



Overview of EPO Benefits

Eastern Shore of Maryland Educational Consortium
(ESMEC)

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Important Terms

- **In-network** refers to the use of providers who are in the Plan's provider network applicable to the product you are enrolled in. Seeking care from in-network providers can reduce your out-of-pocket expenses.
- **Out-of-network** refers to the use of providers who are NOT in the Plan's provider network applicable to the product you are enrolled in. These providers can be in another Plan network or non-participating in any of the Plan's networks. If your plan has out-of-network benefits your out-of-pocket costs will be higher.
- The **CareFirst PPO network** is used for care within the CareFirst Service Area (MD, DC, Northern VA).
- The **National Provider Network** used for care rendered outside of the CareFirst Service area. The Blue Cross and BlueShield Association plans across the country, have a national/international participating network of providers (the **BlueCard®** network).
- The **EPO** uses the Preferred Provider Network Exclusively. Services must be rendered by an in-network PPO provider to be covered. There are no out-of-network benefits (with few exceptions).

Important Terms

- **Allowed Benefit:** the amount CareFirst, or BlueCard® allows for a covered service regardless of the provider's actual charge. A provider who participates in the network cannot charge more than this amount for any covered service.
- **Balance Billing:** Provider billing for the difference between the Allowed Benefit and the provider's charge.
- **Medical Deductible:** the amount of “eligible expenses” you must pay before the plan pays benefits. The deductible renews each calendar year. Expenses incurred for Prescription Drug, Dental or Vision services do not apply towards the medical deductible.
- **Copay** is a fixed amount a member must pay for a covered service (e.g. \$20 per office visit to a PCP).
- **Coinsurance** is a percentage of the doctor's charge or allowed benefit a member must pay for a covered service (e.g. the 10% of the “Allowed benefit” you pay - the plan pays the other 90%).
- **Out-Of-Pocket Expense:** Any amount you pay towards your medical deductible, medical copays and medical coinsurance is an out-of-pocket expense. This does not include expenses over our allowed benefit (balance billing) or for non-covered services

Key Features

- ✓ Open Access feature (no referrals needed)
- ✓ No Primary Care Physician (PCP) selection required to enroll.
- ✓ No claim filing when care is provided by a CareFirst, or national BlueCard® provider.
- ✓ No balance billing when care is provided by a CareFirst, or national BlueCard® provider.
- ✓ No Lifetime dollar maximums or pre-existing condition limitations.

EPO Benefits

- To be eligible for coverage services must be rendered by providers in the CareFirst PPO or BlueCard® PPO network.
- Benefits are paid in full & may have a per visit copay based upon where services are rendered.
 - Doctor's office - \$20 copay.
 - Outpatient department facility charge - \$40
 - Outpatient department professional services - \$30

Find A Doctor

 Medical	 Dental	 Pharmacy	 Vision
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Plan (Recommended)

BlueCross BlueShield Preferred



Exceptions : Out-of-Network Services are paid as In-Network

Benefits must be rendered by an in-network provider for services to be covered with the following exceptions

- ☐ Surgical Assistants
- ☐ Anesthesiologists
- ☐ Radiologist's professional charge for "reading" x-rays
- ☐ Ambulance
- ☐ Emergency Care or other care where, upon appeal, it is determined services of a Preferred Provider were not available.

For providers not participating in the network you are additionally responsible for:

- direct payment to the provider for the provider's TOTAL charge. Plan Payment will be sent to you.**
- the difference between the provider's charge and the CareFirst "allowed benefit"**

Member Liability

	In-Network	Out-of-Network
Deductible	No Deductible	N/A
Co-insurance	Plan Pays 100%	N/A
Copay	Office Visit \$20 Hospital Facility \$40 Practitioner (at hospital) \$30	N/A
Out-of-Pocket Medical EPO	\$1,200/\$3,600	Does not contribute
Out-of-Pocket Prescription Drug	\$5,400/\$9,600	Included in In-Network
Well-Child, Routine Adult Physical & GYN Office Visits	Member pays applicable copay	Member pays entire cost
Preventive Diagnostic Screenings	\$20 copay	Member pays entire cost
Non-Preventive Physician Office Visit	Member pays applicable copay	Member pays entire cost
Non-Preventive Lab Test, X-ray	\$20 copay	Member pays entire cost
Emergency Room	\$70 copay	Member pays entire cost unless authorized
Urgent Care Center	\$20 copay	Member pays entire cost
Inpatient Facility	Plan pays 100%	Member pays entire cost
Outpatient Facility	Member pays applicable copay	Member pays entire cost

