

# BluePreferred • HSA

## Integrated Deductible

### Summary of Benefits

SERVICES	In-Network You Pay <sup>2</sup>	Out-Of-Network You Pay <sup>3</sup>
<b>ANNUAL DEDUCTIBLE<sup>7,8</sup></b>		
Individual	\$1,200	(combined in- and out-of-network)
Individual & Child(ren)	\$2,400	
Individual & Adult	\$2,400	
Family	\$2,400	
<b>ANNUAL OUT-OF-POCKET LIMIT<sup>7,8</sup></b>		
Individual	\$3,400	(combined in- and out-of-network)
Individual & Child(ren)	\$6,800	
Individual & Adult	\$6,800	
Family	\$6,800	
<b>LIFETIME MAXIMUM</b>	\$2,000,000 (combined in- and out-of-network)	
<b>PREVENTIVE SERVICES</b>		
Well-Child Care		
0-24 months	\$10 per visit	\$20 per visit or 30% of AB*
24 months-13 years (immunization visit)	\$10 per visit	\$20 per visit or 30% of AB*
24 months-13 years (non-immunization visit)	\$20 per visit	\$20 per visit or 30% of AB*
14-17 years	\$20 per visit	\$20 per visit or 30% of AB*
Adult Physical Examination	\$20 per visit	\$20 per visit or 30% of AB*
Routine GYN Visits	\$20 per visit	\$20 per visit or 30% of AB*
Mammograms	\$20 per visit	\$20 per visit or 30% of AB*
Cancer Screening (Pap Test, Prostate and Colorectal)	\$20 per visit	\$20 per visit or 30% of AB*
<b>OFFICE VISITS, LABS &amp; TESTING</b>		
Office Visits for Illness	Deductible, then 10% of AB*	Deductible, then 30% of AB
Diagnostic Services	Deductible, then 10% of AB	Deductible, then 30% of AB
X-ray and Lab Tests	Deductible, then 10% of AB	Deductible, then 30% of AB
Allergy Testing	Deductible, then 10% of AB	Deductible, then 30% of AB
Allergy Shots	Deductible, then 10% of AB	Deductible, then 30% of AB
Outpatient Physical, Speech and Occupational Therapy <sup>4</sup> (limited to 30 visits/condition/benefit period)	Deductible, then 10% of AB	Deductible, then 30% of AB
Outpatient Chiropractic <sup>5,6</sup> (limited to 20 visits/condition/benefit period)	Deductible, then 10% of AB	Deductible, then 30% of AB
<b>EMERGENCY CARE AND URGENT CARE</b>		
Physician's Office	Deductible, then 10% of AB	Deductible, then 30% of AB
Urgent Care Center	Deductible, then 10% of AB	Deductible, then 30% of AB
Hospital Emergency Room	Deductible, then \$100 per visit, plus 10% of AB (waived if admitted)	Deductible, then \$100 per visit, plus 10% of AB (waived if admitted)
Ambulance (if medically necessary)	Deductible, then 10% of AB	Deductible, then 30% of AB
<b>HOSPITALIZATION<sup>4,6</sup></b>		
Inpatient Facility Services	Deductible, then 10% of AB	Deductible, then 30% of AB
Outpatient Facility Services	Deductible, then 10% of AB	Deductible, then 30% of AB
Inpatient Physician Services	Deductible, then 10% of AB	Deductible, then 30% of AB
Outpatient Physician Services	Deductible, then 10% of AB	Deductible, then 30% of AB

The Allowed Benefit (AB) is generally the contracted rates or fee schedules that Preferred Providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueCross BlueShield (CareFirst), however, in certain circumstances, an allowance may be established by law.

