

# BlueChoice Opt-Out *Plus* Open Access HSA

## Summary of Benefits

SERVICES	In-Network You Pay	Out-Of-Network You Pay
<b>ANNUAL DEDUCTIBLE<sup>3</sup></b>		
Individual	\$1,200	\$1,800
Individual & Child(ren)	\$2,400	\$3,600
Individual & Adult	\$2,400	\$3,600
Family	\$2,400	\$3,600
<b>ANNUAL OUT-OF-POCKET LIMIT<sup>3</sup></b>		
Individual	\$2,400	\$3,600
Individual & Child(ren)	\$4,800	\$7,200
Individual & Adult	\$4,800	\$7,200
Family	\$4,800	\$7,200
<b>LIFETIME MAXIMUM</b>	Unlimited	\$2,000,000
<b>PREVENTIVE SERVICES</b>		
Well-Child Care		
0-24 months	\$10 per visit	\$10 per visit
24 months-13 years (immunization visit)	\$10 per visit	\$10 per visit
24 months-13 years (non-immunization visit)	\$20 per visit	20% of allowed benefit*
14-17 years	\$20 per visit	20% of allowed benefit*
Adult Physical Examination	\$20 PCP/\$30 Specialist per visit	20% of allowed benefit*
Routine GYN Visits	\$20 per visit	20% of allowed benefit*
Mammograms	\$30 per visit	20% of allowed benefit*
Cancer Screening (Pap Test, Prostate and Colorectal)	\$30 per visit	20% of allowed benefit*
<b>OFFICE VISITS, LABS &amp; TESTING</b>		
Office Visits for Illness	Deductible, then \$20 PCP/\$30 Specialist per visit	Deductible, then 20% of allowed benefit*
Diagnostic Services	Deductible, then \$30 or 50% of cost, whichever is less	Deductible, then 20% of allowed benefit*
X-ray and Lab Tests	Deductible, then \$30 or 50% of cost, whichever is less	Deductible, then 20% of allowed benefit*
Allergy Testing <sup>7</sup>	Deductible, then \$20 PCP/\$30 Specialist per visit	Deductible, then 20% of allowed benefit*
Allergy Shots <sup>7</sup>	Deductible, then \$20 PCP/\$30 Specialist per visit	Deductible, then 20% of allowed benefit*
Outpatient Physical, Speech and Occupational Therapy <sup>8</sup> (limited to 30 visits/condition/benefit period)	Deductible, then \$30 per visit	Deductible, then 30% of allowed benefit*
Outpatient Chiropractic <sup>9</sup> (limited to 20 visits/condition/benefit period)	Deductible, then \$30 per visit	Deductible, then 30% of allowed benefit*
<b>EMERGENCY CARE AND URGENT CARE</b>		
Physician's Office	Deductible, then \$20 PCP/\$30 Specialist per visit	Covered as in-network
Urgent Care Center	Deductible, then \$30 per visit	Covered as in-network
Hospital Emergency Room	Deductible, then \$100 per visit (waived if admitted)	Covered as in-network
Ambulance (if medically necessary)	No charge after deductible <sup>6</sup>	Covered as in-network
<b>HOSPITALIZATION<sup>8</sup></b>		
Inpatient Facility Services	Deductible, then \$250 admission	Deductible, then 20% of allowed benefit*
Outpatient Facility Services	Deductible, then \$30 per visit	Deductible, then 20% of allowed benefit*
Inpatient Physician Services	Deductible, then \$20 PCP/\$30 Specialist per visit	Deductible, then 20% of allowed benefit*
Outpatient Physician Services	Deductible, then \$30 per visit	Deductible, then 20% of allowed benefit*