Refer to your benefit summary for more detail on covered services

Your Benefits...How they Work EPO

CareFirst PPO network
BlueCard®PPO network

In-Network Benefits

You receive prior approval to receive care from a non-PPO provider who does not participate in any BCBS network

You receive care from a non-PPO provider

Provider's
charge

Allowed
Benefit

You
Pay

\$250

\$120

\$20

Provider's
charge

Allowed
Benefit

You
Pay

\$250

\$120

\$150

$\$250 - \$120 = \$130$ (the portion of the out-of-network provider's charge that is above the allowed benefit) plus \$20 copay

Provider's
charge

Allowed
Benefit

You
Pay

\$250

\$0

\$250

If you receive services from a non-participating provider, you will have to:

- Pay the provider's actual charge at the time you receive care.
- File a claim for reimbursement.

Hospital Authorization/Utilization Management (UM)

- Any CareFirst or BCBS Participating Facility is responsible for obtaining any required preauthorization for inpatient services.
- Certain outpatient services require prior authorization: Home Health Care, Hospice Care, Infertility Services, Habilitative Services
- In-Network Providers will obtain prior authorization from CareFirst or their local BlueCross Blue Shield plan.
- Non-Participating Providers may obtain any required preauthorization for services however if they do not you will be responsible for obtaining authorization.
 - Call CareFirst's Utilization Management department at least five business days prior to a scheduled admission date
 - For emergency admissions, call at least two business days after the admission
 - Call the preauthorization/UM number on the back of your CareFirst ID card. If you are unable to call UM, have someone call for you... family member, hospital representative, or provider

The BlueCard® Program

Here's how BlueCard® works

- When you're outside of the Maryland, D.C. and Northern Virginia area and need care, call BlueCard® Access at (800) 810-BLUE (2583) to locate the nearest Blue Cross and Blue Shield doctors and hospitals. You can also search for providers electronically with the BlueCard® Provider Finder at <http://provider.bcbs.com>.
- When you arrive at the doctor's office or hospital, present your current CareFirst member ID card, and the doctor or hospital will verify your membership and coverage.
- After you receive medical attention, your claim is electronically routed to CareFirst for processing.
- All participating doctors and hospitals are paid directly, relieving you of any hassle or worry. You are only responsible for any out-of-pocket expenses (non-covered services, deductibles, copayments or coinsurance).
- CareFirst will send you a detailed Explanation of Benefits advising you of the payments that were made and your liability to the provider of care.

Be a Wise Consumer of Health Care Benefits

- Prior to a procedure, double-check that ALL providers involved are in the appropriate network so you will receive In-Network benefits. For example, the surgical center where your outpatient surgical procedure will be rendered.
- If a medical bill or CareFirst Explanation of Benefits (EOB) doesn't seem right, call CareFirst customer service. If you don't understand, ask questions.
- Going out of area or out of country? Have a child away at college? Have a plan in case of illness while away. Check for in-network providers in the area.



Questions?

Next: Prescription Drug

www.carefirst.com



Drug Program Basics

- The copay is the dollar amount the pharmacy will collect for your prescription.
- Prescription drugs are divided into categories called “tiers” The price you pay is determined by the tier the prescription falls in.
- You will receive a 34 day supply of the prescription for a single copay.
- Tier 1 drugs are generics. These drugs have the lowest copay.
- Brand Name Drugs are categorized as “preferred” or “non-preferred”. The CareFirst Preferred Drug List –Formulary 1 can be found on our website.
- Tier 2 drugs are “preferred brand name”
- Tier 3 drugs are “non-preferred brand name”



Save With Mail Order Maintenance Drugs

Maintenance drugs are prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. When medically appropriate, maintenance drugs can be filled for up to a 90-day supply. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes. .

- ❖ You can receive a 90 day supply of “Maintenance” medication for two (2) copays at a retail pharmacy or via mail order.



What is Mail Order (Rx Delivered)?

