%
Physician/Specialist Visits	$30 / $40 Copay	$45 / $55 Copay	Ded., then Co-Ins.
Emergency Room[1]	$100 Copay	$100 Copay	$100 Copay
Urgent Care	$40 Copay	Ded., then Co-Ins.	Ded., then Co-Ins.
Referral Required	Yes	No	No
PCP Required	Yes	No	No
PRESCRIPTION DRUGS[2] Generic / Preferred / Non-Preferred			
Local Pharmacy *(30-day supply)* *Generic / Formulary / Non-Formulary*	$25 / $40 / $65	$35 / $55 / $90	$40 / $80 / $90
Mail Order *(90-day supply)* *Generic / Formulary / Non-Formulary*	$50 / $80 / $130	$70 / $110 / $180	$80 / $160 / $180

Please note: This is a brief description of the program. Actual benefit payments are made in accordance with the insurance contract and plan documents.

[1] Waived if admitted.

[2] Not all non-Kaiser pharmacies are included. Please visit kp.org for a list of participating pharmacies.

DENTAL

Please see your benefit summary for full details on your benefits.

BLUEDHMO PLAN THROUGH CAREFIRST

The BlueDHMO plan works like a HMO. Each member of your family must select a Primary Care Dentist (PCD) from the list of participating DHMO dentists. You must use participating Dental Network DHMO dentists in this plan. Your PCD will provide routine dental care and refer you to a specialist if needed. Out-of-network services are not covered under this plan.

Before completing your enrollment and selecting your PCD, we suggest calling the participating DHMO providers' office and confirming that they are accepting new patients.

BLUEDENTAL PLUS PPO PLAN THROUGH CAREFIRST

The PPO plan allows you the freedom to seek care both in- and out-of-network. Please note that if you do receive care out-of-network, you will pay more out-of-pocket and will be subject to balance billing.

Please refer to your Paylocity WebBenefits homepage to view the fee schedule for the DHMO plan, and the detailed benefit summary for further details on the PPO plan.

BENEFITS	1 CareFirst BlueDHMO	2 CareFirst BlueDental Plus PPO	
	In-Network	*In-Network*	*Out-of-Network*
Annual Deductible (single/family)	None	$25 / $75	$50 / $150
Annual Maximum	N/A	$1,500 (Combined In and Out-of-Network)	
Orthodontia Lifetime Maximum	$3,000	$1,500 (Combined In and Out-of-Network)	
COVERED SERVICES	**YOU PAY AFTER DEDUCTIBLE**	**YOU PAY AFTER DEDUCTIBLE**	
Preventive Services (Deductible does not apply)	See Fee Schedule	No Charge	20% of Allowed Benefit
Basic Services	See Fee Schedule	20%	40% of Allowed Benefit
Major Services	See Fee Schedule	50%	35% of Allowed Benefit
Orthodontia Services	See Fee Schedule	50%	35% of Allowed Benefit

VISION

The Maryland School for the Blind offers a voluntary vision plan through EyeMed. Every 12 months you are eligible for an eye exam, as well as eyeglass lenses and frames or contact lenses in lieu of eyeglasses. **The benefit period begins on the start of the new plan year, 9/1.**

BENEFITS	*In-Network*	*Out-of-Network Reimbursed up to:*
Eye Exams	$10 copay	$45
Contact Lens Fit/Follow-up	Up to $40	Not Covered
Lens Copay *(single vision, bifocals, trifocals)*	$25 copay	$40-$80
Standard Progressives	$90 copay	$60
Premium Progressives	$110 - $135 Copay	$60
Frames	$130 allowance[1]	$104
Elective Contact Lenses	$110 allowance	$110

[1] *Plus 20% off balance over $130*

Please note: Dental and Vision: *Children may be covered up to age 26.*

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