

**Baltimore County Public Schools
CareFirst Blue Cross Blue Shield Triple Choice MPOS
for Active employees and Retirees Under 65**

UNDERSTANDING YOUR SHARE OF THE COST

If you receive covered services from an in-network provider you **are not responsible** for any charge over the allowed amount. If you receive covered services from an out-of-network provider you **are responsible** for the portion of the charge over the allowed amount, except for emergency situations.

Co-payments

A co-payment is a fixed dollar amount you pay for some covered services. The provider usually collects this amount at the time the service is received. One co-payment covers services at a provider's office as long as it is billed with an office visit, second surgical opinion, surgery, consultation or short-term rehabilitative therapies. Refer to the "Medical Option At-A-Glance" chart for your specific co-payments and coinsurance amounts.

Office visit co-payments are credited to the individual or family out-of-pocket maximum, but do not count toward the calendar year deductible. Co-payments also apply to emergency room services. When you seek these services from an out-of-network provider, you may be required to pay the entire bill at the time of service, and file a claim with CareFirst BCBS. You will then be reimbursed the billed amount minus the co-payment.

Deductibles

A deductible is the dollar amount you must incur for covered services in a calendar year before benefits are payable under the Plan. If one or more dependents are covered under the Plan, you each have an individual and a combined family deductible. Refer to the "Medical Option At-A-Glance" chart for your specific deductible amounts.

The calendar year deductible does not apply to any services where a co-payment applies.

Carryover Provision: If a member contributes towards their calendar year deductible, amounts contributed in October, November and December will carryover toward the next calendar year's deductible.

Coinsurance

Coinsurance applies after you have satisfied your calendar year deductible. The coinsurance percentages shown in the “Medical Option At-A-Glance” chart are the portion that is payable under the Plan.

Below is an example of what your costs could be for in-network or out-of-network services. The scenario is a total outpatient hospital bill of \$5,000. (NOTE: Deductible and coinsurance amounts are for example only, please refer to the “Medical Option At-A-Glance” chart for information specific to your coverage.)

	In-Network	Out-of-Network
A. Total Bill	\$5,000	\$5,000
B. Allowed Amount	\$4,250	\$4,250
C. Deductible Amount	\$150	\$300
D. Allowed Amount Minus Deductible (B-C)	\$4,100	\$3,950
E. Your Coinsurance Amount (x% times D)	(5%) \$205	(25%) \$987.50
F. Amount You Owe Over Allowed Amount	\$0 (In network charges limited to Allowed Amount)	\$750 (difference between Total Bill and Allowed Amount)
G. Total Amount You Owe (C+E+F)	\$355	\$2,037.50

Out-of-Pocket Maximum

The out-of-pocket maximum is the dollar amount you must pay in deductible, coinsurance, and office visit co-payments for covered services in a calendar year before the Plan pays 100% of covered services.

The following special rules apply to the out-of-pocket maximum:

- Mental health co-payments, amounts over allowed amounts, and non-covered services are not included in the out-of-pocket maximum.
- Any family member can contribute toward the out-of-pocket maximum, not to exceed the individual amount.
- Deductibles and out-of-pocket maximums are calculated on a calendar year basis.
- Deductible and out-of-pocket amounts can flow between Levels 1, 2, and 3.