How It Works

Step 1

Gets Mail
Order Forms



1. Download the mail order form from the internet
2. Call CVS Caremark customer service to get a mail order form
3. Use a paper mail order form provided at open enrollment



Step 2

Fill
prescription



New

Refills

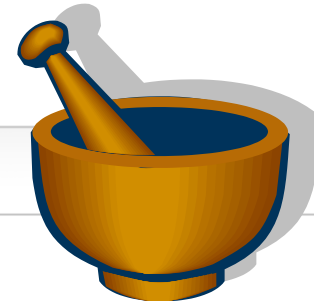


With a new
prescription,
mail in
prescription
with mail order
form

Refills: By web,
phone, or order
form that is
mailed

Payment options:
Electronic check, Bill
Me Later®, credit or
debit card, check or
money order

NOTE: Delivery is free and takes 7 to 10 days from day request/form is sent
Members can pay to expedited delivery (next business day or 2nd business day)



Prescription Drug Copays \$0 Deductible

Retail Pharmacy	34-day supply
Tier 1: Generic Drugs	\$7 copayment
Tier 2: Preferred Brand Drugs	\$12 copayment
Tier 3: Non-Preferred Brand Drugs	\$30 copayment
Maintenance Drugs Mail Order- CVS	90-day supply
Tier 1: Generic Drugs	\$14 copayment
Tier 2: Preferred Brand Drugs	\$24 copayment
Tier 3: Non-Preferred Brand Drugs	\$60 copayment
Maintenance Drugs Retail Pharmacy	90-day supply
Tier 1: Generic Drugs	\$14 copayment
Tier 2: Preferred Brand Drugs	\$24 copayment
Tier 3: Non-Preferred Brand Drugs	\$60 copayment



Prescription Drug Website www.carefirst.com/rx

The preferred drug list is subject to change as new generic and brand name drugs become available. A printable version of the form can be found on-line.

Prior to filling or refilling your prescription check the website to make sure your drug is still in the same “tier”. The tier will determine your copay amount.

Not all prescription drugs are listed on the website. If you cannot find a particular drug, or if you have questions, please call our pharmacy claims processor, CVS Caremark at (800) 241-3371.

Access www.carefirst.com/rx for more information and for the most up-to-date preferred drug list.

Quick Links

[Pay Your Bill ›](#)

[A Look at Blue Rewards ›](#)

[Prescription Drug Information ›](#)

[Stay Connected ›](#)



Prescription Drug Website

Quick Links

[Pay Your Bill ›](#)[A Look at Blue Rewards ›](#)[Prescription Drug Information ›](#)[Stay Connected ›](#)

Care Management Criteria

We are committed to providing safe and effective medications and therapeutic alternatives. To ensure you are receiving the most appropriate medication for your disease(s), we require additional information from your doctor before dispensing certain prescriptions. In those instances, we will work with you and your physician to manage the following formulary processes:

- **Prior authorization** is required before you fill prescriptions for certain drugs. Your doctor may need to provide some of your medical history or laboratory tests to determine if these medications are appropriate. Without prior authorization, your drugs may not be 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.
- **Quantity Limits** are quality and cost-savings initiatives aimed at safe and appropriate use of drugs. They ensure your prescription contains an appropriate amount of medication and are based on clinical guidelines and direction from the U.S. Food and Drug Administration. These limits set the amount of drug your benefit program will cover, but the final decision regarding the amount prescribed remains with you and your physician.

To view the drugs requiring prior authorization, step therapy or quantity limits go to the [Drug Search](#) page.

Specialty Pharmacy Coordination Program

Through this program CareFirst addresses the unique clinical needs of members who take high-cost specialty drugs for certain conditions like multiple sclerosis, hepatitis C and hemophilia. We recognize that members taking specialty drugs require high-touch, high-quality care coordination and support to assure the best possible outcomes.

In order to maximize the effectiveness of the Specialty Pharmacy Coordination Program, your specialty medications must be filled through an exclusive specialty pharmacy in the CareFirst network—CVS/caremark Specialty Pharmacy and OncoSource Rx Specialty Pharmacy, depending on your health condition.

These in-network specialty pharmacies supply medications quickly and provide personalized support from clinical experts specializing in your condition that can be reached 24 hours a day, seven days a week by phone.