SERVICES	In-Network You Pay <sup>2</sup>	Out-Of-Network You Pay <sup>3</sup>
<b>HOSPITAL ALTERNATIVES<sup>4</sup></b>		
Home Health Care	Deductible, then 10% of AB	Deductible, then 30% of AB
Hospice	Deductible, then 10% of AB	Deductible, then 30% of AB
Skilled Nursing Facility (limited to 100 days/benefit period) <sup>4</sup>	Deductible, then 10% of AB	Deductible, then 30% of AB
<b>MATERNITY</b>		
Prenatal and Postnatal Office Visits	Deductible, then 10% of AB	Deductible, then 30% of AB
Delivery and Facility Services <sup>4</sup>	Deductible, then 10% of AB	Deductible, then 30% of AB
Initial Office Consultation(s) for Infertility Services/Procedures	Deductible, then 10% of AB	Deductible, then 30% of AB
Nursery Care of Newborn	Deductible, then 10% of AB	Deductible, then 30% of AB
Artificial Insemination <sup>1</sup>	Deductible, then 50% of AB	Deductible, then 50% of AB
In Vitro Fertilization Procedures <sup>1</sup>	Not covered	Not covered
<b>MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)<sup>4</sup></b>		
Inpatient Facility Services (limited to 60 days/benefit period)	Deductible, then 10% of AB	Deductible, then 30% of AB
Inpatient Physician Services	Deductible, then 10% of AB	Deductible, then 30% of AB
Outpatient Services (MH & SA)	Deductible, then 20% of AB	Deductible, then 35% of AB
Partial Hospitalization <sup>5</sup> (each day counts as 1/2 day toward inpatient limit)	Deductible, then 10% of AB	Deductible, then 30% of AB
Medication Management Visit	Deductible, then 10% of AB	Deductible, then 30% of AB
<b>MISCELLANEOUS</b>		
Durable Medical Equipment <sup>4</sup>	Deductible, then 10% of AB	Deductible, then 30% of AB
Acupuncture	Not covered, unless Plan approved for anesthesia and when services are rendered in conjunction with Physical Therapy	Not covered, unless Plan approved for anesthesia and when services are rendered in conjunction with Physical Therapy
Transplants <sup>4</sup>	Covered as stated in the Certificate of Coverage	Covered as stated in the Certificate of Coverage
Hearing Aids for ages 0-18 (limited to \$1,400 max per hearing aid every 3 years) <sup>6</sup>	Deductible, then 10% of AB	Deductible, then 30% of AB
<b>VISION</b>	Not Covered	Not Covered
<b>PRESCRIPTION DRUGS</b> You pay 100% of the discounted cost of your prescription drugs up to your annual deductible; then, you pay the regular prescription drug copays until you meet your annual out-of-pocket maximum. (Refer to your prescription drug benefit summary for copay amounts).		

The Allowed Benefit (AB) is generally the contracted rates or fee schedules that Preferred Providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueCross BlueShield (CareFirst), however, in certain circumstances, an allowance may be established by law.

<sup>1</sup> Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment option for infertility. However, assisted reproduction (AI only) services performed as treatment option for infertility are only available under the terms of the members contract. Preauthorization required.

<sup>2</sup> In-network: When you have care rendered by or referred to a provider in the Preferred Provider network. In-network coinsurances are based on a percentage of the AB.

<sup>3</sup> Out-of-network: When you have care rendered by a provider not in the Preferred Provider Network, care is reimbursed as out-of-network. Out-of-network coinsurances are based on a percentage of the AB. When services are rendered by Non-Participating Providers, charges in excess of the AB are the member's responsibility. However, when services are rendered by a Participating Provider, then member is only responsible for the amount up to the AB.

<sup>4</sup> Preauthorization required.

<sup>5</sup> Consultation for chiropractic service is charged the same as office visit for illness.

<sup>6</sup> CareFirst BlueCross BlueShield may be providing your benefits on either a contract year or calendar year basis. Please refer to your benefits contract to determine which method applies to your benefit plan.

<sup>7</sup> Please refer to your Certificate of Coverage to determine your coverage level.

<sup>8</sup> The deductible and out-of-pocket limit can be met entirely by one member or by combining eligible expenses of two or more members.

<sup>9</sup> No copayments or coinsurance.

\* Whichever is greater.

