



Retiree Benefits Program Summary

EFFECTIVE

July 1, 2017–June 30, 2018

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Important Resources	Member Services Telephone Number	Web or Claims Mailing Address	
CareFirst BlueCross BlueShield Medical Claims	800-628-8549	www.carefirst.com	Mailroom Administrator PO Box 14651 Lexington, KY 40512
Magellan (Mental Health)	800-245-7013		
CVS Caremark	800-241-3371		
CVS Mail Order Pharmacy	800-745-6285	carefirst.com/rx	
Delta Dental	800-932-0783	deltadentalins.com	PO Box 2105 Mechanicsburg, PA 17055-2105
State Retirement Agency	800-492-5909	www.sra.state.md.us	
Harford County Public Schools Benefits Office	410-588-5275		

What's New for this Plan Year

Changes for 2017–2018

Here is a look at what's changing for 2017:

New insurance premiums

New 2017 insurance premiums are detailed on pages 2–3 of this guide. New premiums are effective July 1, 2017.



Reminder: Social Security Number required

Due to new reporting requirement under the Affordable Care Act we are required to provide reports to the IRS. The IRS requires that the reports include each covered person's, including dependents, social security number (SSN), which is the primary identifier used by the IRS. Therefore we must have the SSN for all enrollees in an HCPS health plan.

Medical and Dental Deductions

Retired Employees

Plan	Total Annual Premium	Retiree Monthly Premium at 100%	BOE % of Annual Cost	Retiree % of Annual Cost	Retiree Monthly Premium
Medical Insurance Rates					
MEDICARE SUPPLEMENTAL			90%	10%	
Supplemental 65	\$6,444.24	\$537.02	\$5,799.82	\$644.42	\$53.70
HMO			95%	5%	
Individual	\$8,880.84	\$740.07	\$8,436.80	\$444.04	\$37.00
Parent & Child	\$17,410.80	\$1,450.90	\$16,540.26	\$870.54	\$72.55
Employee & Spouse	\$20,791.80	\$1,732.65	\$19,752.21	\$1,039.59	\$86.63
Family	\$25,586.40	\$2,132.20	\$24,307.08	\$1,279.32	\$106.61
Supplemental 65	\$5,556.48	\$463.04	\$5,278.66	\$277.82	\$23.15
PREFERRED PROVIDER CORE PLAN			90%	10%	
Individual	\$9,933.36	\$827.78	\$8,940.02	\$993.34	\$82.78
Parent & Child	\$21,468.24	\$1,789.02	\$19,321.42	\$2,146.82	\$178.90
Employee & Spouse	\$25,374.48	\$2,114.54	\$22,837.03	\$2,537.45	\$211.45
Family	\$27,504.96	\$2,292.08	\$24,754.46	\$2,750.50	\$229.21
TRIPLE OPTION			85%	15%	
Individual	\$10,435.92	\$869.66	\$8,870.53	\$1,565.39	\$130.45
Parent & Child	\$22,553.64	\$1,879.47	\$19,170.59	\$3,383.05	\$281.92
Employee & Spouse	\$26,657.40	\$2,221.45	\$22,658.79	\$3,998.61	\$333.22
Family	\$28,895.76	\$2,407.98	\$24,561.40	\$4,334.36	\$361.20
Dental Insurance Rates					
DELTA PREMIER			90%	10%	
Individual	\$259.92	\$21.66	\$233.93	\$25.99	\$2.17
Parent & Child	\$427.32	\$35.61	\$384.59	\$42.73	\$3.56
Employee & Spouse	\$547.44	\$45.62	\$492.70	\$54.74	\$4.56
Family	\$798.36	\$66.53	\$718.52	\$79.84	\$6.65
DELTA PPO			90%	10%	
Individual	\$354.48	\$29.54	\$319.03	\$35.45	\$2.95
Parent & Child	\$581.88	\$48.49	\$523.69	\$58.19	\$4.85
Employee & Spouse	\$746.16	\$62.18	\$671.54	\$74.62	\$6.22
Family	\$1,087.80	\$90.65	\$979.02	\$108.78	\$9.07

Premium deductions will begin in July and coverage will be effective July 1, 2017.

Medical and Dental Deductions

Retired Employees (rates for 7/1/06 hires that retire on or after 8/1/16 with 10 years of service)

Plan	Total Annual Premium	Retiree Monthly Premium at 100%	BOE % of Annual Cost	Retiree % of Annual Cost	Retiree Monthly Premium
Medical Insurance Rates					
MEDICARE SUPPLEMENTAL			1/3	2/3	
			90%	10%	
Supplemental 65	\$6,444.24	\$537.02	\$1,933.27	\$4,510.97	\$375.91
HMO			95%	5%	
Individual	\$8,880.84	\$740.07	\$2,812.27	\$6,068.57	\$505.71
Parent & Child	\$17,410.80	\$1,450.90	\$5,513.42	\$11,897.38	\$991.45
Employee & Spouse	\$20,791.80	\$1,732.65	\$6,584.07	\$14,207.73	\$1,183.98
Family	\$25,586.40	\$2,132.20	\$8,102.36	\$17,484.04	\$1,457.00
Supplemental 65	\$5,556.48	\$463.04	\$1,759.55	\$3,796.93	\$316.41
PREFERRED PROVIDER CORE PLAN			90%	10%	
Individual	\$9,933.36	\$827.78	\$2,980.01	\$6,953.35	\$579.45
Parent & Child	\$21,468.24	\$1,789.02	\$6,440.47	\$15,027.77	\$1,252.31
Employee & Spouse	\$25,374.48	\$2,114.54	\$7,612.34	\$17,762.14	\$1,480.18
Family	\$27,504.96	\$2,292.08	\$8,251.49	\$19,253.47	\$1,604.46
TRIPLE OPTION			85%	15%	
Individual	\$10,435.92	\$869.66	\$2,956.84	\$7,479.08	\$623.26
Parent & Child	\$22,553.64	\$1,879.47	\$6,390.20	\$16,163.44	\$1,346.95
Employee & Spouse	\$26,657.40	\$2,221.45	\$7,552.93	\$19,104.47	\$1,592.04
Family	\$28,895.76	\$2,407.98	\$8,187.13	\$20,708.63	\$1,725.72
Dental Insurance Rates					
DELTA PREMIER			90%	10%	
Individual	\$259.92	\$21.66	\$77.98	\$181.94	\$15.16
Parent & Child	\$427.32	\$35.61	\$128.20	\$299.12	\$24.93
Employee & Spouse	\$547.44	\$45.62	\$164.23	\$383.21	\$31.93
Family	\$798.36	\$66.53	\$239.51	\$558.85	\$46.57
DELTA PPO			90%	10%	
Individual	\$354.48	\$29.54	\$106.34	\$248.14	\$20.68
Parent & Child	\$581.88	\$48.49	\$174.56	\$407.32	\$33.94
Employee & Spouse	\$746.16	\$62.18	\$223.85	\$522.31	\$43.53
Family	\$1,087.80	\$90.65	\$326.34	\$761.46	\$63.46

Premium deductions will begin in July and coverage will be effective July 1, 2017.

Be an Informed Health Care Consumer

Most people are not accustomed to questioning their doctors about the insurance plans they accept, or the cost and medical necessity of a treatment. Knowing what questions to ask and when to ask them makes the process much easier and less stressful! Asking questions of your health care providers helps maintain both the cost and quality of your health care. So it's important for everyone, regardless of the health care option elected, to ask about the medical necessity of any treatment and if there are alternatives to consider.

Here are some tips to help you become a good health care consumer

- Ask your provider or his/her business office if they accept your HCPS health care plan. If they do, evaluate what plan is best for you.
- Make notes in advance of your office visit about the things you want to ask your doctor. Keep a list of any symptoms you have had or are currently experiencing. Keep a list of the medications you take, whether prescriptions or over the counter. Share the list with all health care providers.
- Bring a spouse or friend along with you... chances are if you don't recall something that was said, he or she will!
- Bring a pad and pencil to the doctor's office; don't rely on your memory for everything!
- If your doctor uses a term that you do not understand, ask what it means and ask that it be spelled. Then, write it down and do some more research once you leave the office.
- Get a copy of any test results.
- If your doctor writes a prescription for you, ask your doctor and pharmacist about interactions with other drugs you may be taking or about side effects that you may experience. Remember, if you are taking any maintenance medications, request one prescription for a 30-day supply from a retail pharmacy and another prescription for mail-order. (for up to a 90-day supply, plus up to three refills).

- If you have access to the Internet, use it to learn about your medications or illnesses. The Internet has excellent information on many health-related subjects. One respected resource is **www.webmd.com**. Ask your physician which web-sites they believe are valuable. Be sure to let your physician know your findings.
- Visit **https://share.hcps.org** or **https://hcps.benelogic.com** to link to our health care vendors' websites for more resources.
- Check the vendor websites for details on providers and other useful information.

Help control the cost of health care and promote your well-being

On an almost-daily basis, the rising cost of health care is in the news. Advances in medical technology, expensive prescription drugs, consumer demand, and an aging population are just a few factors that impact health care costs. While some factors are beyond the control of the consumer, there are some things you can do to help keep health care costs down—both for you and for HCPS. Below are a few tips to help you become a wiser consumer of health care.

Maintain a healthy lifestyle

Maintaining your own health can help to minimize your health care costs. The healthier you are, the less likely you are to need costly health care services—which means you spend less on copays, deductibles, and other medical costs. Eat right and get plenty of exercise.

Get regular checkups

Get a regular annual checkup and/or physical exam, which can uncover early warning signs of potential health problems, and can also help you build a good relationship with your doctor.

Save the emergency room for emergencies

Emergency room visits are two to three times more expensive than a visit to the doctor's office or an urgent care center. These ER visits are not only costly, but they can be unnecessarily stressful and time-consuming for you and your family if what you need is routine care. Urgent care facilities are available in the area and may be used for a variety of urgent health problems for a lower copay than the ER.

Get regular screenings

Get regular screenings (e.g., mammograms) as recommended by your carrier and national organizations, such as the American Cancer Society.

Visit a primary care provider before going to see a specialist

Primary care providers are usually family practitioners, general practitioners, internists or pediatricians. A primary care provider can treat many illnesses and injuries at a lower fee—in many cases at half the cost of a specialist's fee. For example, you don't necessarily need to see an orthopedic specialist for back pain. Primary care providers consider your overall health. They can advise you about disease prevention and how to stay healthy. They are also familiar with your personal health history and needs and have your medical records on file.

Ask for Generic

When you need a prescription, ask your doctor to prescribe a generic, if one is available. Generics have the same chemical equivalency as brand-name drugs, and are held to the same standards by the Food and Drug Administration, but they cost less than brand-name drugs.

Review your bills

Reviewing your health care bills can help you identify and prevent unnecessary health care costs. Here's what to look for to determine if a bill is correct:

- Does the date of service on the bill match the date you went to the doctor or the hospital?
- Did you receive all the services or procedures listed on the bill?
- Are you charged for more x-rays or lab work than you received? Call your provider to report any errors you spot on your bills or Explanation of Benefits forms (EOB's).
- Is your share of the cost correct? If not, call the insurance provider to discuss. If there is a referral involved, was the referral processed prior to the claim?

Eligibility Guidelines for Medical & Dental

Dependent children

Dependents are covered to the end of the month in which he or she reaches age 26.

Ineligibility

Any ineligible dependents should be removed from your coverage as soon as they become ineligible. As a reminder we have included a few examples of ineligible dependents:

- Anyone who is not your legal spouse (ex-spouse, fiancé, common-law spouse, etc.)
- Dependents no longer covered by a court order
- Children of live-in partners
- Stepchildren following divorce from natural parent

Dependent Eligibility Documentation Requirements

Relationship to Employee	Eligibility Definition	Documentation for Verification of Relationship
Spouse	A person to whom you are legally married	Copy of Marriage certificate, copy of Social Security card and most recent Federal Tax Form (1040 or 1040A)* that identifies employee-spouse relationship (attach 1st page only & black out financial information) <i>*If marriage occurred in current year, tax form is not needed</i>
Dependent Child(ren)	Dependent children until the end of the month in which they reach age 26	<p>Natural Child – Provide a copy of Social Security card and one of the following:</p> <ul style="list-style-type: none"> ■ Copy of birth certificate showing employee’s name or ■ Hospital verification of birth (must include child's name, date of birth and parents’ names) or ■ Certificate of live birth <p>Step Child – Provide a copy of Social Security card and one of the above showing employee's spouse name; and a copy of marriage certificate showing the employee and parent's name</p> <p>Legal Guardian, Adoption, Grandchild(ren), or Foster Child(ren) –Copy of Final Court Ordered Custody with presiding judge’s signature and seal, or Adoption Final Decree with presiding judge’s signature and seal and a copy of Social Security card</p> <p>Child for whom the court has issued a QMSCO – A copy of the Qualified Medical Child Support Order and a copy of Social Security card</p>
Disabled Dependents	Unmarried dependent children over the age limit if: 1. They are dependent on you for primary financial support and maintenance due to a physical or mental disability, 2. They are incapable of self-support, and 3. The disability existed before reaching age 26 or while covered under the plan.	Copy of Social Security disability award (if a disability ruling by Social Security is pending, include a current copy of the application for disability) and Federal Tax Return for year just filed and copy of Social Security card and Completed Disability Form (Request from Benefits Office)

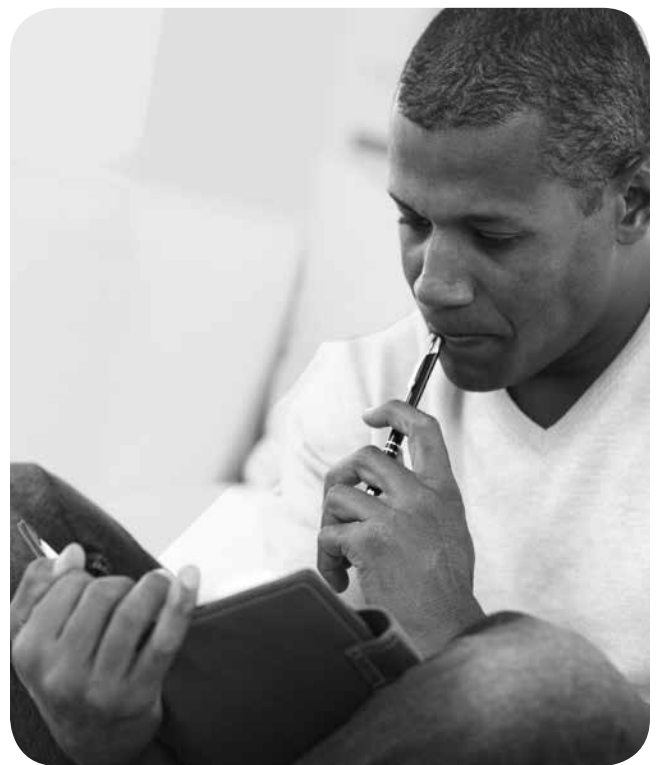
BlueChoice HMO Open Access

An HMO plan with no referrals required

With a BlueChoice HMO *Open Access* plan, your primary care provider (PCP) provides preventive care and works with you to find specialty care using a large network of CareFirst BlueChoice specialists. However, unique to this plan is its Open Access feature which allows you to visit specialists directly without needing a referral from your PCP.

Benefits of BlueChoice HMO Open Access

- Choose from more than 37,000 providers, specialists and hospitals in Maryland, Washington, D.C. and Northern Virginia.
- HMO plans encourage you to establish a relationship with your PCP for consistent, quality care.
- No PCP referral required to see a specialist.
- Receive comprehensive coverage for preventive health care visits at no cost.
- Avoid the unwelcome surprise of high medical costs with predictable copays and deductibles (if applicable).
- Save time—you don't have to file a claim when you receive care from a CareFirst BlueChoice provider.
- Avoid balance billing when you receive care from a CareFirst BlueChoice provider.
- Access the Away from Home Care® program to enjoy plan benefits if you're out of the area for at least 90 days.