In coordination with our care management program, the Customer Care team addresses your unique clinical needs and helps improve medication adherence, persistency to prescribed therapies, and safety, thereby improving your overall health and costs.



Questions?

Next: Vision Coverage

www.carefirst.com



Welcome to BlueVision Plus

Plan S Administered by Davis Vision

Refer to the BlueVision *Plus* Benefit Summary For More Information
Or you can contact Davis Vision at 1-800-783-5602

Find A Doctor



- BlueVision/BlueVision Plus/Pediatric Vision (Davis Vision)

BlueVision Plus Benefits

Davis (Participating) Providers

- \$0 copay for a routine eye exam at a **Participating** Davis Vision provider (once per 12 months).
- \$20 or \$40 copay on “Davis” frames, depending on style chosen
- \$20 copay on “Davis” lenses
- \$40 copay on contact lenses in lieu of glass
- \$45 wholesale allowance toward the cost of non-“Davis” frames
- There may be additional discounts on add-ons such as scratch-resistant coating and progressive lenses. Ask your Davis Vision Provider about other discounts available.



Out of Network Vision Providers

- If your vision provider is not in the Davis Network you can file a claim to be reimbursed at the out of network fee schedule for your eye exam, glasses or contact lenses.

Note: “Safety Frames” are not included in the Vision Program





Questions?

Next: Dental Coverage

www.carefirst.com



Dental Benefits

The Dental program is designed to stress the importance of routine dental care.

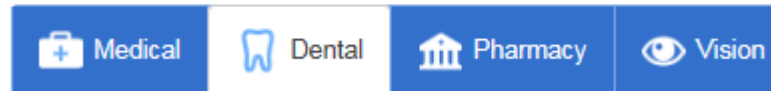
Benefits are paid based upon the “Class” of the dental service.

Refer to the Regional Dental Benefit Summary For More Information.

Or you can contact CareFirst Dental Business Operations at

1-866-891-2802

Find A Doctor

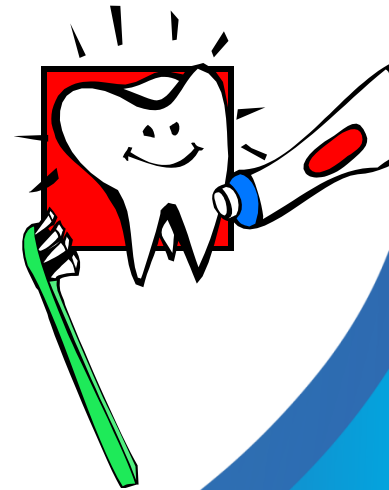


Plan (Recommended)

Select a Plan

- Traditional Dental
- Preferred Dental (PPO)
- Individual Select Preferred
- Dental HMO (The Dental Network)
- CareFirst BlueChoice Discount Dental

Preferred Dental (PPO)



<p>Deductible (Class II, III & IV combined) There is a separate deductible for in and out-of-network services</p>	<p>In-Network You Pay Preferred Dental Provider</p> <p>\$25 Individual \$75 Family</p>	<p>Out-of-Network You Pay Traditional Dental Provider or Non-Participating Dental Provider</p> <p>\$25 Individual \$75 Family</p>
<p>Annual Maximum (Class I, II, III & IV combined)</p>	<p>\$1,000 per member</p>	
<p>Lifetime Orthodontia Maximum (Class V)</p>	<p>\$1,500 per member</p>	
<p>BENEFIT DESCRIPTION</p>	<p>PLAN PAYMENT</p>	
<p>CLASS I: Preventive & Diagnostic Services: exams, x-rays, sealants</p>	<p>100% of AB* no deductible</p>	
<p>CLASS II: Basic Services: Fillings, simple extractions, perio scaling</p>	<p>80% of AB* after deductible</p>	
<p>CLASS III: Major Services – Surgical: periodontal, endodontal, surgical extractions</p>	<p>80% of AB* after deductible</p>	
<p>CLASS IV: Major Services – Restorative: dentures, crowns</p>	<p>50% of AB* after deductible</p>	
<p>CLASS V: Orthodontic Services</p>	<p>50% of AB* no deductible</p>	

Refer to your Benefit Summary For More Information.



Questions?

www.carefirst.com

