

Medical Health Plan Descriptions

CareFirst BlueCross BlueShield Triple Choice

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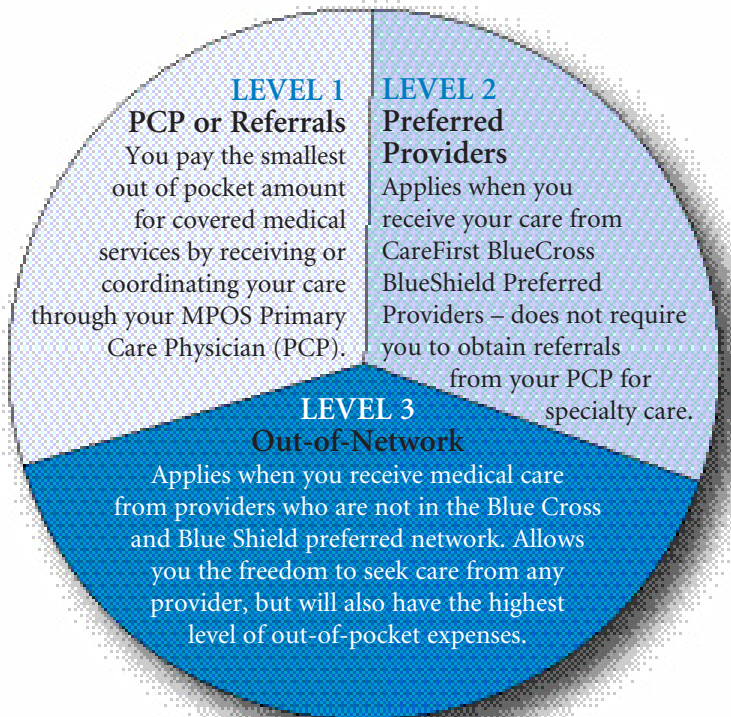
The CareFirst BlueCross BlueShield (CareFirst) Triple Choice plan combines the features of the Preferred Provider (PPO) and Maryland Point of Service plans. Triple Choice is not 3 separate health plans – **rather it is a single plan that allows you to decide who will provide your care and what your share of the cost for the care will be at the time you need medical care.** With Triple Choice, you will make a decision about how much your share of the cost for your care will be each time you receive medical services.

How the Triple Choice Plan for CareFirst BlueCross BlueShield Members Works:

Triple Choice is one health plan, with one set of rates for all members.

- Level 1 is Maryland Point of Service (MPOS)- if care is received through the MPOS Primary Care Physician (PCP) you choose when enrolling in the Plan, or if your PCP refers you for specialty care and out-of-office services, the lowest amount of out-of-pocket expense will apply. In Level 1, office visits are \$10 for primary care. You will pay \$15 for a specialist office visit when your PCP has referred you to that specialist.

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- Level 2 is your access to the Preferred Provider Plan (PPO). You can see any CareFirst Preferred Provider and if that provider is a general practitioner, family medicine practitioner, internist or pediatrician, you will pay just the \$10 copay for office visits. You do not need to use the PCP you chose when enrolling if you want to see a different provider for primary care. You can see Preferred Specialists without a PCP referral and pay \$20 instead of the \$15 you would have paid with a referral for an office visit.
- Level 3 is your out-of-network major medical provisions. You have no restrictions at all on providers. If you choose a provider on your own who is not a CareFirst Preferred Provider, you should verify before receiving care that your provider is at least a Participating Provider with CareFirst. All care in Level 3 requires you to first meet a deductible. After you’ve met the \$300 deductible, Level 3 care is reimbursed at 75% of the CareFirst Allowed Benefit for most of your services.

CareFirst Participating Providers must accept the CareFirst discounted payment amounts. Providers who have no contracts at all with CareFirst are called non-participating providers. These providers have no obligation to accept the CareFirst Allowed Benefit as the basis for their payment – that means you could be paying your 25% share plus any amount a non-participating provider charges in excess of the CareFirst payment.

Out-of-Pocket Maximum Protection

Triple Choice also has an “Out-of-Pocket Maximum” amount to limit the amount of coinsurance and deductible expenses those who need high cost care might experience during the course of any calendar year. Once you reach the out-of-pocket maximum, you will not be responsible for paying coinsurance for the remainder of the calendar year. The individual Out-of-Pocket protection is as follows:

- LEVEL 1 – \$500
- LEVEL 2 – \$1,000
- LEVEL 3 – \$1,500

Office visits are not subject to the annual deductible. You are only responsible for the per visit copay.

