2024-2025 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 Cigna effective 9/1/24. Through Cigna, you have the choice of 3 comprehensive medical plans. None of the plans require PCP designation or referrals, but you can only seek care outside of Cigna's network on the Open Access Plus Plan (OAP) and may be subject to balance billing on out-of-network services.

SUMMARY OF SERVICES	1 HSA OPEN ACCESS HDHP PLAN (OAPIN)	2 HRA OPEN ACCESS PLUS BASIC (OAPIN)	3 OPEN ACCESS PLUS PLAN (OAP)	
	In-Network	*In-Network*	*In-Network*	*Out-of-Network*
Deductible (Ded) *(Ind. / Family)*	$1,600 / $3,200	$3,000 / $6,000	$750 / $1,500	$2,000 / $4,000
Plan Year Out-of-Pocket Maximum	$3,500 / $7,000	$5,000 / $10,000	$3,500 / $7,000	$7,000 / $14,000
Co-Insurance *(Plan pays / You pay)*	90% / 10%	90% / 10%	90% / 10%	70% / 30%
Employer Funding	HSA Eligible	All Coverage Tiers: $3,000 HRA Funding	None	
Physician / Specialist Visits	Ded., then Co-Ins.	Ded., then $45 / $60 Copay	$50 / $70 Copay	Ded., then 20% Co-Ins.
Emergency Room[1]	Ded., then Co-Ins.	Ded., then $250 Copay	$250 Copay	$250 Copay
Urgent Care	Ded., then Co-Ins.	Ded., then $50 Copay + 10% Co-Ins.	Ded., then $55 Copay + 10% Co-Ins.	Ded., then $55 Copay + 10% Co-Ins.
Referral Required	No	No	No	No
PCP Required	No	No	No	No
PRESCRIPTION DRUGS Generic / Preferred / Non-Preferred				
Retail Pharmacy *(30-day supply)*	Ded., then $15 / $35 / $60	Ded., then $30 / $50 / $70	$35 / $55 / $90	20% Co-Ins.
Mail Order *(90-day supply)*	Ded., then $30 / $70 / $120	Ded., then $60 / $100 / $140	$70 / $110 / $180	20% Co-Ins.

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.

The Maryland School for the Blind

DENTAL

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

DHMO PLAN THROUGH CIGNA

The DHMO 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.

PPO PLAN THROUGH CIGNA

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 bSwift Benefits Portal to view the fee schedule for the DHMO plan, and the detailed benefit summary for further details on the PPO plan.

BENEFITS	1 CIGNA DHMO	2 CIGNA PPO	
	In-Network	*In-Network*	*Out-of-Network*
Annual Deductible *(Ind. / Family)*	None	$25 / $75	$50 / $150
Annual Maximum	N/A	$1,500 (Combined In and Out-of-Network)	
Orthodontia Lifetime Maximum	See Fee Schedule	$1,500 (Combined In and Out-of-Network)	
COVERED SERVICES	**YOU PAY**	**YOU PAY AFTER DEDUCTIBLE**	
Preventive Services	See Fee Schedule	No Charge (Deductible does not apply)	20% of Allowed Benefit (Deductible does not apply)
Basic Services	See Fee Schedule	20%	40% of Allowed Benefit
Major Services	See Fee Schedule	50%	65% of Allowed Benefit
Orthodontia Services *(Children and Adults)*	See Fee Schedule	50%	65% of Allowed Benefit

VISION

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

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 eyeglass lenses. **The benefit period begins on the start of the new plan year, 9/1.**

BENEFITS	1 EYEMED VISION	
	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 Plus 20% off balance over $130	$104
Elective Contact Lenses	$110 allowance	$110

Please note for Medical, Dental, and Vision plans: Dependent children may be covered up to age 26.

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