The BlueChoice HMO plan achieved a “Commendable” rating from the National Committee for Quality Assurance (NCQA).

How your plan works

Establishing a relationship with one provider is the best way for you to receive consistent, quality health care. When you enroll in a BlueChoice HMO *Open Access* plan, you will select a PCP to manage your primary medical care. Make sure you select a PCP for not only yourself but each of your family members as well. Your PCP must participate in the CareFirst BlueChoice provider network and must specialize in either family practice, general practice, pediatrics or internal medicine.

To ensure you receive the highest level of benefits (and pay the lowest out-of-pocket cost), you should first call your PCP when you need care.

Your PCP will:

- Provide basic medical care.
- Prescribe any medications you need.
- Maintain your medical history.
- Work with you to determine when you should see a specialist.
- Assist you in the selection of a specialist, if needed.

While traditional HMO plans require you to obtain a written referral from your PCP before seeing a specialist, this plan has an Open Access feature, so you have direct access to CareFirst BlueChoice specialists without needing a written referral from your PCP. Make sure you only receive care from a CareFirst BlueChoice provider or you will not be covered, with the exception of emergency services and follow-up care after emergency surgery.

Your benefits

Step 1: Meet your deductible (if applicable)

If your plan requires you to meet a deductible, you will be responsible for the entire cost of services up to the amount of your deductible. Once your deductible is satisfied, your BlueChoice HMO *Open Access* coverage will become available to you. Some services do not require you to meet a deductible first.

If more than one person is covered under your plan, once the total deductible amount is satisfied, the plan will start to make payments for everyone covered. Deductible requirements can vary based on your coverage level (e.g. individual, family) as well as the specific plan selected. Members should refer to their Evidence of Coverage for detailed deductible information.

Step 2: Your plan will start to pay for services

After you satisfy your deductible (if applicable), your plan will start to pay for covered services, as long as you visit participating CareFirst BlueChoice providers and facilities. Please remember, depending on your particular plan, you may have to pay a copay or coinsurance when you receive care.

Step 3: Your out-of-pocket maximum

Your out-of-pocket maximum is the maximum amount you pay during your benefit period. Should you ever reach your out-of-pocket maximum, CareFirst BlueChoice, Inc. will then pay 100% of the allowed benefit for most covered services for the remainder of the benefit period. Any amount you pay toward your deductible (if applicable) and most copays and/or coinsurance will count toward your out-of-pocket maximum.

If more than one person is covered under your BlueChoice HMO *Open Access* plan, once the total out-of-pocket maximum is satisfied, no copays or coinsurance amounts will be required for anyone covered under your plan. Out-of-pocket maximum requirements vary based on your coverage level (e.g. individual, family). Members should refer to their Certificate or Evidence of Coverage for detailed out-of-pocket maximum information.

Laboratory services

To receive the maximum laboratory benefit from your BlueChoice HMO *Open Access* plan, you must use a LabCorp® facility for any laboratory services. Services performed at a facility that is not part of the LabCorp network may not be covered under your plan. Also, any lab work performed in an outpatient hospital setting will require a prior authorization from your PCP.

LabCorp has approximately 100 locations throughout Maryland, Washington, D.C. and Northern Virginia. To locate the LabCorp patient service center near you, call 888-LAB-CORP (522-2677) or visit www.labcorp.com.

Out-of-area coverage

Out-of-area coverage is limited to emergency or urgent care only. However, members and their covered dependents planning to be out of the CareFirst BlueChoice, Inc. service area for at least 90 consecutive days may be able to take advantage of a special program, Away from Home Care®.

This program allows temporary benefits through another Blue Cross and Blue Shield affiliated HMO. It provides coverage for routine services and is perfect for extended out-of-town business or travel, semesters at school or families living apart. For more information on Away from Home Care, please call Member Services at the phone number listed on your identification card.

Away From Home Care®

Your HMO coverage goes with you

We've got you covered when you're away from home for 90 consecutive days or more. Whether you're out-of-town on extended business, traveling, or going to school out-of-state, you have access to routine and urgent care with our Away From Home Care program.

Coverage while you're away

You're covered when you see a provider of an affiliated Blue Cross Blue Shield HMO (Host HMO) outside of the CareFirst BlueChoice, Inc. service area (Maryland, DC and Northern Virginia). If you receive care, then you're considered a member of that Host HMO receiving the benefits under that plan. So your copays may be different than when you're in the CareFirst BlueChoice service area. You'll be responsible for any copays under that plan.

Enrolling in Away From Home Care

To make sure you and your covered dependents have ongoing access to care:

- Call the Member Service phone number on your ID card and ask for the Away From Home Care Coordinator.
- The coordinator will let you know the name of the Host HMO in the area. **If there are no participating affiliated HMOs in the area, the program will not be available to you.**
- The coordinator will help you choose a primary care physician (PCP) and complete the application. Once completed, the coordinator will send you the application to sign and date.
- Once the application is returned, we will send it to your Host HMO.
- The Host HMO will send you a new, temporary ID card which will identify your PCP and information on how to access your benefits while using Away From Home Care.



Always remember to carry your ID card to access Away From Home Care.

- Simply call your Host HMO primary care physician for an appointment when you need care.

No paperwork or upfront costs

Once you are enrolled in the program and receive care, you don't have to complete claim forms, so there is no paperwork. And you're only responsible for out-of-pocket expenses such as copays, deductibles, coinsurance and the cost of non-covered services.

Triple Option

Open Access

Triple Option Open Access offers you the freedom to visit any provider you wish. You have the flexibility to choose from both in- and out-of-network providers with your out-of-pocket costs determined by your choice. There is no need to choose a primary care provider (PCP) or to obtain a referral before visiting a specialist.

Benefits of the Triple Option Open Access Plan

- The ability to visit providers from either our BlueChoice Network, CareFirst PPO Network, National PPO Network or out-of-area providers
- No PCP referral required to see a specialist
- Receive coverage for preventive health care services at no cost
- Take your health care benefits with you—across the country and around the world

How your plan works

With the Triple Option Open Access plan, you can visit any provider of your choosing. Your out-of-pocket costs are determined by who you decide to see.

In-network benefits provide a higher level of coverage, meaning you have lower out-of-pocket costs. **Out-of-network benefits** provide a lower level of coverage in exchange for the freedom to seek care from any provider you choose.

Your in- and out-of-network benefits are organized into three levels of coverage.

Level 1: For your lowest and most predictable in-network out-of-pocket costs, choose a BlueChoice provider. You can visit any of the 37,000 BlueChoice providers within Maryland, Washington, D.C. and Northern Virginia. Visit our online provider directory at www.carefirst.com/doctor to locate in-network providers.

Remember, you have direct access to CareFirst BlueChoice specialists without needing to obtain a referral from your PCP.

Level 2: To receive level 2 in-network benefits, visit a provider who participates in either:

- The CareFirst PPO Network (MD, DC and Northern Virginia)
- or
- The national BlueCard® PPO network of over 600,000 doctors and 61,000 hospitals.

To locate a PPO provider, visit www.carefirst.com/doctor.

Level 3: This level of coverage is out-of-network and offers you the most flexibility. In exchange for a lower level of coverage, you have the freedom to seek care from any provider you choose.

If you receive services from a provider who does not participate in any of the networks listed above, you may have to:

- Pay the provider's actual charge at the time you receive care
- File a claim for reimbursement
- Satisfy a higher deductible and/or coinsurance amount

In general, out-of-network providers do not have an agreement with CareFirst to accept the allowed benefit as payment in full for their services. Therefore, if you receive services from a non-participating provider, you may be balance billed based on the provider's actual charge.

Certain services under this level of coverage require you to meet a deductible. Check your benefits enrollment guide for details. When applicable, you are responsible for the entire cost of your medical care up to the amount of your deductible. Once your deductible is satisfied, your coverage will become available. Depending on the service, you may have to pay a copay or coinsurance when you receive care.

Laboratory services

To receive the maximum laboratory benefit from your Triple Option plan, you must use a LabCorp® facility for any laboratory services. Lab services at any other independent lab will be processed at Level 2 or Level 3 based on the laboratory’s network status. Also, any lab work performed in an outpatient hospital setting will require a prior authorization.

LabCorp has approximately 100 locations throughout Maryland, Washington, D.C. and Northern Virginia. To locate the LabCorp patient service center near you, call 888-LAB-CORP (522-2677) or visit www.labcorp.com.

Hospital authorization

In-network providers will obtain any necessary admission authorizations for in-area (Maryland, Washington, D.C. and Northern VA). You will be responsible for obtaining authorization for services provided by out-of-network and out-of-area admissions. Call toll-free 888-PRE-AUTH (773-2884).

Examples:

Inpatient Hospital Stay Claim					
PROVIDER STATUS/BENEFIT LEVEL	AMOUNT CHARGED	ALLOWED BENEFIT	CAREFIRST BLUECROSS BLUESHIELD PAYS	MEMBER PAYS	
BlueChoice/Level 1	\$14,800	\$8,160	\$8,160	\$0	
PPO/Level 2	\$14,800	\$9,180	\$9,180	\$0	
Participating*/Level 3	\$14,800	\$10,200	\$8,000	\$2,200	\$200 deductible then 20% AB (\$2,000)
Non-participating*/Level 3	\$14,800	\$10,200	\$8,000	\$6,800	\$200 deductible then 20% AB (\$2,000 + balance to charge \$4,600)
Primary Care Provider Office Visit					
PROVIDER STATUS/BENEFIT LEVEL	AMOUNT CHARGED	ALLOWED BENEFIT	CAREFIRST BLUECROSS BLUESHIELD PAYS	MEMBER PAYS	
BlueChoice/Level 1	\$150	\$64	\$54	\$10	Office Visit copay
PPO/Level 2	\$150	\$72	\$57	\$15	Office Visit copay
Participating*/Level 3	\$150	\$80	\$0	\$80	Deductible applied
Non-participating*/Level 3	\$150	\$80	\$0	\$150	\$80 deductible plus balance to charge \$70
Maternity Provider Delivery Charge					
PROVIDER STATUS/BENEFIT LEVEL	AMOUNT CHARGED	ALLOWED BENEFIT	CAREFIRST BLUECROSS BLUESHIELD PAYS	MEMBER PAYS	
BlueChoice/Level 1	\$5,864	\$3,616	\$3,616 (100% AB)	\$0	
PPO/Level 2	\$5,864	\$4,068	\$4,068 (100% AB)	\$0	
Participating*/Level 3	\$5,864	\$4,520	\$3,616	\$904	Deductible was already met 20% AB
Non-participating*/Level 3	\$5,864	\$4,520	\$3,616	\$2,248	Deductible was met 20% AB \$904 + difference to charge \$1344

* Participating Provider—A physician or other provider who has signed an agreement with CareFirst BlueCross BlueShield to accept the Allowed Benefit as payment in full.

Preferred Provider Organization

A referral-free go anywhere health plan

Designed for today's health conscious and busy families, the Preferred Provider Organization (PPO) plan offers one less thing to worry about during your busy day. Your PPO plan gives you the freedom to visit any provider you wish—any time you wish. This means you can receive care from the provider of your choice without ever needing to select a primary care provider (PCP) or obtaining a PCP referral for specialist care.

Benefits of PPO

- Access to our network of more than 43,000 doctors, specialists and hospitals in Maryland, Washington, D.C. and Northern Virginia.
- No primary care provider required, and no referrals to see a specialist.
- Take your health care benefits with you—across the country and around the world.
- Receive coverage for preventive health care visits at no cost.
- Avoid balance billing when you receive care from a preferred provider.
- Enjoy the freedom to visit providers outside of the PPO network and still be covered but with a higher out-of-pocket cost.

How your plan works

In-network vs. out-of-network coverage

The amount of coverage your PPO plan offers depends on whether you see a provider in the PPO network (preferred provider). You will always receive a higher level of benefits when you visit a preferred provider. However, the choice is entirely yours. That's the advantage of a PPO plan.

In-network benefits provide a higher level of coverage. This means you have lower out-of-pocket costs when you choose a preferred provider. If you are out of the CareFirst BlueCross BlueShield (CareFirst) service area, you have the freedom to select any provider that participates with a Blue Cross and Blue Shield PPO plan across the country and receive benefits at the in-network level.



*No referrals.
No PCPs.
Coverage everywhere.*

Preferred Provider Organization

A referral-free go anywhere health plan

Out-of-network benefits provide a lower level of coverage in exchange for the freedom to seek care from any provider you choose. If you receive services from a provider outside of the PPO network (non-preferred provider), you may have to:

- Pay the provider's actual charge at the time you receive care.
- File a claim for reimbursement.
- Satisfy a higher deductible and/or coinsurance amount.

Hospital authorization/ Utilization management

Preferred providers will obtain any necessary admission authorizations for in-area covered services. You will be responsible for obtaining authorization for services provided by non-preferred providers and out-of-area admissions. Call toll-free at (866)—PREAUTH.

Your benefits

Step 1: Meet your deductible

You will be responsible for the entire cost of your medical care up to the amount of your deductible for services where the deductible applies. Once your deductible is satisfied, your PPO coverage will become available to you.

Following is a list of services for which the deductible does NOT apply in-network:

- Preventive care, including well child care, routine physical exam, routine gynecological exam and routine mammography
- Office Visits for Illness
- Physical, Speech and Occupational Therapy
- Chiropractic Care
- Office Visits for Mental Health and Substance Abuse

PPO CORE members will have a different deductible amount for in-network vs. out-of-network benefits. However, any amount applied to your in-network deductible will also count towards your out-of-network deductible and vice versa.

If more than one person is covered under your PPO plan, once the family deductible amount is satisfied, the plan will start to make payments for everyone covered. Deductible requirements vary based on your coverage level (e.g. individual, family). Members should refer to their Evidence of Coverage for detailed deductible information.

Step 2: Your PPO plan will start to pay for services

After you satisfy your deductible, your PPO plan will start to pay for covered services. The level of those benefits will depend on whether you see preferred or non-preferred providers.

Step 3: Your out-of-pocket maximum

Your out-of-pocket maximum is the maximum amount you will pay during your benefit period. Should you reach your out-of-pocket maximum, CareFirst will then pay 100% of the allowed benefit for most covered services for the remainder of the benefit period. Any amount you pay toward your deductible and most copays and/or coinsurance will count toward your out-of-pocket maximum.

You will have a different out-of-pocket maximum for in-network vs. out-of-network benefits. However, deductible amounts applied to your in-network out-of-pocket maximum will also count toward your out-of-network out-of-pocket maximum and vice versa.

If more than one person is covered under your PPO plan, once the total out-of-pocket maximum is satisfied, no copays or coinsurance amounts will be required for anyone covered under your plan. Out-of-pocket maximum requirements vary based on your coverage level (e.g. individual, family) as well as the specific PPO plan selected. Members should refer to their Certificate or Evidence of Coverage for detailed out-of-pocket maximum information.

Out-of-area coverage

You have the freedom to take your health care benefits with you—across the country and around the world. BlueCard® PPO, a program from the Blue Cross and Blue Shield Association, allows you to receive the same health care benefits when receiving care from a BlueCard® preferred provider while living or traveling outside of the CareFirst service area (Maryland, Washington, D.C. and Northern Virginia). The BlueCard® program includes more than 6,100 hospitals and 600,000 other health care providers nationally.

BlueCard®

Wherever you go, your health care coverage goes with you

With your Blue Cross and Blue Shield member ID card, you have access to doctors and hospitals almost anywhere. BlueCard gives you the peace of mind that you'll always have the care you need when you're away from home.



As always, go directly to the nearest hospital in an emergency.