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Explanation of Deductible, Coinsurance and Out-of-Pocket Maximums

Most medical services other than care received in the doctor's office require you to pay a share of the cost for medical services in the form of deductible and coinsurance amounts. You can keep your share of those costs at the lowest level (Level 1) by coordinating all your care through your MPOS PCP. Your share of deductible and coinsurance is higher in Level 2 – Preferred Providers. Your share of those costs is the greatest when you see providers who are not affiliated with the CareFirst Preferred Provider network.

- **LEVEL 1– MPOS PCP/referral**
DEDUCTIBLE – \$100/\$200
COINSURANCE – 95%/5%
- **LEVEL 2-Pref/no referral**
DEDUCTIBLE – \$200/\$400
COINSURANCE – 85%/15%
- **LEVEL 3-all other**
DEDUCTIBLE – \$300/\$600
COINSURANCE – 75%/25%

The following is an example of how care would be paid in each of the 3 levels – dependent on the level chosen by a patient needing care at the time it is received.

Assume Jane requires knee replacement surgery in the outpatient department of a hospital. She has 3 choices and her share of the cost will be determined by her choice. If she coordinates everything through her MPOS PCP, she will pay deductible and coinsurance amounts required for Level 1. If she goes directly to a Preferred knee specialist, her deductible and coinsurance amounts will be in Level 2. If she prefers a knee specialist that is not in the CareFirst network, she will be responsible for the highest amount of deductible and coinsurance. The following example assumes that this is the first care she has needed this year outside of office visits.

*Flexible Spending Accounts are especially advantageous for plans that have additional out of pocket expenses, such as deductibles, coinsurance, and copays. See page 22 for details.

The first service Jane needs is an MRI. Diagnostic services are always paid at Level 1 since the patient most often does not choose where Diagnostic services will be rendered. The cost of the MRI is \$1,000. The CareFirst Allowed Benefit for the MRI is \$800. The annual deductible at Level 1 is \$100. Her coinsurance requirement is 5% of the balance after the deductible.

Jane will therefore pay :

Total allowed is \$800

- Level 1 Deductible – \$100
- Level 1 Coinsurance – \$35 (5% of \$700)
- Jane Pays – \$135
- Plan Pays – \$665

The participating MRI center will write off the \$200 difference between the cost of the MRI and the plan's Allowed Benefit.

The second service Jane needs is the outpatient knee surgery. The cost of the knee surgery is \$3,500. The CareFirst Allowed Benefit for the procedure is \$3,000. This is how much Jane would have to pay for the procedure across the 3 levels:

Total allowed is \$3,000

■ LEVEL 1

DEDUCTIBLE – \$100 - already met
COINSURANCE – \$150 (5% of 3,000)
JANE PAYS IN TOTAL – \$150
PLAN PAYS – \$2,850

■ LEVEL 2

DEDUCTIBLE – \$200 - \$100 met
COINSURANCE – \$435 (15% of 2,900)
JANE PAYS IN TOTAL – \$535
PLAN PAYS – \$2,465

■ LEVEL 3

DEDUCTIBLE – \$300 - \$100 met
COINSURANCE – \$700 (25% of 2,800)
JANE PAYS IN TOTAL – \$900
PLAN PAYS – \$1,900

Using the above example, Jane has satisfied \$285 of her \$500 individual maximum this year if she continues to receive Level 1 care. She has satisfied \$670 of her individual maximum this year for Level 2 care. She has satisfied \$1,035 of her Level 3 individual maximum. Once she meets the maximum limit, covered services, other than office visit and prescription copays, will be paid at 100% for the rest of the year.

Prescription Coverage with CareFirst Triple Choice

How are Prescriptions Covered under the CareFirst Triple Choice Plan?

The prescription plan included in the premium cost for Triple Choice is administered by Express Scripts (ESI). When you enroll in Triple Choice, you will receive a separate prescription card to use when you fill your prescription medications.

The Express Scripts plan covers most medications which require a prescription by either State or Federal law and are prescribed by a licensed practitioner.