All copayments apply towards the deductible and out-of-pocket limit.

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

The benefits described are issued under form numbers: MD/CF/MSGR/GC (2/07); COC-NCA (MSGR) REV 10/05; MD/CF/MSGR/DOCS (2/07); PPO-HSA DOCS AMEND (MSGR) 9/04; MD/CF/MSGR/SOB/PPO/HSA/ENHANCE (7/06); MD/GHMSI/MD-DOL APPEAL (7/02); GS-NCA (MSGR) (09/05) and any amendments.

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[www.carefirst.com](http://www.carefirst.com)

**HSA OPTION 1**

# Prescription Drug Program

## Integrated Deductible HSA

**Deductible:** See annual deductible on medical summary of benefits

**\$0/25/45 Retail Copays**

**50% Injectables Coinsurance\***

### The Four Tier Prescription Drug Program

This prescription drug program is offered as part of your health care benefits. This program covers both non-maintenance and maintenance prescription drugs including injectables dispensed by a retail pharmacy or designated mail service pharmacy.

This program is based on the CareFirst BlueCross BlueShield (CareFirst) preferred drug list, which is made up of certain brand name prescription drugs (Tier 2) and all generic prescription drugs (Tier 1). Your participating physician has a complete copy of the CareFirst preferred drug list. A copy can also be found at [www.carefirst.com/rx](http://www.carefirst.com/rx).

### Combined Medical and Prescription Drug Deductible

If you have a combined deductible you also have a combined out-of-pocket maximum. This means your eligible medical and prescription drug out-of-pocket expenses will be applied towards meeting your out-of-pocket maximum. Once you reach your out-of-pocket maximum, CareFirst will pay 100% of the allowed benefit for most covered services for the remainder of the year. Please see your medical summary of benefits for the combined annual deductible.

### How Do I Use My Benefit?

You will be required to pay the total discounted cost for your prescription drugs until you meet your annual deductible. Once you've reached your annual deductible, the prescription drug plan provides three tier coverage.

Talk to your doctor when you are prescribed medications to see if you are using drugs that are on the preferred drug list – these are also known as Tier 1 or Tier 2 drugs. You will save the most money if you can take those medications. You can also see if medications you are currently taking are on the preferred drug list by visiting the prescription drug site at [www.carefirst.com/rx](http://www.carefirst.com/rx). You can get your prescription filled by using the retail or mail order programs.

### Did You Know?

- If the cost of your medication is less than your copayment, you pay the cost of the medication.
- A generic drug is a prescription drug that by law must have the equivalent chemical composition as a specific brand name prescription drug.
- You can use your prescription drug card at more than 59,000 participating pharmacies nationwide.
- Frequently asked questions about your prescription benefits are available at [www.carefirst.com/rx](http://www.carefirst.com/rx).

### Retail Program

The retail program provides up to a 34-day supply of medication. Simply present your prescription drug identification card at one of more than 59,000 participating pharmacies nationwide and pay the appropriate copayment for your medication. Once your annual deductible (see medical summary of benefits) has been met, you will pay the following for drugs:

Generic Drug (Tier 1)	\$0
Preferred Brand Name Drug (Tier 2)	\$25

\*\*Non-Preferred Brand Name Drug (Tier 3) \$45

Injectables (excluding insulin) are available for 50% coinsurance up to a maximum payment of \$75 per injection (Tier 4).

### Mail Order Program

The mail service program is a convenient way for you to order medications. Your prescription is reviewed and dispensed by registered pharmacists and mailed directly to your home. Call Walgreens Mail Service at (800) 745-6285 for more information.

34-day supply	1 Copay
Up to a 90-day supply (maintenance only)	2 Copays

### Maintenance Drugs

Up to a 90-day supply of maintenance drugs are available through mail order or retail pharmacy. Maintenance medication is a prescription drug anticipated to be required for 6 months or more to treat a chronic condition.