Your membership gives you a world of choices. More than 85% of all doctors and hospitals throughout the U.S. contract with Blue Cross and Blue Shield plans. Whether you need care here in the United States or abroad, you'll have access to health care in more than 190 countries.

When you're outside of the CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. service area (Maryland, D.C., and Northern VA), you'll have access to the local Blue Cross Blue Shield Plan and their negotiated rates with doctors and hospitals in that area. You shouldn't have to pay any amount above these negotiated rates. Also, you shouldn't have to complete a claim form or pay up front for your health care services, except for those out-of-pocket expenses (like non-covered services, deductibles, copayments, and coinsurance) that you'd pay anyway.

Within the U.S.

1. Always carry your current member ID card for easy reference and access to service.
2. To find names and addresses of nearby doctors and hospitals, visit the National Doctor and Hospital Finder at www.bcbs.com, or call BlueCard Access at 800-810-BLUE (2583).
3. Call Member Services for pre-certification or prior authorization, if necessary. Refer to the phone number on your ID card because it's different from the BlueCard Access number listed in Step 2.
4. When you arrive at the participating doctor's office or hospital, simply present your ID card.
5. After you receive care, you shouldn't have to complete any claim forms or have to pay up front for medical services other than the usual out-of-pocket expenses. CareFirst will send you a complete explanation of benefits.



Around the world

Like your passport, you should always carry your ID card when you travel or live outside the U.S. The BlueCard Worldwide program provides medical assistance services and access to doctors, hospitals and other health care professionals around the world. Follow the same process as if you were in the U.S. with the following exceptions:

- At BlueCard Worldwide hospitals, you shouldn't have to pay up front for inpatient care, in most cases. You're responsible for the usual out-of-pocket expenses. And, the hospital should submit your claim.
- At non-BlueCard Worldwide hospitals, you pay the doctor or hospital for inpatient care, outpatient hospital care, and other medical services. Then, complete an international claim form and send it to the BlueCard Worldwide Service Center. The claim form is available online at www.bcbs.com.
- To find a BlueCard provider outside of the U.S. visit www.bcbs.com, select *Find a Doctor or Hospital*.

Medical assistance when outside the U.S.

Call 800-810-BLUE (2583) toll-free or (804) 673-1177, 24 hours a day, 7 days a week for information on doctors, hospitals, other health care professionals or to receive medical assistance services. A medical assistance coordinator, in conjunction with a medical professional, will make an appointment with a doctor or arrange hospitalization if necessary.



Visit www.bcbs.com to find providers within the U.S. and around the world.

Find a Doctor, Hospital or Urgent Care

www.carefirst.com/doctor

It's easy to find the most up-to-date information on health care providers and facilities who participate with CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively CareFirst).

Whether you need a doctor, nurse practitioner or health care facility, www.carefirst.com/doctor can help you find what you're looking for based on your specific needs.

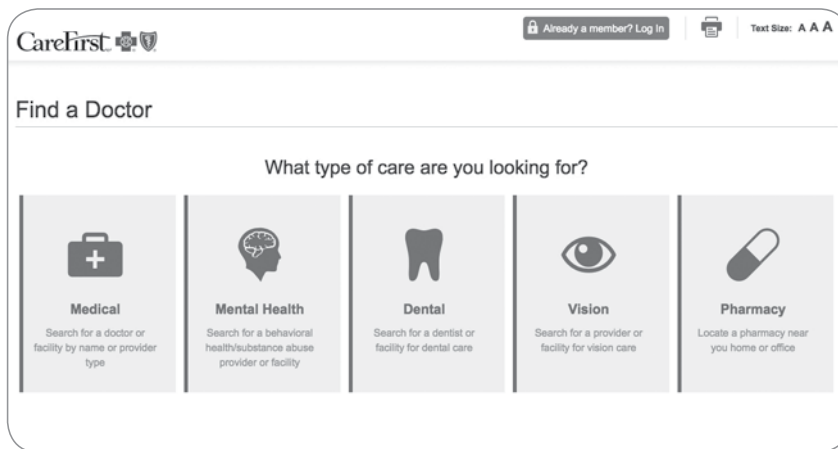
To view personalized information on which doctors are in your network based on your plan, log in to *My Account* on your computer, tablet or smartphone.



The most up-to-date information

Go to www.carefirst.com/doctor. From here you can:

- Find a doctor or provider in your plan.
- Search for a doctor by name.
- Search for a doctor by specialty.



CareFirst Prescription Drug Program

For BlueChoice HMO, Triple Option and PPO Plans

Your pharmacy benefit program is now administered by CVS Caremark. This program is based on the CareFirst Preferred Drug List, formerly formulary, that encourages the use of Generic drugs and certain Brand drugs. You pay a different copay depending on whether you choose a Generic drug, a Brand drug on the Preferred Drug List, or a Non-preferred Brand drug. Always remember to talk to your doctor about using Preferred drugs that can save you money. You and your doctor should check your Preferred Drug List before you receive a prescription.

Retail program

The retail program provides a 34-day or less supply of medication when purchased at a participating retail pharmacy. Present your prescription drug identification card at any participating pharmacy and pay the appropriate copayment for your medication. Maintenance medication when purchased at a participating pharmacy is dispensed up to a 90-day supply for one copay for Triple Option members, two copays for PPO CORE Plan members and three copays for HMO Plan members.

Mail order service prescription program

Your mail order prescription drug program is administered by CVS Caremark. The Mail Order Service Prescription Program is a special added feature to your CareFirst Plan. For those who regularly take one or more types of maintenance medication, this service provides a convenient, inexpensive way for you to order these medications and have them delivered at home.

For Triple Option, you can order up to a 90-day supply of maintenance medication for the \$20 copayment. For PPO CORE, you can order up to a 90-day supply of maintenance medication for 1 times the required copayment (\$10/25/40). For HMO, you can order a 90-day supply of maintenance medication for 2 times the copayment (\$5/15/35). The copayment cannot be reimbursed through your Medical Benefits Plan.



Medications are delivered to your home postage paid via UPS or First Class U.S. Mail.

If you have any questions regarding this prescription service, call the CareFirst Pharmacy Services toll-free telephone number Monday through Friday 8:00 a.m. – 8:00 p.m. and Saturday 8:00 a.m. – 12:00 p.m. at (800) 241-3371.

Refill guidelines

Refills will not be authorized on any prescriptions until 25% or less of the original quantity is remaining in your possession (75% has been used).

Vacation supply

Since your program has a nationwide network, in most cases there are several area participating pharmacies available when on vacation. You may obtain a written prescription from the physician prior to leaving and obtain a list of pharmacies in the area in which you will be traveling.

- If you are traveling out of the country for less than one month, call CareFirst Pharmacy Services at (800) 241-3371 to receive authorization for an additional short-term supply.
- For additional quantities greater than one month, please contact CareFirst Member Services using the number on your ID card.

Please call no less than 10 days in advance of your departure date to request the additional supply.

Non-participating pharmacy

If a pharmacy is non-participating you will be required to pay the full cost of the prescription at the time of purchase. Claims for these prescriptions should be submitted on the appropriate claim form.

CVS Caremark claim forms are available on the CareFirst website at www.carefirst.com or you can contact CareFirst Pharmacy Services at (800) 241-3371.

Generic drug appeal process when medically necessary

1. When members cannot take the Generic medication due to medical reasons, the member's physician would be required to supply medical justification for prescribing the Brand medication.
2. The member's physician must initiate the request process.
3. Requests will be forwarded directly to the Carefirst Pharmacy Management Department. Requests will be reviewed and turned around within 2 business days when submitted during business hours.
4. Once the appeal is received and approval is given by CareFirst pharmacy department, the prescribing physician and the pharmacy are provided notification of the appeal, and the pharmacy will be requested to reprocess the claim.
5. The approval of a Brand medication will be valid for 12 months from the original fill date of the medication.

CareFirst Drug Program

Summary of Benefits

Plan Feature	BlueChoice HMO Open Access	Triple Option	PPO CORE	Description
DEDUCTIBLE	None	None	None	Your benefit does not have a deductible.
FAMILY DEDUCTIBLE MAXIMUM	None	None	None	Your benefit does not have a family deductible maximum.
PREVENTIVE DRUGS (up to a 34-day supply)	\$0	\$0	\$0	A Preventive Drug (not subject to any copay and deductible) is a medication or item on CareFirst's Preventive Drug List that is prescribed under certain medical criteria by a provider under a written prescription for – Aspirin, Folic Acid, Fluoride, Iron Supplements, Smoking Cessation Products, and FDA approved contraceptives for women.
ORAL CHEMOTHERAPY & DIABETIC SUPPLIES (up to a 34-day supply)	\$0	\$0	\$0	Diabetic supplies include needles, lancets, test strips and alcohol swabs.
GENERIC DRUGS (TIER 1) (up to a 34-day supply)	\$5	\$10	\$10	All Generic drugs are covered at this copay level.
PREFERRED BRAND DRUGS (TIER 2) (up to a 34-day supply)	\$15	\$25	\$25	All Preferred Brand drugs are covered at this copay level.
NON-PREFERRED BRAND DRUGS (TIER 3) (up to a 34-day supply)	\$35	\$40	\$40	All Non-preferred Brand drugs are covered at this copay level. If you choose a Non-preferred brand drug (Tier 3) instead of its Generic equivalent, you will pay the highest copay plus, the difference in cost between the Non-preferred Brand drug and the Generic. These drugs are not on the Preferred Drug List. Check the online Preferred Drug List to see if there is an alternative drug available. Discuss using alternatives with your physician or pharmacist.
MAINTENANCE COPAYS (up to a 90-day supply)				Maintenance drugs of up to a 90-day supply are available through Rx Mail Order or retail pharmacy.
Mail Order:				
Generic	\$10	\$20	\$10	
Preferred	\$30	\$20	\$25	
Non-preferred	\$70	\$20	\$40	
Retail:				
Generic	\$15	\$10	\$20	
Preferred	\$45	\$25	\$50	
Non-preferred	\$105	\$40	\$80	
PRIOR AUTHORIZATION	Yes	Yes	Yes	Some prescription drugs require Prior Authorization. Prior Authorization is a tool used to ensure that you will achieve the maximum clinical benefit from the use of specific targeted drugs. Your physician or pharmacist must call (800) 294-5979 to begin the prior authorization process. For the most up-to-date prior authorization list, visit the prescription drug website at www.carefirst.com/rx .
MANDATORY GENERIC SUBSTITUTION	Yes	Yes	Yes	If you choose a Non-preferred Brand drug (Tier 3) instead of its Generic equivalent, you will pay the highest copay plus, the difference in cost between the Non-preferred Brand drug and the Generic. If a Generic version is not available, you will only pay the copay.

Rx Drug Program—3 Tiers

A total prescription for health

Prescription drugs are an integral part of high-quality health care. The prescription benefits your employer is offering give you an affordable and convenient way to make the best decisions when it comes to your prescriptions.

Your Rx benefits

As a CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc. (CareFirst) member, you have access to:

- A nationwide network with more than 60,000 participating pharmacies
- Nearly 5,000 drugs
- Mail Service Pharmacy, our convenient, fast and accurate mail order drug program
- Coordinated medical and pharmacy programs to help improve your overall health and reduce costs
- Personalized notices detailing cost savings opportunities, safety alerts and other important drug information

How your plan works

A formulary is a list of covered prescription drugs. Our drug list is reviewed and approved by an independent national committee comprised of physicians, pharmacists and other health care professionals who make sure the drugs on the formulary are safe and clinically effective.



Talk to your doctor to make sure you are using drugs on CareFirst's Preferred Drug List. Remember, you'll save the most money when using drugs on the Preferred Drug List.

The prescription drugs found on the CareFirst Formulary (drug list) are divided into tiers. These tiers include no cost drugs, generics, preferred brand and non-preferred brand name drugs and the price you pay is determined by the tier the drug falls into.

Drug tier (Cost-share)	Definition	More information
No cost drugs (preventive drugs)	The Affordable Care Act (ACA) classifies certain drug therapies as “preventive” if they reduce the risk of some serious health conditions.	Preventive drugs (aspirin, folic acid, fluoride, iron supplements, smoking cessation products and FDA-approved contraceptives for women) are available at no cost if prescribed under certain medical criteria by your doctor.
Tier 1 You pay: lowest copay (\$)	Generic drugs	Generic drugs will be in Tier 1.
Tier 2* You pay: higher copay (\$\$)	Preferred brand drugs	If a generic version of a Tier 2 drug is released then: The generic drug is added to Tier 1. The brand drug moves to Tier 3 and becomes a non-preferred brand drug.
Tier 3* You pay: highest copay (\$\$\$)	Non-preferred brand drugs	Drugs in this tier will cost the most.

* Self-Injectable drugs are covered under Tier 2 or Tier 3 in three-tier designs.

Note: If the cost of your medication is less than your copay or coinsurance, you only pay the cost of the medication. Once you meet your deductible (if applicable to your plan), you may pay a different copay or coinsurance amount for drugs depending on if you use generic, preferred brand or non-preferred brand drugs. Check your benefit summary or enrollment materials for specific plan information. Once you are a member, you can view specific cost-share information in *My Account*.

Preferred Drug List

CareFirst has identified a Preferred Drug List that may save you money. The list includes generic and preferred brand drugs selected for their quality, effectiveness, safety and cost by an independent CVS/caremark¹ national Pharmacy and Therapeutics (P&T) committee.

- By using the CareFirst Preferred Drug List, you can work with your doctor or pharmacists to make safe and cost-effective decisions to better manage your health care and costs.
- Even though non-preferred drugs aren't part of the Preferred Drug List, they're still covered, but at the highest cost-share. Go to www.carefirst.com/rxgroup to view the entire formulary.

Two ways to fill

Retail pharmacies

With access to more than 60,000 pharmacies across the country, you can visit www.carefirst.com/rxgroup and use our *Find a Pharmacy* tool to locate a convenient participating pharmacy. Be sure to take your prescription and member ID card with you when filling prescriptions.

Mail Service Pharmacy

Mail Service Pharmacy is a convenient way to fill your prescriptions, especially for refilling medications taken frequently. You can register three ways—online through *My Account*, by phone or by mail. Once you register for Mail Service Pharmacy you'll be able to:

- Refill prescriptions online, by phone or by email
- Choose your delivery location

¹ CVS/caremark is an independent company that provides pharmacy benefit management services.

Rx Drug Program—3 Tiers

A total prescription for health

- Consult with pharmacists by phone 24 hours a day, seven days a week
- Schedule automatic refills
- Receive email notification of order status
- Choose from multiple payment options

Prescription guidelines

In addition, some medications are only intended to be used in limited quantities; others require that your doctor obtain prior authorization through CareFirst before they can be filled. These drug provisions are indicated on the formulary found on www.carefirst.com/rxgroup.

- **Quantity limits** have been placed on the use of selected drugs for quality, safety or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.
- **Prior authorization** is required before you fill prescriptions for certain drugs. Your doctor must obtain prior authorization from CareFirst before these drugs are covered.
- **Step therapy** asks that you try lower-cost, equally effective drugs that treat the same medical condition before trying a higher-cost alternative. Your physician can speak to your experience with these alternatives prior to dispensing a more expensive drug.

Care management

Take advantage of the following programs and resources available at no cost to you with your CareFirst prescription drug plan.

Specialty Pharmacy Coordination Program

The specialty pharmacy program provides personalized care for our members with certain chronic conditions requiring specialty medications. Working together, we can help you achieve the best possible results from your specialty medication therapy.

Personal Attention

The more you know about your health condition, the better you can successfully manage it. Our specialty customer care team works together with your doctors and case managers to provide you with in-depth support and service for your particular condition. We offer:

- One-on-one therapy support with a registered nurse for certain chronic conditions like multiple sclerosis, hepatitis C, hemophilia, and selected autoimmune diseases
- Injection training coordination
- Medications mailed to your home or office, or available for pick up at any CVS retail pharmacy
- 24-hour pharmacist assistance
- Educational materials for your specific condition
- Drug interaction monitoring and review
- Refill reminders

To take full advantage of these program benefits, your specialty medications must be filled through the CVS/caremark Specialty Pharmacy².

