This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.wcps.k12.md.us or by calling CareFirst BlueCross BlueShield at 1-800-628-8549.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Preferred: $100 Individual; $200 Family Non-Preferred: $200 Individual; $400 Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Preferred: $1,000 Individual; $2,000 Family Non-Preferred: $1,000 Individual; $2,000 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?	Copayments, premiums, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. Please visit www.CareFirst.com or call 1-877-691-5856 for a listing of Preferred Providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes	You need a referral to see a participating **specialist** on this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Please call 800-628-8549 if you aren't clear about any of the bolded terms used in this form, see the Glossary at www.healthcare.gov/glossary.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay	30% coinsurance subject to deductible	none
	Specialist visit	$20 copay	30% coinsurance subject to deductible	none
	Other practitioner office visit	$20 copay for Chiropractic and Acupuncture Services	30% coinsurance subject to deductible for Chiropractic and Acupuncture Services	none
	Preventive care/screening/immunization	No member liability	No benefit	none
If you have a test	Diagnostic test (x-ray, blood work)	Deductible; 0% coinsurance	Deductible; 0% coinsurance	none
	Imaging (CT/PET scans, MRIs)	Deductible; 0% coinsurance	Deductible; 0% coinsurance	none
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.expressscripts.com	Generic drugs	$10	No benefit	Up to a 34 day supply
	Preferred brand drugs	$30	No benefit	Up to a 34 day supply
	Non-preferred brand drugs	$50	No benefit	Up to a 34 day supply
	Specialty drugs	$50	No benefit	Up to a 34 day supply

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible; 0% coinsurance	30% coinsurance subject to deductible	——————none——————
	Physician/surgeon fees	Deductible; 0% coinsurance	30% coinsurance subject to deductible	——————none——————
If you need immediate medical attention	Emergency room services	$50 copay	$50 copay	Copay waived if admitted
	Emergency medical transportation	No member liability	No copay, coinsurance or deductible	——————none——————
	Urgent care	$20 copay	$20 copay	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 per admission copay	30% coinsurance subject to deductible	Preauthorization required 20% non-compliance penalty
	Physician/surgeon fee	Deductible; 0% coinsurance	30% coinsurance subject to deductible	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Facility: $25 copay Office: $20 copay	30% coinsurance subject to deductible	——————none——————
	Mental/Behavioral health inpatient services	$100 per admission copay	30% coinsurance subject to deductible	Preauthorization required 20% non-compliance penalty
	Substance use disorder outpatient services	Facility: $25 copay Office: $20 copay	30% coinsurance subject to deductible	——————none——————
	Substance use disorder inpatient services	$100 per admission copay	30% coinsurance subject to deductible	Preauthorization required 20% non-compliance penalty
If you are pregnant	Prenatal and postnatal care	Deductible; 0% coinsurance	30% coinsurance subject to deductible	——————none——————
	Delivery and all inpatient services	$100 per admission copay	30% coinsurance subject to deductible	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	Deductible; 0% coinsurance	Deductible; 0% coinsurance	90 days of unlimited visits per benefit period Home health aid limited to 40 visits
	Rehabilitation services	Facility: $25 copay Office: $20 copay	30% coinsurance subject to deductible	60 visits combined for Physical, Speech and Occupational Therapies
	Habilitation services	This service may be covered or may have limited coverage, please refer to your contract	This service may be covered or may have limited coverage, please refer to your contract	——————none——————
	Skilled nursing care	Deductible; 0% coinsurance	30% coinsurance subject to deductible	60 days per benefit period
	Durable medical equipment	Deductible; 0% coinsurance	Deductible; 0% coinsurance	——————none——————
	Hospice service	Deductible; 0% coinsurance	Deductible; 0% coinsurance	210 days Lifetime Maximum
If your child needs dental or eye care	Eye exam	Not covered through CareFirst BCBS	Not covered through CareFirst BCBS	Coverage provided through National Vision Administrators at www.e-nva.com
	Glasses	Not covered through CareFirst BCBS	Not covered through CareFirst BCBS	Coverage provided through National Vision Administrators at www.e-nva.com
	Dental check-up	Not covered through CareFirst BCBS	Not covered through CareFirst BCBS	Coverage provided through United Concordia at www.ucci.com

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Cardiac rehabilitation
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture (if prescribed for rehabilitation purposes)
- Chiropractic care
- Infertility treatment
- Private-duty nursing
- Most coverage provided outside the United States. See www.carefirst.com
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 800-628-8549. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 800-628-8549. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 800-628-8549. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,320
- **Patient pays** $220

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$100
Co-pays	$120
Co-insurance	$0
Limits or exclusions	$0
Total	**$210**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,920
- **Patient pays** $480

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$380
Coinsurance	$0
Limits or exclusions	$0
Total	**$480**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.member.carefirst.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Please call 800-628-8549 if you aren't clear about any of the bolded terms used in this form, see the Glossary at www.healthcare.gov/glossary. CareFirst's role is limited to the provision of administrative services only and that CareFirst assumes no financial responsibility for claims arising from these described benefits