SERVICES	In-Network You Pay	Out-Of-Network You Pay
<b>HOSPITAL ALTERNATIVES<sup>8</sup></b>		
Home Health Care	No charge after deductible <sup>2</sup>	Deductible, then 20% of allowed benefit*
Hospice	No charge after deductible <sup>2</sup>	Deductible, then 20% of allowed benefit*
Skilled Nursing Facility <sup>5</sup> (limited to 100 days/benefit period)	Deductible, then \$30 per day	Deductible, then 20% of allowed benefit*
<b>MATERNITY</b>		
Prenatal and Postnatal Office Visits	Deductible, then \$20 per visit	Deductible, then 20% of allowed benefit*
Delivery and Facility Services <sup>3</sup>	Deductible, then \$250 per admission	Deductible, then 20% of allowed benefit*
Nursery Care of Newborn <sup>4</sup>	No charge after deductible <sup>2</sup>	Deductible, then 20% of allowed benefit*
Initial Office Consultation(s) for Infertility Services/Procedures	Deductible, then \$20 PCP/\$30 Specialist per visit	Deductible, then 20% of allowed benefit*
Artificial Insemination <sup>1</sup>	Deductible, then 50% of allowed charges (after diagnosis is confirmed)	Deductible, then 50% of allowed benefit*
In Vitro Fertilization Procedures <sup>5</sup>	Not covered	Not covered
<b>MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)<sup>8</sup></b>		
Inpatient Facility Services (limited to 60 days/benefit period)	Deductible, then \$250 per admission	Deductible, then 20% of allowed benefit*
Inpatient Physician Services	Deductible, then \$20 PCP/\$30 Specialist per visit	Deductible, then 20% of allowed benefit*
Outpatient Services (MH & SA)	Deductible, then 30% of allowed benefit	Deductible, then 50% of allowed benefit*
Partial Hospitalization <sup>5</sup> (each day counts as 1/2 day toward inpatient limit)	Deductible, then \$250 per admission	Deductible, then 20% of allowed benefit*
Medication Management Visit	Deductible, then \$20 PCP/\$30 Specialist per visit	Deductible, then 20% of allowed benefit*
<b>MISCELLANEOUS</b>		
Durable Medical Equipment <sup>8</sup>	No charge after deductible <sup>2</sup>	Deductible, then 20% of allowed benefit*
Acupuncture	Not covered, unless medically necessary and Plan approved for anesthesia and when services are rendered in conjunction with Physical Therapy	Not covered, unless Plan approved for and Plan approved for anesthesia and when services are rendered in conjunction with Physical Therapy
Transplants <sup>6,8</sup>	Deductible, then covered as stated in Evidence of Coverage	Deductible, then covered as stated in Evidence of Coverage
Hearing Aids for ages 0-18 (limited to \$1,400 max per hearing aid every 3 years) <sup>5</sup>	No charge after deductible <sup>2</sup>	Deductible, then 20% of allowed benefit*
<b>VISION</b>		
Routine Exam (Optometrist or Ophthalmologist) (limited to 1 visit/benefit period)	Not covered	Not covered
Eyeglasses and Contact Lenses	Not covered	Not covered

<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) services performed as treatment option for infertility are only available under the terms of the members contract. Preauthorization required.

<sup>2</sup> No copayments or coinsurance.

<sup>3</sup> The deductible can be met entirely by one Member or by combining eligible expenses of two or more members. The Out-of-Pocket can be met in the same way. The Out-of-Network and In-Network deductibles, Out-of-Pocket maximum and Lifetime maximum are separate and do not contribute to each other.

<sup>4</sup> Newborns must be enrolled within 31 days of birth.

<sup>5</sup> CareFirst BlueChoice may be providing your BlueChoice benefits on either a contract or calendar year basis. Please refer to your benefits contract to determine which method applies to your group benefit plan.

<sup>6</sup> Please refer to your Evidence of Coverage to determine your coverage level.

<sup>7</sup> If office copayment has been paid, additional office copayment not required for this service.

<sup>8</sup> Preauthorization required.

<sup>9</sup> Consultation for chiropractic services is the same as office visit for illness.

\* Out-of-network coinsurances are based on a percentage of the out-of-network allowed benefit. If services are rendered from a nonparticipating provider, member is responsible for 100% of charges above the allowed benefit. However, if services are rendered by a participating provider, member is only responsible for amount up to the allowed benefit.

HSA plans must be sold with an integrated Rx benefit.

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

**Note: Upon enrollment in CareFirst BlueChoice Opt-Out Plus Open Access, you will need to select a Primary Care Physician (PCP).**

To select a PCP, go to [www.carefirst.com](http://www.carefirst.com) for the most current listing of PCPs from our online provider directory. You may also call the Member Services toll free phone number on the front of your CareFirst BlueChoice ID card for assistance in selecting a PCP or obtaining a printed copy of the CareFirst BlueChoice provider directory.

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.

Policy form numbers: MD/CFBC/MSGR/GC (2/07) • MD/CFBC/MSGR/DOCS (7/07) • MD/CFBC/MSGR/EOC (7/07) • MD/CFBC/MSGR/HSA/OOP/OA (R. 7/07) •

MD/CFBC/MSGR/HSA/SOB/ENHANCE (7/06) • GS-CC (MSGR) REV (09/05) • MD/CFBC/DOC APPEAL (R. 6/06) • MD/CFBC/MSGR/BLUECARD (7/07) and any amendments.



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

# 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 BlueChoice, Inc. (CareFirst BlueChoice) 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 BlueChoice 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 BlueChoice 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 BlueChoice 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).

This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

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



CareFirst BlueChoice, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.

® Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.