Comprehensive Medication Review (CMR)

Medication complications cause 10% of hospital admissions³. The Comprehensive Medication Review program seeks to reduce prescription drug-related complications, and related hospitalizations, and ensure the best possible outcomes for members with high potential for medication-related issues. If you are identified for the program, a dedicated team of pharmacists will collaborate with you and your doctor(s) to review and evaluate:

- Possibilities for drug interactions
- Opportunities to support medication adherence
- Cost effective therapy
- Gaps in care
- Duplications in drug therapy

The program's one-on-one support ensures you are not only taking the most favorable drug therapy to manage your conditions, but you are also able to take your medications as prescribed.

Medication Therapy Management (MTM) program

Taking medications as prescribed not only helps improve your health but can also reduce health care costs. Working together with CVS/caremark, CareFirst’s MTM program is designed to help you get the best results from your medication therapy.

We review pharmacy claims for opportunities to:

- Save you money;
- Support compliance with medications;
- Improve your care; and
- Ensure safe use of high risk medications.

When opportunities are identified, “Drug Advisories” are mailed to you and/or your providers outlining potential for savings for any medication-related issues. You may also have the opportunity to speak one-to-one with pharmacist, through the Pharmacy Advisor program, who can answer questions and help you manage your prescription medications.

Online tools and resources

To get the most from your prescription drug plan, you need to stay informed. Our easy-to-use, interactive tools and resources are available 24 hours a day, seven days a week. Visit www.carefirst.com/rxgroup to see if a drug is covered, find a pharmacy, learn how drugs interact with each other and get more information about medications. You can access even more tools and resources once you’re a member through *My Account*.

Keeping you informed

Our pharmacy benefit manager, CVS/caremark, keeps you informed about your prescription drug coverage and provides you with periodic updates about your plan through targeted mailings. You could get notices about lower cost drug alternatives, alerts about possible safety concerns, drug tier changes and more.

Ways to save

Here are some ways to help you save on your prescription drug costs.

- **Use generic drugs**—generic drugs can cost up to 80 percent less than their brand-name counterparts. Made with the same active ingredients as their brand-name counterparts, generics are also equivalent in dosage, safety, strength, quality, performance and intended use.
- **Use drugs on the Preferred Drug List**—the Preferred Drug List identifies generic and preferred brand drugs that may save you money.
- **Use maintenance medications**—maintenance medications are drugs you take regularly for ongoing conditions such as diabetes, high blood pressure or asthma. You can get up to a three-month supply of your maintenance medications for the cost of two copays through any pharmacy in the network, including through mail order.
- **Use mail order**—by using our Mail Service Pharmacy you get the added convenience of having your prescriptions delivered right to your home. Plus, if you pay a coinsurance for your maintenance drugs, the overall cost of the drug may be less expensive through mail order, reducing your out-of-pocket costs.

Should you have any questions about your prescription benefits, please call CareFirst Pharmacy Services at 800-241-3371.

BlueVision

Discounts included when you elect BlueChoice or Triple Option medical plans

Professional vision services including routine eye examinations, eyeglasses and contact lenses offered by CareFirst BlueChoice, through the Davis Vision, Inc. national network of providers.

How the plan works

How do I find a provider?

To find a provider, go to www.carefirst.com and utilize the *Find a Provider* feature or call Davis Vision at **800-783-5602** for a list of network providers closest to you. Be sure to ask your provider if he or she participates with the Davis Vision network before you receive care.

How do I receive care from a network provider?

Simply call your provider and schedule an appointment. Identify yourself as a CareFirst BlueChoice member and provide the doctor with your identification number, as well as your date of birth. Then go to the provider to receive your service. There are no claim forms to file.

Can I get contacts and eyeglasses in the same benefit period?

With BlueVision, you receive one pair of eyeglasses or a supply of contact lenses per benefit period at a discounted price.¹

Mail order replacement contact lenses

DavisVisionContacts.com offers members the flexibility to shop for replacement contact lenses online after benefits are spent. This website offers a wide array of contact lenses, easy, convenient purchasing online and quick shipping direct to your door.



Need more information?
Please visit
www.carefirst.com or
call **800-783-5602**.

¹As of 4/1/14, some providers in Maryland and Virginia may no longer provide these discounts.

Summary of Benefits *(12-month benefit period)*

In-Network	You Pay
EYE EXAMINATIONS¹	
Routine Eye Examination with dilation (per benefit period)	\$10
FRAMES^{1,2}	
Priced up to \$70 retail	\$40
Priced above \$70 retail	\$40, plus 90% of the amount over \$70
SPECTACLE LENSES²	
Single Vision	\$35
Bifocal	\$55
Trifocal	\$65
Lenticular	\$110
LENS OPTIONS^{2,3} (add to spectacle lens prices above)	
Standard Progressive Lenses	\$75
Premium Progressive Lenses (Varilux®, etc.)	\$125
Ultra Progressive Lenses (digital)	\$140
Polarized Lenses	\$75
High Index Lenses	\$55
Glass Lenses	\$18
Polycarbonate Lenses	\$30
Blended Invisible Bifocals	\$20
Intermediate Vision Lenses	\$30
Photochromic Lenses	\$35
Scratch-Resistant Coating	\$20
Standard Anti-Reflective Coating	\$45
Ultraviolet (UV) Coating	\$15
Solid Tint	\$10
Gradient Tint	\$12
Plastic Photosensitive Lenses	\$65
CONTACT LENSES^{1,2}	
Contact Lens Evaluation and Fitting	85% of retail price
Conventional	80% of retail price
Disposable/Planned Replacement	90% of retail price
DavisVisionContacts.com Mail Order Contact Lens Replacement Online	Discounted prices
LASER VISION CORRECTION²	Up to 25% off allowed amount or 5% off any advertised special ⁴

¹ At certain retail locations, members receive comparable value through their everyday low price on examination, frame and contact lens purchase.

² CareFirst BlueChoice does not underwrite lenses, frames and contact lenses in this program. This portion of the Plan is not an insurance product. As of 4/1/14, some providers in Maryland and Virginia may no longer provide these discounts.

³ Special lens designs, materials, powers and frames may require additional cost.

⁴ Some providers have flat fees that are equivalent to these discounts.

Exclusions

The following services are excluded from coverage:

1. Diagnostic services, except as listed in *What's Covered* under the Evidence of Coverage.
2. Medical care or surgery. Covered services related to medical conditions of the eye may be covered under the Evidence of Coverage.
3. Prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage or a rider or endorsement purchased by your Group and attached to the Evidence of Coverage.
4. Services or supplies not specifically approved by the Vision Care Designee where required in *What's Covered* under the Evidence of Coverage.
5. Orthoptics, vision training and low vision aids.
6. Glasses, sunglasses or contact lenses.
7. Vision Care services for cosmetic use.
8. Services obtained from Non-Contracting Providers.

For BlueChoice Opt-Out Plus members, Vision Care benefits are not available under the Out-of-Network Evidence of Coverage.

Exclusions apply to the Routine Eye Examination portion of your vision coverage. Discounts on materials such as glasses and contacts may still apply.

Benefits issued under policy form numbers: MD/BC-OOP/VISION (R. 6/04) • DC/BC-OOP/VISION (R. 6/04) • VA/BC-OOP/VISION (R. 6/04)

Patient-Centered Medical Home

Focusing on you and your health

Whether you're trying to get healthy or stay healthy, you need the best care available. That's why the CareFirst BlueCross BlueShield¹ family of health plans has created a program to improve health care quality and help slow rising health care costs over time.

Our Patient-Centered Medical Home (PCMH) program focuses on the relationship between you and your primary care provider (PCP)—whether a physician or nurse practitioner (NP). It's designed to provide your PCP² with a more complete view of your health needs, as well as the care you're receiving from other providers. As the leader of your health care team, your PCP will be able to use this information to better manage and coordinate your care, a key to better health.

Treating your overall health

Whether you see your PCP for preventive care, or you need more care, your PCP is expected to:

- Coordinate your care with all your health care providers, including specialists, labs, pharmacies, and mental health facilities to help you get access to, and receive, the most appropriate care available in the most affordable settings.
- Identify and address any impact the care you receive for one health issue may have on another.
- Review all of your medications and possible drug interactions with you.
- Review your health records for duplicate tests or services already ordered or performed by another provider.



Why a PCP is important to your health

By visiting your PCP for routine visits as recommended, you can build a relationship, and your PCP will get to know you and your medical history.

A PCP is concerned with your overall health. If you have an urgent health issue, having a PCP who knows your health history often makes it easier and faster to get the care you need. Your PCP can sometimes provide advice over the phone or fit you in for a visit. That helps you avoid long lines and expensive charges at the emergency room.

When you visit your PCP for screenings and preventive services, he or she can detect health concerns in the early stages, when they are easier and less costly to treat.

¹ All references to CareFirst refer to CareFirst BlueCross BlueShield and CareFirst, BlueChoice, Inc., collectively.

² The doctors and other medical providers, who provide your care, are independent providers making their own medical determinations and are not employed by either CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc.

Patient-Centered Medical Home

Focusing on you and your health

If you have a chronic condition, or are at risk for one, your PCP may:

- Create a Care Plan based on your health needs with specific follow-up activities to help you manage your health.
- Provide access to a care coordinator, who is a registered nurse (RN), so you have the support you need, answers to your questions and information about your care.

Extra care for certain health issues

When you participate in PCMH, your PCP will take specific steps to coordinate and manage your care. If you have certain health issues, your PCP will create an online record of your health needs with specific follow-up activities.

Your care coordinator is expected to:

- Assist your PCP by coordinating your care and answering your questions.
- Follow up with you to make sure you're not having problems following your treatment plan. For example, if you have diabetes, the care coordinator can help you take steps to better understand and control your diabetes.
- Assist you in obtaining services and equipment necessary to manage your health condition.

It's your choice

PCMH is a voluntary program. When you participate:

- You pay no additional premium.
- There is no change in your benefits.
- There is no change to your health plan requirements.
- You can opt-out at any time without penalty and without changing your PCP and/or NP.

Please note that if you have a high deductible health plan, certain charges may apply until you meet your deductible.



How do I get started?

Simply sign the Election to Participate form and return it to your PCP.

You can get the form from your PCP, or you can download it from the Forms section at www.carefirst.com/memberpcmh. By signing the election form, you agree to give your PCP access to your health information on file with CareFirst. This includes data from claims and notes from any CareFirst programs in which you have participated.

Health & Wellness

Take charge

Whether you're looking for health and wellness tips, discounts on health-related services, or support to manage a health condition, we have the resources to help you get on the path to better well-being.

With our Health & Wellness program you can

- Become aware of unhealthy habits.
- Improve your health with programs that target your specific health or lifestyle issues.
- Access online tools to help you get and stay healthy.
- Manage chronic conditions and deal with unexpected health issues.

15 minutes can help improve your well-being

When it comes to your health, it's important to know where you stand. You can get an accurate picture of your health status with our confidential, online assessment. 24 hours after you complete the survey, you'll receive your personalized well-being score, along with a link to create your own personal well-being plan.

Take your well-being assessment today—these may be the most important questions you'll ever answer! Get started by logging in to *My Account* at www.carefirst.com/myaccount. Next, click on *Health Assessment and Online Coaching* under *Quick Links*.

Getting healthy

Based on your results after completing the well-being assessment, a health coach may contact you to discuss your results. The health coach will refer you to the appropriate resources, tools and programs that can guide you toward better health.

Health Coaching

Participate in confidential lifestyle and health coaching programs to help improve your health. Your coach will monitor your progress and provide support with programs like tobacco cessation, weight loss and disease management for conditions like diabetes or chronic obstructive pulmonary disease.

Online health and wellness tools

Looking for tools and resources that empower you to take action, stay connected and get inspired? Log in to *My Account* at www.carefirst.com/myaccount to take advantage of

Well-Being Connect™, our wellness portal:

- **Well-Being Plan**—A personalized, easy-to-navigate interactive plan including recommendations and focus areas to help keep you on track.
- **Resource Center**—Find a library of articles, videos and other resources specific to your interests and focus areas.
- **Trackers**—Record daily behaviors and check your progress for weight, exercise, medication, tobacco use, healthy eating and more. Share within your community group or on Facebook.
- **Social Networking**—Join chat sessions, update group activities and share information, personal stories, tips and successes even on Facebook.
- **Recipe Center**—Search thousands of healthy meal ideas, including cuisine-specific recipes and menus that map out calories and nutrition.
- **Message Center**—Receive health tips, activity tracker reminders and encouraging emails.

Vitality magazine

Vitality provides information about your health plan and includes articles on health and wellness topics, including nutrition, physical fitness and preventive health.

Wellness discount program

Blue365 delivers great discounts from top national and local retailers on fitness gear, gym memberships, family activities, healthy eating options and more.

Coordinating your care

Whether you're trying to get healthy or stay healthy, you need the best care. CareFirst has programs to help you take an active role in your health, address any health care issues and enjoy a healthier future.

Patient-Centered Medical Home (PCMH)

PCMH was designed to provide your primary care provider (PCP) with a more complete view of your health needs, as well as the care you receive from other providers. When you participate in this program, you are the focus of an entire health care team whose goal is to keep you in better health and manage any current or potential health risks.

If you have a chronic condition, or are at risk for one, your PCP may:

- Create a care plan based on your health needs with specific follow-up activities to help you manage your health.
- Provide access to a care coordinator, who is a registered nurse, so you have the support you need, answers to your questions and information about your care.

Find a participating PCMH provider in our provider directory at www.carefirst.com/findadoc.

Case Management

If you have a serious illness or injury, our Case Management program can help you navigate the health care system and provide support along the way. Our case managers are registered nurses who will:

- Work closely with you and your doctors to develop a personalized treatment plan.



Don't forget to take your well-being assessment to get an immediate picture of your health.

- Coordinate necessary services.
- Answer any of your questions.

Our Case Management program is voluntary and confidential. For more information, or to enroll, call 888-264-8648.

Mental Health Benefits

All CareFirst Plans

Participants enrolled in the CareFirst medical plans must use Magellan's Behavioral Health Plan for inpatient mental health services. To receive benefits, all participants must certify their care at 1-800-245-7013 before they may access mental health services. Magellan can help you and your eligible family members with a variety of issues including, but not limited to, depression, stress, and alcohol and drug abuse.

A Magellan representative will help you access care within the Magellan network, certify your care, and/or provide authorization to non-participating providers if necessary. Visit www.magellanhealth.com for more information on accessing care and providers, as well as wellness topics and self-assessment tools and resources.

Mental Health Support

Well-being for mind and body

Living your best life involves good physical and mental health. Emotional well-being is important at every stage in life, from adolescence through adulthood.

It's common to face some form of mental health challenge during your life, caused by a variety of reasons, many of which are beyond your control. Some of the contributing factors include:

- Biology, such as genes, brain chemistry, physical illness or injury
- Life experiences, such as trauma, tragedy or abuse
- Family history

When mental health difficulties arise for you or a loved one, remember you are not alone. Help is available and feeling better is possible.

Our partner, Magellan* Healthcare, offers specialized services and programs to help you get well, if and when you need assistance related to:

- Depression
- Drug or alcohol dependence
- Stress
- Work-life balance
- Eating disorders



One in five American adults has experienced a mental health issue.¹

If you or someone close to you needs support or help making an appointment, call Magellan Healthcare at 800-245-7013.

* Magellan Healthcare is an independent company that provides managed behavioral health services to CareFirst BlueCross BlueShield and CareFirst BlueChoice members. Magellan Healthcare does not provide Blue Cross Blue Shield products or services.

