

CareFirst BlueCross BlueShield Medical & Express Scripts Pharmacy Plan (Faculty/Staff)

Coverage Period: 01/01/2014 – 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | Plan Type: COMP



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <http://benefits.jhu.edu/health-and-life/medical-plans.cfm> or by calling 410-516-2000.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$500 Individual \$1,500 Family	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	There is a \$250 per admission deductible.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	\$2,000 Individual \$6,000 Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Premiums, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers ?	Yes. Please visit www.CareFirst.com or call 1-855-258-6518 for a listing of Participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	No, you do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services .

Questions: If you are a member please call the number on the back of your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the bolded terms used in this form, see the Glossary at www.carefirst.com/sbcg.



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance subject to deductible	20% coinsurance subject to deductible	Deductible, 0% coinsurance for Special Provider Network, Non-participating may balance bill
	Specialist visit	20% coinsurance subject to deductible	20% coinsurance subject to deductible	Deductible, 0% coinsurance for Special Provider Network, Non-participating may balance bill
	Other practitioner office visit	20% coinsurance subject to deductible for Chiropractic and Acupuncture Services	20% coinsurance subject to deductible for Chiropractic and Acupuncture Services	Deductible, 0% coinsurance for Chiropractic and Acupuncture Services for Special Provider Network, Non-participating may balance bill
	Preventive care/screening/immunization	No member liability	No member liability	Non-participating may balance bill
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance subject to deductible	20% coinsurance subject to deductible	Non-participating may balance bill
	Imaging (CT/PET scans, MRIs)	20% coinsurance subject to deductible	20% coinsurance subject to deductible	Non-participating may balance bill

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage through ESI is available at www.Express-Scripts.com	Generic drugs	\$10 copay/prescription at retail \$25 copay/prescription for mail-order		Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	20% coinsurance with \$30 min and \$45 max/prescription at retail \$75 copay/prescription for mail order		
	Non-preferred brand drugs	25% coinsurance with \$60 min and \$100 max/prescription at retail \$150 copay/prescription for mail-order		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No member liability	No member liability	Non-participating may balance bill
	Physician/surgeon fees	20% coinsurance subject to deductible	20% coinsurance subject to deductible	Non-participating may balance bill
If you need immediate medical attention	Emergency room services	\$100 Copay	\$100 Copay	Non-participating may balance bill
	Emergency medical transportation	20% coinsurance subject to deductible	20% coinsurance subject to deductible	Non-participating may balance bill
	Urgent care	\$50 Copay	\$50 Copay	Non-participating may balance bill
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 per admission deductible; then 20% coinsurance	\$250 per admission deductible; then 20% coinsurance	Non-participating may balance bill
	Physician/surgeon fee	20% coinsurance subject to deductible	20% coinsurance subject to deductible	Non-participating may balance bill

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance subject to deductible	20% coinsurance subject to deductible	Non-participating may balance bill
	Mental/Behavioral health inpatient services	\$250 per admission copay; then 20% coinsurance subject to deductible	\$250 per admission copay; 20% coinsurance subject to deductible	Non-participating may balance bill
	Substance use disorder outpatient services	20% coinsurance subject to deductible	20% coinsurance subject to deductible	Non-participating may balance bill
	Substance use disorder inpatient services	\$250 per admission copay; then 20% coinsurance subject to deductible	\$250 per admission copay; 20% coinsurance subject to deductible	Non-participating may balance bill
If you are pregnant	Prenatal and postnatal care	100% covered, subject to deductible	20% coinsurance subject to deductible	Non-participating may balance bill
	Delivery and all inpatient services	\$250 per admission deductible 20% coinsurance subject to deductible	\$250 per admission deductible 20% coinsurance subject to deductible	Non-participating may balance bill

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	20% coinsurance, not subject to deductible	20% coinsurance, not subject to deductible	Non-participating provider may balance bill Limited to 90 days of unlimited visits per benefit period
	Rehabilitation services	20% coinsurance subject to deductible	20% coinsurance subject to deductible	Non-participating may balance bill
	Habilitation services	20% coinsurance subject to deductible	20% coinsurance subject to deductible	Non-participating provider may balance bill Preauthorization required
	Skilled nursing care	\$250 per admission deductible 20% coinsurance subject to deductible	\$250 per admission deductible 20% coinsurance subject to deductible	Non-participating provider may balance bill
	Durable medical equipment	20% coinsurance subject to deductible	20% coinsurance subject to deductible	Non-participating may balance bill
	Hospice service	No member liability	No member liability	Non-participating may balance bill
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	—————none—————
	Glasses	Not Covered	Not Covered	—————none—————
	Dental check-up	Not Covered	Not Covered	—————none—————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Most coverage provided outside the United States
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage:

** Individual health insurance–

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or <http://www.mdinsurance.state.md.us>
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

** Group health coverage–

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 410-516-2000. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 410-516-2000. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or <http://www.mdinsurance.state.md.us>
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-258-6518

Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijigo holne’ 1-855-258-6518

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,160
- Patient pays \$1,380

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$500
Co-pays	\$270
Co-insurance	\$460
Limits or exclusions	\$150
Total	\$1,380

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,000
- Patient pays \$1,400

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$500
Copays	\$380
Coinsurance	\$440
Limits or exclusions	\$80
Total	\$1,400

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-783-4582.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers**

charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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