Generic Drug (Tier 1)	\$0
Preferred Brand Name Drug (Tier 2)	\$50

\*\*Non-Preferred Brand Name Drug (Tier 3) \$90

Injectables (excluding insulin) are available for 50% coinsurance up to a maximum payment of \$150 (Tier 4).

*\*Injectables = Self-Administered Injectables*

*\*\*Non-preferred brand name drugs are not part of the preferred drug list and are covered at the highest copay.*

ACCESS [www.carefirst.com/rx](http://www.carefirst.com/rx) FOR MORE INFORMATION ABOUT THE 4-TIER PRESCRIPTION DRUG PROGRAM AND FOR THE MOST UP-TO-DATE PREFERRED DRUG LIST.

# Benefits Summary

Plan Feature	Amount	Description
Deductible	See medical summary of benefits for annual deductible amount	Once you meet your combined medical and drug deductible, you will pay a different copay depending on whether you receive a generic drug, preferred brand name drug or non-preferred brand name drug.
Out-of-Pocket Maximum	See medical summary of benefits for annual deductible amount	Once you reach your out-of-pocket maximum, CareFirst will pay 100% of the allowed benefit for most covered services for the remainder of the year. All deductibles, copays, coinsurance, and other eligible out-of-pocket costs count toward your out-of-pocket maximum. Keep in mind that balance billed amounts do not count toward your annual out-of-pocket maximum.
Generic Drugs (Tier 1) <i>(up to a 34-day supply)</i>	\$0	All generic drugs are covered at this copay level.
Preferred Brand Name Drugs (Tier 2) <i>(up to a 34-day supply)</i>	\$25	All preferred brand name drugs are covered at this copay level.
Non-Preferred Brand Name Drugs (Tier 3) <i>(up to a 34-day supply)</i>	\$45	All non-preferred brand name drugs are covered at this copay level. 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.
Injectables (excluding insulin) <i>(up to a 34-day supply)</i>	50% coinsurance up to a maximum payment of \$75 per injectable	All injectable drugs (excluding insulin) are covered at this payment level. Insulin is covered at appropriate copay level.
Annual Maximum	N/A	Your benefit does not have an annual benefit maximum.
Maintenance Copays <i>(up to a 90-day supply)</i>	generic: \$0 preferred: \$50 non-preferred: \$90 injectables: 50% coinsurance, up to a maximum payment of \$150	Maintenance drugs of up to a 90-day supply are available for twice the copay only through the mail service or retail pharmacy. Injectables (excluding insulin) are covered at 50% coinsurance up to a maximum payment of \$150.
Generic Substitution	Yes	If you choose a non-preferred brand name drug (Tier 3) over its generic equivalent (Tier 1), you will pay the highest copay PLUS the difference in cost between the non-preferred brand name drug and the generic drug up to the cost of the prescription.
Prior Authorization	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 to begin the prior authorization process. For the most up-to-date prior authorization list, visit the prescription drug web site at <a href="http://www.carefirst.com/rx">www.carefirst.com/rx</a> .

## Need More Information?

### On the Phone...

If you have questions about your prescription drug coverage or the preferred drug list, call Argus Health Systems at (800) 241-3371.

You should contact your physician or pharmacist if you have questions regarding the type of drug, side effects, drug interactions, storage, etc.

### By Mail...

If you have questions about your Mail Order benefits, call Walgreens Mail Service at (800) 745-6285.

### On the Web...

For the most recent information regarding the 4-tier prescription drug program, changes to the preferred drug list, etc. visit the prescription drug web site at [www.carefirst.com/rx](http://www.carefirst.com/rx).

The preferred drug list changes frequently in response to Food and Drug Administration (FDA) requirements. The list is also adjusted when a generic drug is introduced for a brand name drug. When that happens, the generic drug will be added to the Tier 1 list and the brand name drug will move from Tier 2 to Tier 3. For the most recent information about the preferred drug list, visit the prescription drug web site at [www.carefirst.com/rx](http://www.carefirst.com/rx).

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Policy Form Numbers: MD/CF/MSGR/RX/PPO (7/06)



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