¹ United States Department of Health and Human Services. *Mental Health Myths and Facts*. Accessed August 21, 2015 at: <http://www.mentalhealth.gov/basics/myths-facts/index.html>.

Connecting to support

Magellan Customer Service associates can answer your questions and connect you to the services and programs that best fit your needs, including:

Appointment assistance

The associate can help you find a provider or transfer you to a *My Care Link Up* specialist to help you schedule an appointment.

Telehealth services are also available. Telehealth allows you and your behavioral health provider to communicate via an online appointment. Receive the same services as an in-person visit (including prescribing medication, if appropriate) via a secure, private online connection.

Note: to access this service, you will need a computer with a webcam and high-speed Internet.

Assistance with outpatient and non-emergency services is available Monday through Friday, 8 a.m. to 6 p.m. ET.

Emergency and inpatient services

Care managers are available 24-hours a day, seven days a week to assist you with a clinical emergency or an inpatient prior authorization.

Case management

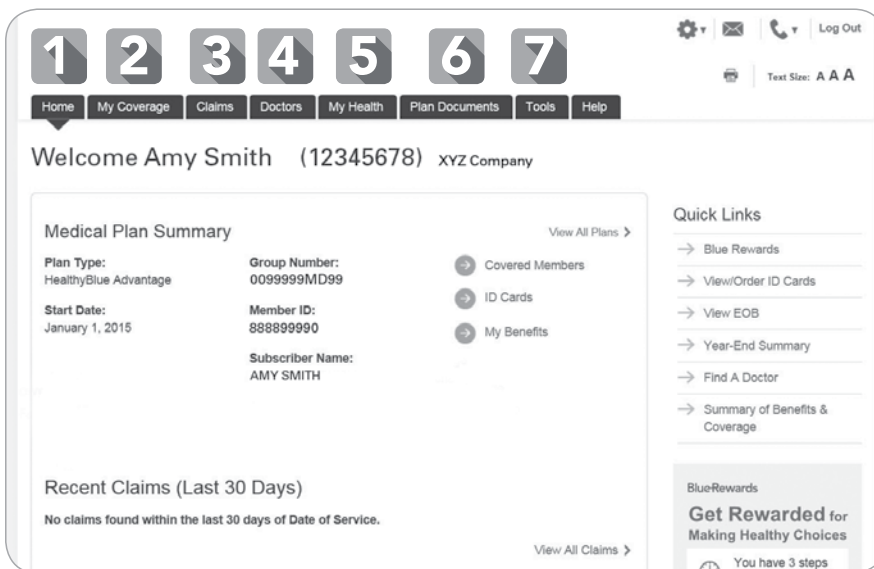
Additional support is available through the mental health and substance abuse case management program. A personal care coordinator will discuss your situation with you, determine an appropriate treatment plan and help you work toward individualized goals to improve your health. (**Note:** Parents or guardians can provide the necessary information for minors).

If you are more comfortable discussing your concerns with your primary care provider (PCP) first, he or she may contact Magellan on your behalf. Just remember, help is available by calling Magellan Healthcare at 800-245-7013.

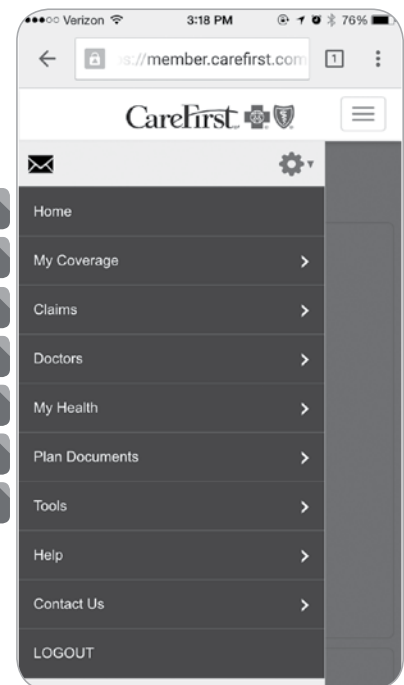
My Account

Online access to your health care information

View your personalized health insurance information online with *My Account*. Simply log on to **www.carefirst.com** from your computer, tablet or smartphone for real-time information about your plan.



As viewed on a computer.



As viewed on a smartphone.

My Account at a glance

1. Home

- Quickly view your coverage, deductible, copays, claims and out-of-pocket costs
- Use *Settings* ⚙️ to manage your password and communications preferences
- Access the Message Center ✉️

2. My Coverage

- Access your plan information, including who is covered
- Update your other health insurance info
- View/order ID cards
- Order and refill prescriptions^{1,2}
- View prescription drug claims^{1,2}
- Find a pharmacy¹
- Oversee your BlueFund account

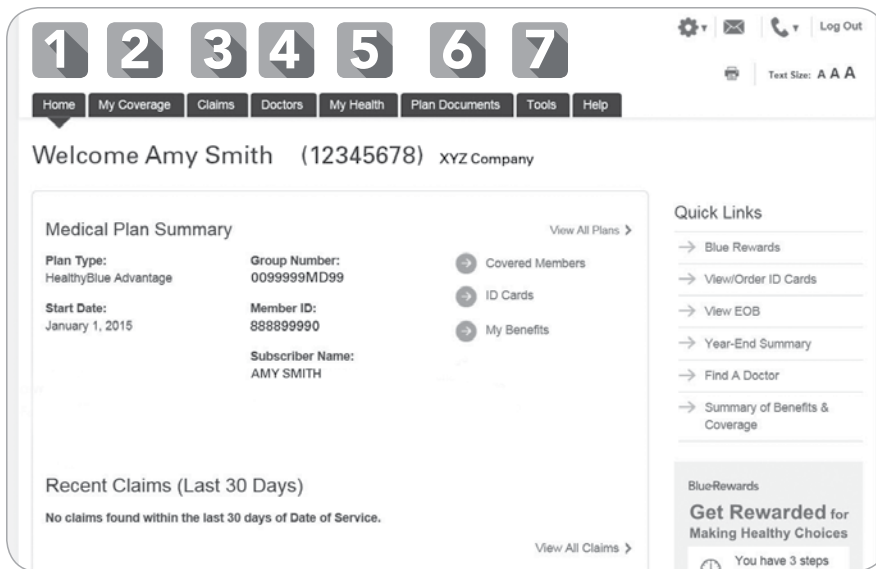
Signing up is easy

Information included on your member ID card will be needed to set up your account.

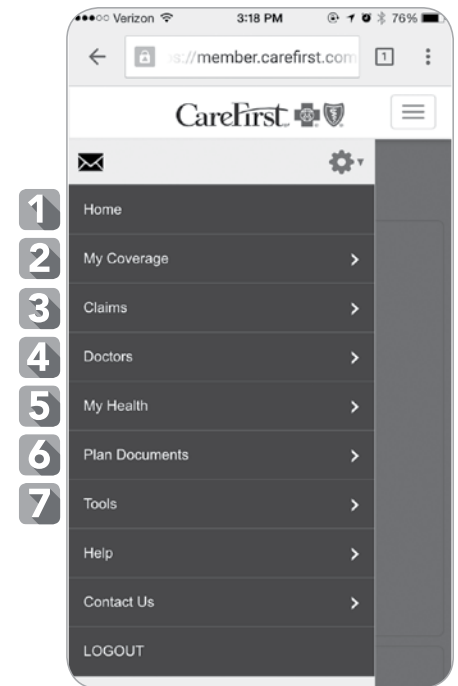
- Visit www.carefirst.com
- Select *Register Now*
- Create your User ID and Password

My Account

Online access to your health care information



As viewed on a computer.



As viewed on a smartphone.

3. Claims

- Check your paid claims, deductible and out-of-pocket totals
- Research your Explanation of Benefits (EOBs) history
- Review your year-end claims summary

4. Doctors

- Select or change your primary care provider (PCP)
- Search for a specialist

5. My Health

- Learn about your wellness program options²
- Locate an online wellness coach²
- Track your Blue Rewards progress

6. Plan Documents

- Look up your forms and other plan documentation²
- Review your member handbook²

7. Tools

- Treatment Cost Estimator
- Drug pricing tool^{1,2}
- Hospital comparison tool²

¹ These features are available only if your drug benefits are provided by CareFirst.

² These features are available only when using a computer at this time.

Medical Benefits Options

Effective for plan year July 1, 2017–June 30, 2018

The Benefits	BlueChoice HMO OpenAccess BlueChoice Providers	Level 1 BlueChoice Providers
	DEDUCTIBLE – CONTRACT YEAR JULY 1 – JUNE 30	\$100 Individual / \$200 Family aggregate (does not apply to Rx benefits)
MEDICAL OUT-OF-POCKET MAXIMUM	None	\$1,200 Individual/\$2,400 Family
LIFETIME MAXIMUM	Unlimited	
HOSPITAL		
Hospital Room/Semi-Private*	100% AB	365 days at 100% AB
Skilled Nursing Facility*	100% AB (limited to 60 days/contract year)	100% AB
Inpatient Rehabilitation*	100% AB (limited to 60 days/contract year)	100% AB
Outpatient Surgery	100% AB	100% AB
Emergency Care**	Emergency Room—\$50 copay, (waived if admitted) Urgent Care Center—\$30 copay	Emergency Room—\$50 copay, (waived if admitted) Urgent Care Center—\$15 copay
PHYSICIAN SERVICES		
Surgeon	100% AB	100% AB
Assistant Surgeon	100% AB	100% AB
Anesthesiologist	100% AB	100% AB
In-Hospital Medical	100% AB	100% AB
MEDICAL SERVICES		
Office Visits	\$10 PCP/\$15 Specialist copay	\$10 PCP/\$15 Specialist copay
Outpatient Facility	100% AB	100% AB
Outpatient Physician	\$10 PCP/\$15 Specialist copay	\$10 PCP/\$15 Specialist copay
Diagnostic X-rays	100% AB	100% AB (LabCorp only)
Radiation Therapy	\$15 Specialist copay	100% AB
Chemotherapy	\$15 Specialist copay	100% AB
Laboratory Tests	100% AB (LabCorp only)	100% AB
Allergy Testing	\$10 PCP/\$15 Specialist copay	100% AB
Allergy Treatment/Injections	\$10 PCP/\$15 Specialist copay	100% AB
Physical, Speech and Occupational Therapy (combined visits)	\$15 Specialist copay; 60 visit maximum per condition per contract year combined with speech and occupational therapy	\$15 Specialist copay; 100 visit maximum per contract year combined with speech and occupational therapy
Chiropractic Care (Spinal Manipulation)	\$15 Specialist copay	\$15 Specialist copay
Acupuncture	Not covered	\$15 Specialist copay

AB = Allowed Benefit

This chart contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations are contained in the Summary Plan Description, the Group Benefit Guide or the Group Service Agreement. AB—Allowed Benefit. AWP—Average Wholesale Price.

* Precertification required or penalties may apply.

** Overnight stays for observation are not considered an inpatient admission.

Triple Option		CareFirst BlueCross BlueShield Preferred Provider Organization CORE	
Level 2 BlueCross BlueShield PPO Providers	Level 3 Participating and Non-participating Providers	In-Network BlueCross BlueShield PPO Providers	Out-of-Network Participating and Non-participating Providers
None	\$200 Individual \$400 Family aggregate (Deductible applies to all services unless otherwise noted.)	\$100 Individual / \$200 Family aggregate (Deductible applies to all services unless otherwise noted.)	\$300 Individual / \$600 Family aggregate (Deductible applies to all services unless otherwise noted.)
100 Family (combined in- and out-of-network)		\$2,400 Individual / \$4,800 Family (combined in- and out-of-network)	
Unlimited		Unlimited	
365 days at 100% AB	365 days at 80% AB	365 days at 90% AB	365 days at 70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
Emergency Room—\$50 copay, (waived if admitted) Urgent Care Center—\$20 copay	Emergency Room—\$50 copay, (waived if admitted) Urgent Care Center—80% AB	Emergency Room—\$75 copay (waived if admitted) Urgent Care Center—\$20 copay	Emergency Room—\$75 copay (waived if admitted) Urgent Care Center—70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	100% AB (no deductible)	90% AB	90% AB
100% AB	100% AB (no deductible)	90% AB	90% AB
100% AB	80% AB	90% AB	70% AB
\$15 PCP/\$20 Specialist copay	80% AB	\$15 PCP / \$20 Specialist copay (no deductible)	70% AB
100% AB	80% AB	100% AB	70% AB
\$25 copay	80% AB	\$25 copay	70% AB
100% AB	100% AB inpatient (no deductible) 80% AB outpatient	90% AB	90% AB inpatient / 70% AB office
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	100% AB inpatient (no deductible) 80% AB outpatient	90% AB	90% AB inpatient / 70% AB office
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
\$20 Specialist office; \$25 OP Facility; \$25 OP Professional; 100 visit maximum per contract year (occupational/speech combined in- and out-of-network)	80% AB; 100 visit maximum per contract year (occupational/speech combined in- and out-of-network)	\$20 Specialist office; \$25 OP Facility, \$25 OP Professional (no deductible); 100 visit maximum per contract year (occupational/speech combined in- and out-of-network)	70% AB; 100 visit maximum per contract year (occupational/speech combined in- and out-of-network)
\$20 Specialist copay	80% AB	\$20 Specialist copay	70% AB
\$20 Specialist copay	80% AB	\$20 Specialist copay	70% AB

Medical Benefits Options

Effective for plan year July 1, 2017–June 30, 2018

The Benefits	BlueChoice HMO OpenAccess BlueChoice Providers	Level 1 BlueChoice Providers
	PREVENTIVE CARE	
Well Child Care/Immunization	100% AB (no deductible)	100% AB
Routine Physical Exam	100% AB (no deductible)	100% AB
Breast Cancer Screening/ Routine Mammography	100% AB (no deductible)	100% AB
Prostate Cancer Screening	100% AB (no deductible)	100% AB
Routine Gynecological Exam (one per contract year)	100% AB (no deductible)	100% AB
Eye Exams	\$10 copay per annual visit no-referral (Davis Vision provider)	
Eye Glasses/Lenses/Contact Lenses	Discounts available. See pages 24-25	Discounts available.
SPECIAL SERVICES		
Durable Medical Equipment	100% AB	100% AB
Home Health Care Visits*	100% AB	100% AB
Hospice*	100% AB	100% AB
Maternity Care (Pre/Post/Delivery)	100% AB	100% AB
Nursery Care (Must be enrolled within 30 days)	100% AB	100% AB
Infertility Services	Pre-approval required Artificial Insemination—50% copayment of charges; In Vitro Fertilization—50% copayment of charges (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of \$100,000)	Pre-approval required Artificial Insemination—100% copayment of charges; In Vitro Fertilization—100% copayment of charges (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of \$100,000)
Lapband Benefits	100% AB	100% AB
Surgical Treatment for Morbid Obesity (Gastric Bypass)	Not Covered	Not Covered
Ambulance When Medically Necessary (surface, air, private, and public)	100% AB	100% AB
Hearing Exam	\$15 copay	\$15 copay
Hearing Aids (one per hearing impaired ear every 36 months)	100% AB	100% AB
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		(administered by Magellan Behavioral Health)
Inpatient Care*	100% AB	100% AB
Outpatient Facility	100% AB	100% AB
Office Visits	\$10 copay	\$10 copay

Triple Option		CareFirst BlueCross BlueShield Preferred Provider Organization CORE	
Level 2 BlueCross BlueShield PPO Providers	Level 3 Participating and Non-participating Providers	In-Network BlueCross BlueShield PPO Providers	Out-of-Network Participating and Non-participating Providers
100% AB	80% AB	100% AB (no deductible)	70% AB
100% AB	80% AB	100% AB (no deductible)	70% AB
100% AB	100% AB (no deductible)	100% AB (no deductible)	100% AB (no deductible)
100% AB	100% AB (no deductible)	100% AB (no deductible)	100% AB (no deductible)
100% AB	80% AB	100% AB (no deductible)	70% AB
\$10 copay per annual visit no-referral (Davis Vision provider)		No Benefit	No Benefit
See pages 24-25		No Benefit	No Benefit
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	100% AB (no deductible)	90% AB	70% AB
100% AB	80% AB	100% AB (no deductible)	70% AB
100% AB	80% AB	90% AB	70% AB
Artificial Insemination—100% AB, pre-approval required; In Vitro Fertilization—100% AB, pre-approval required; (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of \$100,000)	Artificial Insemination—80% AB, pre-approval required; In Vitro Fertilization—80% AB, pre-approval required; (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of \$100,000)	Artificial Insemination – 90% AB, pre-approval required; In Vitro Fertilization – 90% AB, pre-approval required; (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of \$100,000)	Artificial Insemination – 70% AB, pre-approval required; In Vitro Fertilization – 70% AB, pre-approval required; (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of \$100,000)
100% AB	80% AB	90% AB	70% AB
Not Covered	Not Covered	Not Covered	Not Covered
100% AB	100% AB (no deductible)	90% AB	90% AB
\$20 copay	80% AB	\$20 copay (no deductible)	70% AB
100% AB	80% AB	90% AB	70% AB
(administered by Magellan Behavioral Health)		(administered by Magellan Behavioral Health)	
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
\$15 copay	80% AB	\$15 copay (no deductible)	70% AB

AB = Allowed Benefit

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* Precertification required or penalties may apply.

