Calvert County Public Schools – Traditional Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2024 – 06/30/2025

Coverage for: Individual | **Plan Type: Indemnity**

This Plan is only open to employees hired by CCPS prior to July 1, 2001. 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 more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. 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 view the Glossary at content.carefirst.com/sbc/contracts/APHDBN6BRXMDBN6L.pdf or by logging into My Account

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$100 Individual/$300 Family Does not apply to prescription drugs	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 services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your 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?	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.
What is the out-of-pocket limit for this plan?	$400 Individual; $800 Family; separate $6,200 Individual, $12,400 Family for prescriptions	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, balanced 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.
Will you pay less if you use a network provider?	Yes. See www.carefirst.com or call for a list of network 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 In-Network for providers in their network. See the chart starting on page 3 for how this plan pays different kinds of providers.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

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% after deductible	20% after deductible	For treatment at an Outpatient Hospital Facility, an additional charge may apply
	Specialist visit	20% after deductible	20% after deductible	For treatment at an Outpatient Hospital Facility, an additional charge may apply
	Preventive care/screening/ immunization	No member liability	Charges above CareFirst Allowed Benefit	Some services may have limitations or exclusions based on your contract. OON Deductible does not apply to Well Child Exams, Immunizations or related diagnostic services. Adult Routine Exam: 1 visit maximum per benefit period Routine GYN Exam: 1 visit maximum per benefit period
If you have a test	Diagnostic test (x-ray, blood work)	$0	Charges above CareFirst Allowed Benefit	
	Imaging (CT/PET scans, MRIs)	$0	Charges above CareFirst Allowed Benefit	

[* For more information about limitations and exceptions, see the plan or policy document at [www.carefirst.com/ccps].]

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.[insert].com	Generic drugs	$8 copay (34-day supply) CVS Smart90: $8 copay for a 90-day supply for CVS retail or mail order or $16 copay for a 90-day supply for other retail	Paid As In-Network	If a Member selects a brand name drug when a generic drug is available, the Member will pay the generic drug copayment plus the difference between the generic drug and the brand name drug cost. Prior authorization may be required for certain drugs; no Charge for preventive drugs or contraceptives. In-Network Providers: Specialty Drugs are only covered when purchased through the Accredo Specialty Pharmacy Network Out-of-Network Providers: Specialty Drugs are not covered
	Preferred brand drugs	$15 copay (34-day supply) CVS Smart90: $15 copay for a 90-day supply for CVS retail or mail order or $30 copay for a 90-day supply for other retail	Paid As In-Network	
	Non-preferred brand drugs	$30 copay (34-day supply) CVS Smart90: $30 copay for a 90-day supply for CVS retail or mail order or a $60 copay for a 90-day supply for other retail	Paid As In-Network	
	Specialty drugs	$8 generic; $15 Preferred Brand; $30 Non-Preferred Brand; available only through the Accredo Specialty Pharmacy	Paid As In-Network	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No member liability	Charges above CareFirst Allowed Benefit	
	Physician/surgeon fees	No member liability	Charges above CareFirst Allowed Benefit	
If you need immediate medical attention	Emergency room care	No member liability	20% Coinsurance	

[* For more information about limitations and exceptions, see the plan or policy document at [www.carefirst.com/ccps].]

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)	
	Emergency medical transportation	No member liability	No copay, coinsurance or deductible	Out of network payment limited to allowed benefit amount
	Urgent care	No member liability	No copay, coinsurance or deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	No member liability	Charges above CareFirst Allowed Benefit	Preauthorization required
	Physician/surgeon fees	No member liability	Charges above CareFirst Allowed Benefit	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance subject to deductible	20% coinsurance subject to deductible	
	Inpatient services	No member liability (70 days)	Charges above CareFirst Allowed Benefit	Preauthorization required
If you are pregnant	Office visits	No member liability	20% coinsurance subject to deductible	
	Childbirth/delivery professional services	No member liability	20% coinsurance subject to deductible	
	Childbirth/delivery facility services	No member liability	20% coinsurance subject to deductible	
If you need help recovering or have other special health needs	Home health care	No member liability	No copay, coinsurance or deductible	Limited to 90 days; After 90 days – deductible, the 20% of Allowed Benefit
	Rehabilitation services	20% coinsurance	20% coinsurance subject to deductible	Physical Therapy services are limited to 100 visits per benefit period
	Habilitation services	20% coinsurance	20% coinsurance subject to deductible	Preauthorization required after the initial visit
	Skilled nursing care	No member liability	20% coinsurance subject to deductible	70 days
	Durable medical equipment	20% coinsurance subject to deductible	20% coinsurance subject to deductible	
	Hospice services	No member liability	No copay, coinsurance or deductible	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

[* For more information about limitations and exceptions, see the plan or policy document at [www.carefirst.com/ccps].]

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)
- Hearing aids (Adult)
- Long-term care
- Routine foot care
- Weight loss programs
- Routine eye care (adult)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Most coverage provided outside the United States. See www.carefirst.com
- Non-emergency care when traveling outside the U.S.
- 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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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.

[* For more information about limitations and exceptions, see the plan or policy document at [www.carefirst.com/ccps].]

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	$100
Specialist *coinsurance*	20%
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	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	**$12,735**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$32
Coinsurance	$40
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$232**

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

The plan's overall deductible	$100
Specialist *coinsurance*	20%
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	20%

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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$93
Coinsurance	$207
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$455**

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

The plan's overall deductible	$100
Specialist *coinsurance*	20%
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$90
Coinsurance	$109
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$299**

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