## ESMEC
## PPO BlueChoice Advantage

**Coverage Period: 09/01/2024 – 08/31/2025**
**Coverage for:** Individual | **Plan Type:** POS

**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: |
|---|---|---|
| **What is the overall deductible?** | In-Network: $0; Out-of-Network: $200 individual/$600 family | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | Yes, all In-Network services are provided without a deductible. | 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. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Medical: In-Network: $800 individual/$2,400 family; Out-of-Network: $800 individual/$2,400 family. Prescription Drug: $5,100 individual/$10,200 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. | 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. | 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. | 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 | Provider:<br>$20 copay per visit<br>Hospital Facility:<br>$40 copay per visit | Provider & Hospital Facility:<br>Deductible, then<br>20% of Allowed Benefit | If a service is rendered at a Hospital Facility, the additional Facility charge may apply |
| | Specialist visit | Provider:<br>$30 copay per visit<br>Hospital Facility:<br>$40 copay per visit | Provider & Hospital Facility:<br>Deductible, then<br>20% of Allowed Benefit | If a service is rendered at a Hospital Facility, the additional Facility charge may apply |
| | Retail health clinic | $20 copay per visit | Deductible, then<br>20% of Allowed Benefit | None |
| | Preventive care/screening/ immunization | No Charge | Deductible, then<br>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 Tests:<br>Non-Hospital:<br>$20 PCP/$30 Specialist copay per visit<br>Hospital:<br>$20 copay per visit<br>X-Ray:<br>Non-Hospital:<br>$20 PCP/$30 Specialist copay per visit<br>Hospital:<br>$20 copay per visit | Lab Tests:<br>Non-Hospital & Hospital:<br>Paid As In-Network<br>X-Ray:<br>Non-Hospital & Hospital:<br>Paid As In-Network | In-Network Lab Test benefits apply only to tests performed at LabCorp. |
| | Imaging (CT/PET scans, MRIs) | Non-Hospital:<br>$20 PCP/$30 Specialist copay per visit<br>Hospital:<br>$20 copay per visit | Non-Hospital & Hospital:<br>Paid As In-Network | 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) | |
| **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 | $8 copay | Paid As In-Network | For all prescription drugs: Prior authorization may be required for certain drugs; No Charge for preventive drugs or contraceptives; Copay applies to up to 34-day supply; Up to 100-day supply of maintenance drugs is 2 copays; Specialty Drugs: Participating Providers: covered when purchased through the Exclusive Specialty Pharmacy Network Non-Participating Providers: Not Covered |
| | Preferred brand drugs | $30 copay | Paid As In-Network | |
| | Non-preferred brand drugs | $45 copay | Paid As In-Network | |
| | Preferred Specialty drugs | $8/$30/$45 copay | Not Covered | |
| | Non-preferred Specialty drugs | $8/$30/$45 copay | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Non-Hospital: No Charge Hospital: $40 copay per visit | Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit | None |
| | Physician/surgeon fees | Non-Hospital & Hospital: $30 copay per visit | Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit | None |
| **If you need immediate medical attention** | Emergency room care | $100 copay per visit | Paid As In-Network | Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply |
| | Emergency medical transportation | No Charge | No Charge | None |
| | Urgent care | $20 PCP/$30 Specialist 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) | $100 per day up to $300 maximum per admission | Deductible, then 20% of Allowed Benefit | Prior authorization is required |
| | Physician/surgeon fees | No Charge | Deductible, then 20% of Allowed Benefit | 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) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit:<br>$20 copay per visit<br>Hospital Facility:<br>$30 copay per visit | Office Visit & Hospital Facility: Deductible, then 20% of Allowed Benefit | For treatment at an Outpatient Hospital Facility, additional charges may apply |
| | Inpatient services | $100 per day up to $300 maximum per admission | Deductible, then 20% of Allowed Benefit | Prior authorization is required; Additional professional charges may apply |
| **If you are pregnant** | Office visits | 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 20% of Allowed Benefit | None |
| | Childbirth/delivery facility services | $100 per day up to $300 maximum per admission | 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 | 20% of Allowed Benefit | Prior authorization is required |
| | Rehabilitation services | Provider:<br>$30 copay per visit<br>Hospital Facility:<br>$40 copay per visit | Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit | If a service is rendered at a Hospital Facility, the additional Facility charge may apply |
| | Habilitation services | Provider:<br>$30 copay per visit<br>Hospital Facility:<br>$40 copay per visit | Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit | Prior authorization is required after the first visit<br>Benefits are limited to Members under the age of 19<br>If a service is rendered at a Hospital Facility, the additional Facility charge may apply |
| | Skilled nursing care | No Charge | Deductible, then 20% of Allowed Benefit | Prior authorization is required |
| | Durable medical equipment | No Charge | Deductible, then 20% of Allowed Benefit | 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) | |
| | Hospice services | Inpatient and Outpatient Facility: No Charge | Inpatient and Outpatient Facility: 20% of Allowed Benefit | Prior authorization is required<br>Hospice Maximum:<br>There must be a willing and able Caregiver available<br>Bereavement:<br>Benefits are limited to 6 months or 15 visits whichever occurs first<br>Respite Care:<br>Benefits are limited to 14 days. Respite Care may be limited to five consecutive days for each inpatient stay |
| **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**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**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** **$0**
- **Specialist *Copayment*** **$30**
- **Hospital (facility) *Copayment*** **$300**
- **Other *Copayment*** **$20**

**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** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $720 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| **The total Peg would pay is** | **$730** |

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

- **The plan's overall deductible** **$0**
- **Specialist *Copayment*** **$30**
- **Hospital (facility) *Copayment*** **$300**
- **Other *Copayment*** **$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)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $650 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$650** |

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

- **The plan's overall deductible** **$0**
- **Specialist *Copayment*** **$30**
- **Hospital (facility) *Copayment*** **$100**
- **Other *Copayment*** **$20**

**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** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $328 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$328** |

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