** Mandatory generic substitution—see the CareFirst Drug Program section on page 19.

Medical Benefits Options

Effective for plan year July 1, 2016–June 30, 2017

The Benefits	BlueChoice HMO OpenAccess BlueChoice Providers	Level 1 BlueChoice Providers
	PRESCRIPTION DRUGS	
Prescription Drug Out-of-Pocket Max.	\$6,600 Individual / \$13,200 Family	\$5,400 Individual / \$10,800 Family
Retail Prescription Drug**	\$5 copay – Generic drug (Tier 1) \$15 copay – Preferred Brand (Tier 2) \$35 copay – Non-preferred Brand (Tier 3) Maintenance drugs: 90 day supply, 3 times retail copay: \$15 copay – Generic drug (Tier 1) \$45 copay – Preferred Brand (Tier 2) \$105 copay – Non-preferred Brand (Tier 3)	\$10 copay Generic drug (Tier 1) \$25 copay Preferred Brand (Tier 2) \$40 copay Non-preferred Brand (Tier 3) (Maintenance medication up to 90 day supply 1X copay)
Mail Order Drug**	CVS Caremark Mail Order – 2X retail copay – up to 90 day supply \$10 copay – Generic drug (Tier 1) \$30 copay – Preferred Brand (Tier 2) \$70 copay – Non-preferred Brand (Tier 3)	CVS Caremark Mail Order Prescription Program for maintenance medication \$20 copay – Up to 90 day supply
Oral Contraceptives**	100% AB	100% AB
Diabetic supplies	100% AB	100% AB

Triple Option		CareFirst BlueCross BlueShield Preferred Provider Organization CORE	
Level 2 BlueCross BlueShield PPO Providers	Level 3 Participating and Non-participating Providers	In-Network BlueCross BlueShield PPO Providers	Out-of-Network Participating and Non-participating Providers
\$5,400 Individual / \$10,800 Family		\$4,200 Individual / \$8,400 Family	
\$10 copay Generic drug (Tier 1) \$25 copay Preferred Brand (Tier 2) \$40 copay Non-preferred Brand (Tier 3) (Maintenance medication up to 90 day supply 1X copay)		\$10 copay Generic drug (Tier 1) \$25 copay Preferred Brand (Tier 2) \$40 copay Non-preferred Brand (Tier 3) Maintenance medication up to 90 day supply 2X copay: \$20 copay – Generic drug (Tier 1) \$50 copay – Preferred Brand (Tier 2) \$80 copay – Non-preferred Brand (Tier 3)	
CVS Caremark Mail Order Prescription Program for maintenance medication \$20 copay – Up to 90 day supply		CVS Caremark Mail Order Prescription Program for maintenance medication 1X copay – Up to 90 day supply	
		\$10 copay – Generic drug (Tier 1) \$25 copay – Preferred Brand (Tier 2) \$40 copay – Non-preferred Brand (Tier 3)	
	100% AB	100% AB	
	100% AB	100% AB	

AB = Allowed Benefit

This chart contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations are contained in the Summary Plan Description, the Group Benefit Guide or the Group Service Agreement. AB—Allowed Benefit. AWP—Average Wholesale Price.

* Precertification required or penalties may apply.

** Mandatory generic substitution—see the CareFirst Drug Program section on page 19.

Your Medicare Supplemental Plan

Your protection against illness and high medical costs

Times have changed, and so have your needs. Even though you have Medicare, you still need additional health insurance to help cover your medical expenses. That's why Harford County Board of Education has selected the CareFirst BlueCross BlueShield Medicare Supplemental Plan for you. When you use the providers who participate with Medicare, you will have little to pay for Medicare—covered services. That way, you can just concentrate on feeling better.

Using your benefit summary

This benefit summary will show you how to use the Traditional Medicare Supplemental Plan. As you read through it, you see terms such as deductible and approved amount. The definitions for these terms can be found in the Definitions Section of this book. They will help you understand how your plan can save you money and make your Medicare coverage even better than before.

This benefit summary will also tell you the following:

- What the Medicare Supplemental Plan is and how it works
- What Medicare does and doesn't cover
- When you'll need to file claims, and how to file them
- How to get the most from your health care plans
- What your Medicare Supplemental benefits are

If you have any questions, just call CareFirst BlueCross BlueShield's Customer Service Department at (800) 628-8549. You can call between 8:00 a.m. and 10:00 p.m., Monday through Friday and 8:00 a.m. and 1:00 p.m., Saturday. A customer service representative will be happy to help you.



What your plan is and how it works

What does the Medicare Supplemental Plan cover?

First, it covers your inpatient Medicare deductible and coinsurance, costs associated with emergency care, outpatient surgery and diagnostic services. Second, CareFirst BlueCross BlueShield will pay 80% of the difference between what Medicare pays and the Medicare approved amount (when you visit Medicare participating providers) or limiting charge (when you visit Medicare non-participating providers) for Major Medical services such as office visits and durable medical equipment.

How does the Medicare Supplemental Plan work?

Your Medicare coverage is always primary. That means that Medicare always pays first for Medicare—covered services. Your Medicare Supplemental Plan is your secondary plan. It provides benefits for some charges and services not covered by Medicare.

When you use a Medicare participating provider for medical services, you will have less to pay for Medicare - covered services because these providers have agreed to accept the Medicare approved amount for their services, commonly referred to as “accepting assignment.”

Medicare non-participating providers do not always accept the Medicare approved amount. You will pay more for your care when you use Medicare non-participating providers.

Sometimes Medicare non-participating providers will agree to accept the Medicare approved amount for some services. Whenever they do, you will have less to pay for covered services. Please refer to questions 4 & 5 for examples.

How can I save money with my Medicare Supplemental Plan?

Your Medicare Supplemental Plan pays all of your up-front Medicare Part A deductibles and coinsurance amounts, regardless if you see a Medicare participating or Medicare non-participating provider.

In addition, your Medicare Supplemental Plan covers the Medicare Part B deductible for most services. In these cases, you will not have to pay the deductible, even if you see a Medicare participating or Medicare non-participating provider.

Why is it better to use Medicare participating providers?

When you use Medicare participating providers for Medicare and Major Medical covered services, you save money. Here’s an example of a Major Medical service:

Provider’s charge	\$50.00
Medicare approved amount	\$28.00
Medicare pays 80% of \$28 approved amount (after Part B deductible)	\$22.40
Balance	\$5.60
CareFirst pays 80% of \$5.60 balance	\$4.48
You pay remaining 20% coinsurance	\$1.12

How much will I pay if I use Medicare non-participating providers?

Medicare non-participating providers can charge you the difference between the Medicare approved amount and the Medicare limiting balance. The difference is usually 15% more than the approved amount.

Here’s an example of a Major Medical service:

Provider’s charge	\$50.00
Medicare approved amount	\$28.00
Medicare limiting charge (15% greater than Medicare approved amount)	\$32.20
Medicare pays 80% of \$28 approved amount (after Part B deductible)	\$22.40
Balance	\$9.80
CareFirst pays 80% of \$5.60 balance	\$4.48
You pay remaining balance up to Medicare limiting charge	\$5.32

CareFirst’s allowed benefit for services covered by Medicare and CareFirst will not exceed the Medicare approved amount/Medicare limiting charge.

How can I find out if a doctor is participating with Medicare?

There are two ways you can check on a doctor's participation with Medicare:

- Check the Medicare MedPar Directory (you can receive your own copy by calling Medicare)
- Call the provider directly

What Medicare does and doesn't cover

What does Medicare cover?

Medicare has two parts, A and B. Medicare Part A (hospital insurance) partially pays for medically necessary:

- Inpatient hospital facility charges
- Care in a skilled nursing facility after a hospital stay
- Home health care provided by a Medicare—participating home health agency
- Hospice care for the terminally ill

Medicare Part B (medical services insurance) partially pays for medically necessary:

- Physician's services
- Outpatient hospital services
- Home health visits
- Physical and speech therapy
- Services and supplies covered by Medicare, such as x-rays and durable medical equipment

What isn't covered by Medicare?

Medicare does not pay the full cost of all covered services. Medicare requires that you pay a share of the costs in the form of deductibles and coinsurance/copays.

What you'll need to file claims

You never have to submit a claim to Medicare. By law all providers must file these claims for you. And that applies to non-participating providers as well as participating providers.

If I receive care in Maryland, will I have to file any claims to CareFirst?

You will not have to file any claims with CareFirst for covered services if you receive the services in Maryland, Washington D.C., Delaware, New Jersey, Pennsylvania and Northern Virginia. While you may be asked to fill out claim forms for the provider, you will not have to submit the claims yourself.

CareFirst electronically receives claims from Medicare for covered services received in Maryland, Washington D.C., Delaware, New Jersey, Pennsylvania and Northern Virginia. That means that your claims automatically come to us from Medicare when you give your CareFirst membership number to your provider at the time you receive care.

Make sure that you always give your CareFirst membership number to your provider when you give your Medicare membership number. Without your CareFirst number, Medicare won't know to forward your claim information to us. You will then have to file your own claim.

Will I have to file any claims to CareFirst if I receive care outside of the states listed above?

Yes, your providers will file your Medicare claims for you. That's the law. But you will have to file claims with CareFirst to get benefits from your Traditional Medicare Supplemental Plan.

Here's what you should do. After Medicare has paid its share, you will receive an "Explanation of Medicare Benefits" (EOMB). Make copies of this form and of your bills for each claim. Do not send the original EOMB and medical bills. Keep the originals in your files. Claims rarely get lost, but if that should happen, you can resubmit your claim if you have kept the originals.

Send a copy of the EOMB, your bills and a completed claim form to the following address:

CareFirst Blue Cross Blue Shield
Mail Administrator
P.O. Box 14114
Lexington, KY 40512

What if I need a claim form or help submitting a claim?

Just call your CareFirst customer service representative. The numbers to call are (410) 581-3539 or (800) 342-7287. You can also call these numbers if you want to find out if your claim has been received.

Is there a deadline for filing claims?

Yes, we must receive your claims by December 31 following the year in which you receive medical care.

For example, if you received care in January of 2016, you should file your claim no later than December 31, 2017.

What happens if my claim arrives after the deadline?

Your claim will not be covered, and you will not receive payment. So be sure to file your claim right away.

Getting the most from your health care plan

To make sure that you make the most of your benefits and pay the least for care, follow these simple guidelines:

- Always find out if a provider is participating (accepts the Medicare approved amount) or non-participating (does not accept the Medicare approved amount) before you receive care.
- Avoid additional out-of-pocket expenses by using Medicare participating providers when you need Medicare-covered services.
- Always give your Medicare membership number and your CareFirst membership number when you receive care.
- If you need to file a claim, file right away so that you don't miss the filing deadline.

Your retail prescription drug plan

Your medical ID card is also your Rx card and should be given to the pharmacy each time you fill a prescription. You will pay a 20% copayment up front for your prescriptions. We encourage you to shop around for the best price to reduce your out-of-pocket expense. Pharmacy claims cannot be submitted on a Major Medical claim form for reimbursement.

Mail Service prescription drug program sponsored by CVS Caremark

A mail service prescription drug program is a special added feature to your Traditional Medicare Supplemental Plan. For those who regularly take maintenance medications, this service provides a convenient and inexpensive way for you to order these medications and have them delivered to your home.

You can order up to a 90-day supply of medication for the required copayment of \$20. You must send the \$20 copayment with your prescription to CVS Caremark. The copayment will not be reimbursed through your medical benefits.

Medications are delivered to your home postage paid via UPS or First Class U.S. Mail.

If you have any questions regarding this prescription service, call the CareFirst Pharmacy Services telephone number, Monday through Friday at (800) 241-3371.

Medicare Supplemental Plan

Summary of Benefits

Benefits	Other Payments Made		Member Payment	
	Remaining Costs after Medicare Payment	CareFirst Plan Payment	Provider Accepting Medicare Assignment	Provider Not Accepting Medicare Assignment
DEDUCTIBLE			\$200 Major Medical Deductible	
FACILITY				
Inpatient Hospital Days 1–60 Days 61–90 Lifetime reserve	Part A initial deductible \$1,316 \$329 per day \$658 per day	\$1,316 \$329 per day \$658 per day	No member payment No member payment No member payment	No member payment No member payment No member payment
Skilled Nursing Facility Days 1–20 Days 21–100	None \$165 per day	None \$165 per day	No member payment No member payment	No member payment No member payment
Home Health	None	None		
Hospice Care	Medicare pays most charges. Remaining costs include drug copayment and limited cost for respite care.	Remaining cost	No member payment	No member payment
PHYSICIAN SERVICES				
Inpatient	20% of Medicare's approved amount and Part B deductible if accepting assignment	100% up to CareFirst allowed benefit	No member payment	No member payment
Emergency	20% of Medicare's approved amount and Part B deductible	80% up to CareFirst allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's approved amount
Surgery	20% of Medicare's approved amount and Part B deductible	100% up to CareFirst allowed benefit	No member payment	No member payment
Laboratory Services	100%	None	No member payment	No member payment
Radiology Services (Inpatient)	20% of Medicare's approved amount and Part B deductible	100% up to CareFirst allowed benefit	No member payment	No member payment
Radiology Services (Outpatient or Office)	20% of Medicare's approved amount and Part B deductible	80% up to CareFirst allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's approved amount
Office Visit	20% of Medicare's approved amount and Part B deductible	80% up to CareFirst allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's approved amount
OFFICE THERAPY				
Radiation/Chemotherapy	20% of Medicare's approved amount	100% up to CareFirst allowed benefit	No member payment	No member payment
Physical Therapy	20% of Medicare's approved amount and Part B deductible	80% up to CareFirst allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's approved amount

Your Medicare Supplemental Plan

Summary of Benefits

Benefits	Other Payments Made		Member Payment	
	Remaining Costs after Medicare Payment	CareFirst Plan Payment	Provider Accepting Medicare Assignment	Provider Not Accepting Medicare Assignment
OTHER SERVICES				
Ambulance Services	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's approved amount
Durable Medical Equipment	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's approved amount
Prosthetic Appliances	20% of Medicare's approved amount deductible	80% up to allowed benefit	No member payment	No member payment
Whole Blood (In full—Part A, 3 pint deductible—Part B)	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's approved amount
Medical Supplies	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's approved amount
Hearing Exam (once every 36 months)	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's approved amount
Hearing Aid	20% of Medicare's approved amount and Part A/B deductible	100% up to allowed benefit	No member payment	No member payment
Physical Exam		100% of allowed benefit	No member payment	No member payment
Mammograms	Pays for one every 12 months	Difference up to Medicare's approved amount or 100% of CareFirst allowed benefit when not covered by Medicare	No member payment	No member payment when Medicare approved. Difference between CareFirst allowed benefit and provider's charge when not Medicare approved.
Prostate Cancer Screening	Pays for one every 12 months	Difference up to Medicare's approved amount or 100% of CareFirst allowed benefit when not covered by Medicare	No member payment	No member payment when Medicare approved. Difference between CareFirst allowed benefit and provider's charge when not Medicare approved.
PRESCRIPTION DRUGS				
Retail Prescription Drug			20% Coinsurance of Average Wholesale Price	
Mail Order Drug			CVS/Caremark Mail Order Prescription Program for maintenance supply medication \$20 copay—up to 100 day supply	

The Medicare deductibles and coinsurance amounts shown are based on 2016 figures. Your benefits will automatically adjust to meet any amounts that change in 2017.