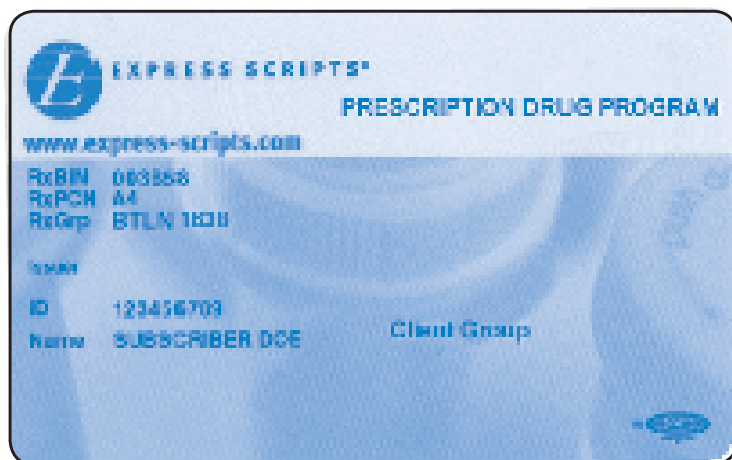
The plan allows for a 34-day supply per copayment and up to a maximum 102-day supply with refills based on your physician's instruction, for acute medications. ESI allows for a 100-day supply of maintenance medications with refills based on your physician's instructions. You may look up drug classifications on the Express Scripts web site.

ESI's network of participating pharmacies can be located by contacting ESI at 800-467-2006 or www.express-scripts.com.

Retail and mail order copayments:

- Generic drug - \$15 copayment
- Brand name drug with no FDA generic equivalent - \$15 copayment
- **Brand name drug that has an FDA generic equivalent - \$15 copayment plus the cost difference between the brand name drug and its generic equivalent regardless of physicians instructions.**
- Some medications currently require prior authorization. This list is subject to periodic review and amendment. Contact ESI if you need additional information about this program.
- The Express Scripts mail order program is through CFI. The CFI Mail Order Program provides you with the convenience of receiving up to a 100-day supply of prescription maintenance medications at your home, for the cost of one copay. To obtain further information about the mail order program or to get an order form, call CFI at 800-233-7139.

ESI Card



Please note: Your copays for a prescription may change during the plan year if a drug is reclassified (i.e., a generic becomes available on the market).

Benefit questions? E-mail benefits@ccbcmd.edu

Mental Health/Substance Abuse Benefits for CareFirst Triple Choice

These benefits apply to members in CareFirst BlueCross BlueShield Triple Choice plan. All services require preauthorization through Magellan Behavioral Health (MBH). Call 800-245-7013 for assistance and preauthorizations.

Mental Health	In-Network (Provider has agreement with Magellan)	Out-of-Network (Provider does not have agreement with Magellan)
Inpatient Care limit: 70 days per 180 day period	Authorized Inpatient Care will be paid at 100% of Magellan Allowed Benefit	Authorized Inpatient Care will be paid at 80% of Magellan Allowed Benefit After Level 3 deductible
Outpatient Care OOPM does not apply	Authorized care/treatments reimbursed as follows: Visit 1-100: 100% allowed amount less \$30 per visit copayment (individual) 100% allowed amount less \$20 per visit copayment (group)	Authorized care/treatments reimbursed as follows: Visit 1-20 - 52% After Level 3 deductible Visit 21-100 - 50% After Level 3 deductible
Substance Abuse	In-Network	Out-of-Network
Inpatient Care Rehabilitation benefits limited to 30 days per year Withdrawal benefits limited to 7 days per year	100% of AB	80% of AB after deductible met
Outpatient Care	100% of AB - first \$3,000 50% of AB - next \$3,000 OOPM does not apply	80% of first \$3,000 after deductible met 40% of next \$3,000 OOPM does not apply
*Magellan Allowed Benefit is the Magellan fee schedule amount for services. Providers who do not have an agreement with Magellan can bill patients for the difference when their charge is more than Magellan Allowed Benefit.		

How do I access my mental health or substance abuse benefits?

Before you receive any inpatient or outpatient care, you must contact Magellan Behavioral Health (MBH) to obtain the name of the participating provider and initiate the pre-certification/authorization process.

1. Call MBH at 800-245-7013.
2. You will be asked for your insurance information to verify eligibility.
3. You will be asked for a brief explanation of your needs so you can be directed to the appropriate type of provider.
4. MBH will give you the names of several MBH participating providers, or they can verify if a particular provider is participating with MBH.
5. Once a MBH provider is selected, you must call MBH with the name of the provider, the first appointment date, and the provider's address to secure authorization for the first visit.
6. A treatment plan needs to be completed by the provider after the first visit. The treatment plan details for what you are seeking care and the planned treatment. The provider completes the treatment plan, and the provider has the responsibility to file all claims.
7. Written approval of the treatment plan will be sent to the policyholder with a copy to the provider. The approval will indicate the number of visits approved, the applicable timeframe, the provider rendering the care and the address to file the claim.
8. Treatment plans will have to be updated by the provider when care extends beyond the approved treatment plan.

This is only a brief overview of Mental Health benefits. Except in cases of extreme emergency, please contact Magellan for preauthorizing care prior to receiving care and for additional information about treatment options and plan providers.