CareFirst's allowed benefit for services covered by Medicare and CareFirst will not exceed the Medicare approved amount/Medicare limiting charge. Medicare does not place a limiting charge on durable medical equipment, therefore the CareFirst allowed benefit will prevail. If Medicare benefits are exhausted, or service is not covered by Medicare, CareFirst Medicare Supplemental Plan benefits may be provided.

Blue Cross and Blue Shield benefits for inpatient hospital services are provided for 90 days per inpatient stay with a 60-day renewal interval. That is, an inpatient stay will be one stay if discharge date and readmission date are not separated by at least 60 days.

Reimbursement under Major Medical is subject to an annual deductible of \$200 per individual. After your deductible is met, payment is made at 80% of allowed benefit and you pay the coinsurance of 20%.

Words You Need to Know

Medicare Supplemental

Approved amount

The amount that Medicare allows participating providers to be paid for Medicare—covered services. Payments are made according to the Medicare fee schedule (see following pages).

Participating providers agree to accept the approved amount as payment in full for covered services. Non-participating providers can charge you more than this amount for your care (see limiting charge). The “approved amount” also may be called the “allowed amount” or “assignment”.

Coinsurance

Some services require that you pay a percentage of the costs for your medical care. For example, under Medicare Part B, you pay 20% and Medicare pays 80%.

Some services require that you pay a set-dollar amount for your care. For example, under Medicare Part A, you must pay a set amount per day for inpatient hospital care after you’ve been hospitalized for over 60 days.

Your Traditional Medicare Supplemental Plan pays the Part A coinsurance for you.

Deductibles

Some services require that you pay a deductible before Medicare begins to pay. For example, under Medicare Part A, you must pay the first \$1,100 of your hospital bill. And under Medicare Part B, you must pay the \$200 deductible for services. Then Medicare begins to pay its share.

Limiting charge

Some providers do not accept the Medicare approved amount as payment in full for Medicare—covered services. To protect you from high charges for these services, Medicare limits the amount that these non-participating providers can bill you.

The limiting charge does not apply to any of the Traditional Medicare. Supplemental Plan benefits that Medicare does not cover.

Medicare fee schedule

In general, payments for services are made according to the standard Medicare – approved fee schedule.

Medicare participating providers

Physicians and suppliers who agree to always accept the Medicare approved amount as payment in full for services. (You still pay deductibles and coinsurance.) Medicare participating providers can charge you full price for services that Medicare does not cover.

Medicare non-participating providers

Other physicians and suppliers who do not agree to always accept the Medicare approved amount as payment in full for services. Medicare limits the amount that non-participating providers can charge for Medicare – covered services. If you choose to see a non-participating provider, you must pay any difference between the limiting charge and the Medicare approved amount.

Provider

Any licensed doctor, nurse or professional. A provider may also be a health care facility, such as a hospital, laboratory or clinic.

DELTA DENTAL PPOSM: Your smile is covered



Go PPO

Visit a PPO¹ dentist to maximize your savings.² These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.³ Find a PPO dentist at deltadentalins.com.⁴

Access online services

Get information about your plan anytime, anywhere by signing up for an Online Services account at deltadentalins.com. This free service lets you check benefits and eligibility information, find a network dentist and more.

Check in with ease

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or social security number. If your family

members are covered under your plan, they will need your name, birth date and enrollee or social security number. Prefer to take a paper or electronic ID card with you? Simply sign in to Online Services, where you can view or print your card with the click of a button. If you're covered under two plans, ask your dental office to include information about both plans with your claim, and we'll handle the rest.

Understand transition of care

Did you start on a dental treatment plan before your PPO coverage kicked in? Multi-stage procedures are only covered under your current plan if treatment began after your plan's effective date of coverage.⁵ You can find this date by logging in to Online Services.

Newly covered? Visit deltadentalins.com/welcome.

Save with a PPO dentist



PPO



Non-PPO

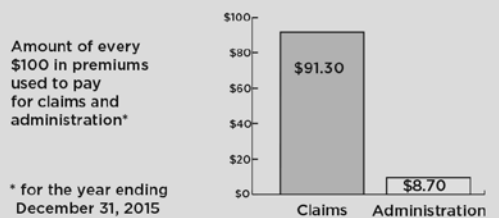
Maryland law requires we make the following statement:

Our compensation to physicians who offer health care services to our insured members of enrollees may be based on a variety of payment mechanisms such as fee-for-service payments, salary or capitation. Bounties may be used with these various types of payment methods. If you desire method(s) apply to your physician, please call additional information about our methods of paying physicians, or if you want to know which Delta Dental at 800-932-0783 or write to: Delta Dental of Pennsylvania, One Delta Drive, Mechanicsburg, PA 17055.

Please note that the benefit payments made by Delta Dental to dentists, other dental care providers or enrollees are based on fee-for-service payment mechanisms and do not include salary, capitation or bonuses.

In Maryland, Delta Dental PPOSM and Delta Dental Premier[®] are underwritten by Delta Dental of Pennsylvania, a not-for-profit dental service company.

Where your dental benefits premium goes



FFS #95422A1 (1/16)

Legal notices: Access federal and state legal notices related to your plan at deltadentalins.com/about/legal/index-enrollee.html

- ¹ In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.
- ² You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.
- ³ You are responsible for any applicable deductibles, coinsurance, amounts over plan maximums and charges for non-covered services.

- ⁴ Verify that your dentist is a PPO dentist before each appointment.
- ⁵ Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier are responsible for any costs. Group- and state-specific exceptions may apply. Enrollees currently undergoing active orthodontic treatment may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.



deltadentalins.com/enrollees

We keep you smiling[®]

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Plan Benefit Highlights for: Harford County Public Schools

Group No: 00528 - PPO - Comprehensive

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26			
Deductibles Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	Delta Dental PPO dentists: \$25 per person / \$50 per family each plan year Non-Delta Dental PPO dentists: \$50 per person / \$150 per family each plan year			
	Yes			
Maximums D & P counts toward maximum?	\$1,500 per person each plan year			
	No			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services Exams, cleanings, x-rays and sealants	100 %	65 %
Surgical Removal of Impacted Teeth	100 %	65 %
Basic Services Fillings, denture repair/relining, stainless steel crowns, bridges, bridge recementation/repair and posterior composite restorations	80 %	50 %
Endodontics (root canals) Covered Under Basic Services	80 %	50 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	50 %
Oral Surgery Covered Under Basic Services	80 %	50 %
Major Services Crowns, inlays, onlays and cast restorations	50 %	30 %
Prosthodontics Dentures	50 %	30 %
Implants Covered <u>only</u> as an alternative to a fixed bridge	80 %	50 %
Orthodontic Benefits Dependent children to age 19	50 %	50 %
Orthodontic Maximums	\$800 Lifetime	\$800 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, PPO contracted fees for Premier dentists and PPO contracted fees for non-Delta Dental dentists.

Delta Dental of Pennsylvania One Delta Drive Mechanicsburg, PA 17055	Customer Service 800-932-0783	Claims Address P.O. Box 2105 Mechanicsburg, PA 17055-6999
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deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Plan Benefit Highlights for: Harford County Public Schools

Group No: 00528 - PPO plus Premier - Standard

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26		
Deductibles	\$25 per person / \$50 per family each plan year		
Deductibles waived for Diagnostic & Preventive (D & P)?	Yes		
Maximums	\$1,500 per person each plan year		
D & P counts toward maximum?	No		
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services Exams, cleanings, x-rays and sealants	100 %	100 %
Basic Services Fillings, stainless steel crowns and posterior composite restorations	100 %	100 %
Endodontics (root canals)	100 %	100 %
Oral Surgery	100 %	100 %
Periodontics (gum treatment)	0 %	0 %
Major Services Crowns, inlays, onlays and cast restorations	0 %	0 %
Prosthodontics Bridges and dentures	0 %	0 %

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

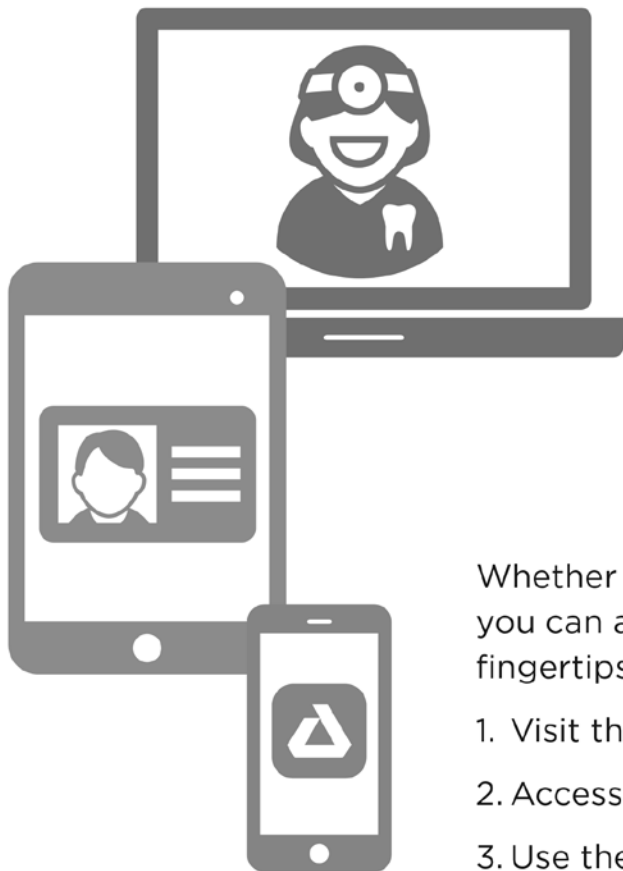
** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and Premier contracted fees for non-Delta Dental dentists.

Delta Dental of Pennsylvania One Delta Drive Mechanicsburg, PA 17055	Customer Service 800-932-0783	Claims Address P.O. Box 2105 Mechanicsburg, PA 17055-6999
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deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Stay Connected



Want information about your dental plan? Take advantage of our web and mobile resources to:

- **check your eligibility**
- **look up coverage details**
- **check claims**
- **find a network dentist**
- **improve your oral wellness**
- **and more**

Whether you're on a computer, tablet or smartphone, you can access all the information you need at your fingertips.

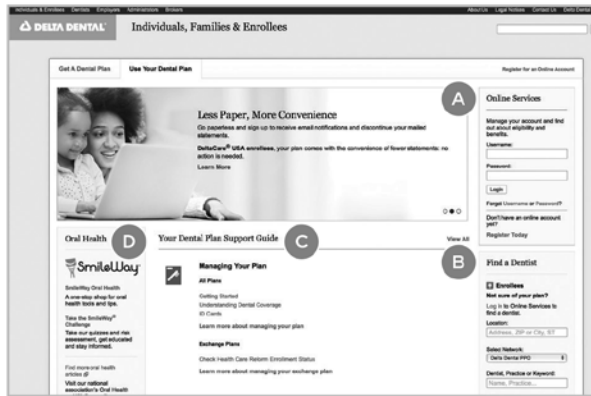
1. Visit the **website**
2. Access the **mobile-optimized site**
3. Use the **free app**

¿Habla español?
es.deltadentalins.com



We keep you smiling®
deltadentalins.com/enrollees

Check the site

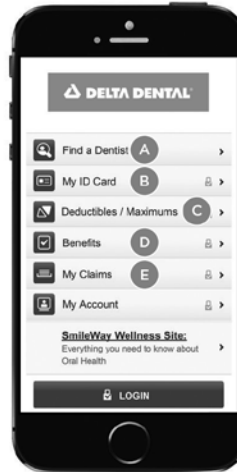


1. Enter **deltadentalins.com/enrollees** on your computer's browser.
2. Browse the features listed below. If you haven't already done so, register for Online Services. Already got an account? Log in!

Features:

- A. Online Services** (register or log in): See benefits, eligibility, deductibles and maximums; check claims; view or print an ID card
- B. Find a dentist**
- C. Dental Plan Support Guide**
- D. SmileWay® Wellness site**

Go mobile¹

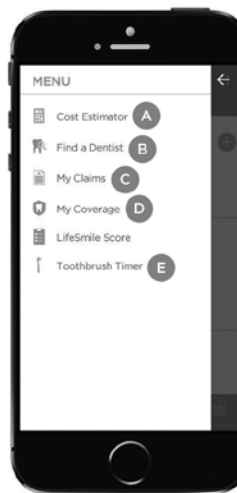


1. Enter **deltadentalins.com** on your smartphone's browser.
2. Click the **Visit Mobile Site** button.

Features:

- A. Find a dentist**
- B. View your electronic ID card**
- C. Check deductibles and maximums**
- D. See your benefits and eligibility**
- E. Check claims**

Get the app²



1. Open the **App Store** or **Google Play**.
2. Search for "**Delta Dental**."
3. Download the free app titled **Delta Dental** by Delta Dental Plans Association.

Features:

- A. Get a cost estimate**
- B. Find a dentist**
- C. Check claims**
- D. See your benefits, eligibility, deductibles and maximums**
- E. Use a musical timer to brush for 2 minutes**

¹ Available to Delta Dental PPOSM and Delta Dental Premier[®] enrollees only.

² Some features available to PPO and Premier enrollees only.

DELTACARE[®] USA: 800-422-4234

DELTA DENTAL PPO AND DELTA DENTAL PREMIER

Delta Dental of California: 800-765-6003

Delta Dental of Delaware, Inc., Delta Dental of the District of Columbia, Delta Dental of New York, Inc., Delta Dental of Pennsylvania (and Maryland), Delta Dental of West Virginia, Inc.: 800-932-0783

Delta Dental Insurance Company (Alabama, Florida, Georgia, Louisiana, Mississippi, Montana, Nevada, Texas, Utah): 800-521-2651

Delta Dental Premier and Delta Dental PPO are underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV, TX and UT and by not-for-profit dental service companies in these states: CA – Delta Dental of California; PA, MD – Delta Dental of Pennsylvania; NY – Delta Dental of New York; DE – Delta Dental of Delaware; WV – Delta Dental of West Virginia. In Texas, Delta Dental PPO is underwritten as a Dental Provider Organization (DPO) plan.

These enterprise companies are members, or affiliates of members, of the Delta Dental Plans Association, a network of 39 Delta Dental companies that together provide dental coverage to 73 million people in the U.S. The website deltadentalins.com is the home of the Delta Dental companies listed above. For other Delta Dental companies, visit the Delta Dental Plans Association website at deltadental.com.

Elevate Your Smile

8 ways to make the most of your dental plan



1 Save with PPO.
Visit a dentist from the PPO¹ network to maximize your savings.² These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.³ Find a PPO dentist at deltadentalins.com.⁴

2 Seek preventive care.
Regular exams and cleanings are available at low or no cost. These services help catch problems before they require costly and extensive treatment.

3 Set up an online account.
Get information about your plan anytime, anywhere by signing up for an Online Services account. Available once your coverage kicks in, this free service lets you find a network dentist, view or print your ID card and more. The one-time registration process takes only a minute.

4 Go paperless.
Receive an email when a new dental benefits statement is available. Save time, reduce clutter and preserve environmental resources. To enroll, log in to Online Services and update your settings.

Newly covered?

Visit deltadentalins.com/welcome

¹ In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.

² You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist.

³ You are responsible for any applicable deductibles, coinsurance, amounts over plan maximums and charges for non-covered services. PPO dentists won't bill you for any amount over their PPO fees.

⁴ We recommend confirming that your dentist is a PPO dentist before each appointment.



We keep you smiling®
deltadentalins.com/enrollees

5 Go mobile.
Visit deltadentalins.com on your smartphone to access mobile-optimized Online Services on the go — including a helpful dentist locator tool. Or, download the Delta Dental app, available through the App Store or Google Play, to access your plan information and try out the handy toothbrush timer.

6 Coordinate benefits.
Are you covered under a second dental plan? Ask your dentist to include information about both plans with your claim, and we'll handle the rest.⁵

7 Talk to your dentist.
From pregnancy to diabetes, overall health can affect your dental health. Start each visit with a quick chat about any issues.

8 Stay informed.
Get tools and tips at our SmileWay® Wellness site (mysmileway.com). Don't forget to subscribe to *Grin!*, our free dental wellness e-magazine: ddins.grinmag.com.

⁵ Group- and state-specific exceptions may apply. Please review your plan booklet for details about coordination of benefits, including rules for determining primary and secondary coverage.

Contact us

Online assistance:

For quick and easy online assistance, go to deltadentalins.com > **Contact Us**, select the Delta Dental company and choose the applicable customer service form.

Telephone assistance:

Delta Dental of California: **800-765-6003**

California School District Employees: **866-499-3001**

Delta Dental of Delaware; Delta Dental of the District of Columbia; Delta Dental of New York; Delta Dental of Pennsylvania (and Maryland); Delta Dental of West Virginia: **800-932-0783**

Delta Dental Insurance Company (Alabama, Florida, Georgia, Louisiana, Mississippi, Montana, Nevada, Texas, Utah): **800-521-2651**

Got a simple question? Use our automated phone system, available 24/7. You can check your coverage levels, remaining maximum and more. Just call one of the customer service numbers listed above and follow the prompts.

Delta Dental PPOSM is underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV, TX and UT and by not-for-profit dental service companies in these states: CA - Delta Dental of California; PA, MD - Delta Dental of Pennsylvania; NY - Delta Dental of New York, Inc.; DE - Delta Dental of Delaware, Inc.; WV - Delta Dental of West Virginia, Inc.

Delta Dental of California, Delta Dental of New York, Inc., Delta Dental of Pennsylvania, Delta Dental Insurance Company and our affiliated companies form one of the nation's largest dental benefits delivery systems, covering 34.5 million enrollees. All of our companies are members, or affiliates of members, of the Delta Dental Plans Association, a network of 39 Delta Dental companies that together provide dental coverage to 73 million people in the U.S.

LEGAL NOTICES: Access federal and state legal notices related to your plan: deltadentalins.com/about/legal/index-enrollee.html.

Life Insurance

For those retirees participating, this policy is written through the MetLife Insurance Company. The policy provides an initial death benefit of \$20,000. The death benefit will be reduced annually by \$2,000 on July 1 until the amount of \$10,000 has been reached. Thereafter, the coverage will remain at \$10,000 for as long as the policy is in force.

Currently, the Board of Education pays 90% and the retiree will pay 10% of the premium for this coverage. The monthly cost to the retiree for \$20,000 is currently \$.33 cents. This premium will be deducted from your monthly State Retirement System check.



Frequently Asked Questions

When should I apply for Medicare?

You're eligible when you turn 65. Contact Social Security 3 months prior to your 65th birthday.

How can I sign up for Part A & B of Medicare?

- Apply online at www.socialsecurity.gov.
- Visit your local Social Security office.
- Call Social Security at 1-800-772-1213

What happens once a covered member becomes eligible for Medicare?

Once you or your dependent becomes eligible for Medicare, enrollment in Medicare Part A & B is required to maintain coverage with HCPS. All retirees are required to provide the HCPS Benefits office with a copy of their Medicare card.

If you are participating in a CareFirst Preferred Provider (PPO) health program, the medicare eligible member will automatically be transferred to the CareFirst Medicare Supplemental plan once eligible for Medicare. The

Medicare eligible member will have the supplemental plan and the remaining member(s) will still be enrolled in the PPO Plan with Individual, Parent/Child, Husband/Wife or Family coverage.

Medicare will be your primary insurance and your HCPS plan will be secondary.

Will my pharmacy benefit change once I go on Medicare?

Yes. Your Mail Order will be \$20 for a 90 day supply of a maintenance medication. At retail you will be responsible for 20% of the cost.

What about Medicare Part D?

Currently, all retirees of HCPS should waive Medicare Part D. Any retiree who chooses to enroll in a Medicare D plan will lose prescription benefits with their HCPS plan. Harford County receives a Medicare subsidy for retirees who are not enrolled in Part D. Currently, this money is designated to other post employment benefits OPEB.



Who is an eligible dependent?

- Your legal spouse
- Your dependent children up to age 26.
- Your unmarried children of any age who are physically/mentally incapable of self-support and cannot earn their own living (onset of disability must be prior to age 26 or while covered under the plan).

When can I add a spouse, child or newborn to my insurance coverage?

Contact the Benefits Office to obtain an Enrollment/Change Application to add your new child or spouse. You have 30 days from date of birth/adoption or marriage to add him/her to your health/dental plans. Coverage will take effect retroactively to the date of birth/date of adoption or marriage. Failure to add within the 30 days will result in your dependent losing the opportunity to enroll in our benefits. You will need to provide proper documentation (birth certificate, marriage certificate, adoption paperwork).

What should I do when my dependent loses eligibility for coverage?

You are responsible for notifying the Benefits Office as soon as you know that your dependent will no longer meet the eligibility requirements for coverage. You should notify the Benefits Office in advance so the dependent can be removed from coverage at the appropriate time. There are no refunds of premiums paid during any period of ineligibility.

When coverage ends for a dependent, he or she may choose to continue coverage under COBRA for a maximum of 36 months, providing the Benefits Office is notified within 60 days of the loss of eligibility.

Should any of your dependents become ineligible for coverage due to any of the following reasons: over the age limit, divorce, military or death, their coverage ceases the end of the month in which the event occurred. It is your responsibility to notify the Benefits Office.

NOTE: Coverage continues for a child until the end of the month in which the child turns 26. For example, a child whose 26th birthday is May 12 can be covered through May 31st.

When does coverage end for my dependents should I die?

End of the month in which the death occurred. Your surviving spouse/dependent will have the option of continuing coverage on Harford County Public Schools plan throughout their lifetime but is responsible for paying 100% of the premium.

What if I move?

Should your address change, you will need to notify the State Retirement Agency in writing at 120 E. Baltimore Street, Baltimore MD 21202 and the HCPS Benefits Office of your new address and telephone number.

Moving out-of-state?

Members enrolled in the HMO should contact the Benefits Office for guidance.

Health Insurance Portability Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) places limitations on a group health plan's ability to impose pre-existing condition exclusions, provides special enrollment rights for certain individuals, and prohibits discrimination in group health plans based on health status.

We are electronically transmitting data to the vendors for eligibility purposes. The vendors and HCPS are in compliance with the HIPAA requirements. No personally identifiable information may be released to a third party.

Special enrollment rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Important Notice from Harford County Public Schools About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Harford County Public Schools and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Harford County Public Schools has determined that the prescription drug coverage offered by our CareFirst BlueCross Medicare Supplemental Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Harford County Public Schools coverage will be affected. For those individuals who elect Part D coverage, prescription coverage under Harford County Public Schools medical plan will end for the individual and all covered dependents.

If you do decide to join a Medicare drug plan and drop your Harford County Public Schools prescription drug coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Harford County Public Schools and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

Important Notice from Harford County Public Schools About Your Prescription Drug Coverage and Medicare

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Harford County Public Schools changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Name of Entity/Sender: Harford County Public Schools

Contact—Position/Office: Audrey Simpson, Coordinator of Benefits

Privacy Notice

Your privacy is a high priority for Harford County Public Schools and it will be treated with the highest degree of confidentiality.

Harford County Public Schools (the Board) is required under the Medical Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA) to provide all of its employees and retirees participating in its self-funded health care plans with this PRIVACY NOTICE, which concerns personal, protected health information you have provided to the Board as a condition of your employment.

In providing health insurance benefits to you, the Board collects the following types of personal information: (1) information you provide to us on an application or enrollment form in order to obtain insurance including your name, address, telephone number, date of birth, and Social Security number; (2) premium payments the Board pays on your behalf; (3) the fact that you are currently or have been one of our employees; (4) information you have given to us from any of your physicians or other health care providers; (5) information related to your health care status including diagnosis and claims payment information and (6) other information about you that is necessary for us to have in order to provide you with health insurance.

We may disclose this information to our third party vendors (the Vendors) without prior authorization, as permitted by law. We do not disclose any personal information about either our current employees or former employees to anyone, except as permitted by law. We may, from time to time, disclose personal information about you without prior authorization, as permitted by

law, to the Vendors to perform services or functions on our behalf. If we make such a disclosure, we will do so only if we have a contract in place that prohibits the Vendors from disclosing or using the information for any purpose other than the purpose of the disclosure, except as permitted by law. We restrict access to your personal information to those employees of the Board who need to know that information in order to provide services to you.

We maintain physical, electronic and procedural safeguards that comply with HIPAA regulations to guard your personal information. Employees, who have access to your personal information, are required to abide by the following standards: (1) to safeguard and secure confidential personal information as required by law; (2) to limit the collection and use of any participants information to the minimum necessary and (3) to permit only trained, authorized employees to have access to your personal information. Employees who violate the policy will be subject to our established disciplinary policy. In addition, the Board will: (1) provide all of our participants, at least annually, with any updates to this policy; (2) provide information about you to the Vendors only in accordance with the law; (3) require the Vendors to enter into a contract that prohibits disclosure or the use of your personal information other than to carry out the purpose of the disclosure, except as permitted by law; (4) not share your personal information for purposes other than allowed by law; (5) allow participants the opportunity to correct personal information that they believe is not accurate.

Definitions

These definitions have been developed to help you become familiar with some of the terms in this manual.

Allowed Benefit

The criteria CareFirst BlueCross BlueShield uses to determine payments to your physician. It is based upon the Resource Based Relative Value Unit System. This system takes 3 factors into consideration; work value (amount of skill/time/effort required for service), practice expense (cost of overhead expenses), and the liability/malpractice expense for covered services.

Card (Identification/Membership)

Identification or membership card for medical/pharmacy coverage. The card identifies the retiree, types of elected coverage, type of membership and the effective date of coverage.

Coinsurance

A cost-sharing requirement under your CareFirst BlueCross BlueShield policy which requires you to assume a percentage of the costs of covered services.

Copay

Cost sharing in which you pay a flat amount per service. Unlike coinsurance the amount does not vary as a percentage of the cost of the service.

Deductible

Amount of expense you must incur before CareFirst BlueCross BlueShield or Delta Dental will assume any liability for all or part of the remaining cost of covered services.

Eligibility

State of fulfilling requirements for coverage.

In-network Provider

A preferred provider within a Preferred Provider Organization.

Medical Emergency

The sudden and unexpected onset of a serious illness or condition which requires necessary, immediate medical care.

Member Hospital

A hospital that has signed a contract with CareFirst BlueCross BlueShield to provide services to CareFirst BlueCross BlueShield subscribers.

Non-Participating Provider

A physician or other provider who has not signed an agreement with the CareFirst BlueCross BlueShield plan to accept the Allowed Benefit as payment in full.

Out-of-Network Provider

A provider that is not part of the PPO network

Out-of-pocket

The deductible copayment plus any coinsurance amount that the subscriber pays; once this has been met the policy will normally pay at 100% of the Allowed Benefit for most covered services.

Participating Provider

A physician or other provider who has signed an agreement with CareFirst BlueCross BlueShield to accept the Allowed Benefit as payment in full.

Medical Plan Year

The Plan Year is twelve months July 1–June 30.

Professional Component

That portion of a charge for x-ray or laboratory services performed in a hospital which is allocated to a physician as his professional fee.

Provider

An individual or institution that provides medical care.

Fully-Insured vs. Self-Insured

What is the Difference?

Employers that offer health insurance benefits finance those benefits in one of two ways: They purchase health insurance from an insurance company (fully-insured plans), or they provide health benefits directly to employees (self-insured plans). Typically, these plans differ by who assumes the insurance risk, plan characteristics, and employer size.

If an employer-sponsored plan is fully-insured:

The insurance company is ultimately responsible for the health care costs and the employer pays premiums. In a fully-insured plan, the employer pays a per-employee premium to someone else (an insurance company) to take on the risk that they will pay out more in benefits than they collect from you in premiums. The insurer collects the premiums and pays the health care claims based on your policy benefits. The covered persons are responsible to pay any deductible amounts or copayments required for covered services under the policy.

If an employer-sponsored plan is self-insured:

The employer assume the financial risk and acts as its own insurer and is ultimately responsible for the health care costs, and pays for all of those costs plus administration fees. Self-insured plans often contract with an insurance company or other third party to administer the plan, but the employer bears the risk associated with offering health benefits.

Harford County Public Schools (HCPS) self-insures all medical and dental plans offered

This means we assume the risk for every dollar of health care expense our employees and their families incur. We use the dollars collected through your payroll contributions and HCPS's contributions to pay employees' claims and the administration costs of the plans. In addition we also share in costs with employees at the point of care, through the plan's benefit features (e.g., coinsurance and copayments). Our third party administrators are CareFirst and Delta Dental.

Self-insuring our medical and dental plans benefits HCPS and our employees in many ways:

- **Our benefit dollars go toward benefits.** Built into the cost of any insurance policy is the

insurer's profit. When we self-insure, we eliminate the middleman—the insurer—and its built-in profit. Though third-party insurers administer our plans, they do so on a fee-for-service basis; they take no financial risk for paying our claims. And since HCPS is not making a profit by providing health insurance coverage to you, every dollar of your and HCPS's contributions are used to pay claims and the administrative expenses for our plans.

- **We have more flexibility.** When we self-insure our plans, HCPS, and not an insurance company, decides how our plans work. This provides us with more flexibility in designing our plans (e.g., deciding on copayment and coinsurance levels) to fit the needs of our employees. The insurance carrier is responsible for negotiating rates with in-network providers and the processing of claims.
- **We have more control.** Self-insured plans are subject to federal regulations, while fully-insured plans are regulated by the state in which the plan operates. This exempts HCPS from providing for state-mandated benefits in our plans (which can be costly) and from paying state-mandated taxes on health care premiums (an additional expense for the plans).

Even though HCPS plans are self-funded, HCPS does not assume 100% of the risk for catastrophic claims. Rather, we purchase what is known as Stop-Loss insurance to protect against large individual claims as well as total claims which exceed the expected level for our group of covered persons.

The total cost of a self-funded plan is the fixed costs plus the claims expense less any stop-loss reimbursements.

CareFirst BlueCross BlueShield
CareFirst BlueChoice, Inc.
10455 Mill Run Circle
Owings Mills, MD 21117-5559

www.carefirst.com

Health benefits administered by:



CONNECT WITH US:



CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc.
CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are both independent licensees of the Blue Cross and Blue Shield Association.
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