

Your Medical Options – Highlights

BCPS offers eligible employees the choice of the following medical plan options:

- CareFirst BlueCross BlueShield MPOS (Triple Choice)
- Kaiser Permanente HMO
- Keystone Health Plan Central HMO (for Pennsylvania residents only)

None of these plans contain a pre-existing condition limitation. This means that each plan will not exclude benefits for illnesses you had when you joined BCPS.

About Our Medical Plan Options

The medical plans offered through BCPS' flexible benefits program have different ways of delivering health care. BCPS gives you the choice of one Point-of-Service plan (POS) and two Health Maintenance Organization (HMO) options. The differences between the POS plan and an HMO are the levels of coverage, and the selection of providers. The POS plan offers three different levels of coverage depending on whether you use in- or out-of-network providers. A HMO offers only one level of coverage and you must use the network of participating providers. The flexibility to seek care outside the network translates into a higher price tag from your paycheck. You decide which plan works best for you.

On the following pages you will find a comparison of the benefits provided under each medical option.

Important Note: *This enrollment guide is neither a contract nor a summary description of your health plan choices. If you have specific questions about a particular plan before enrolling in it, call the Office of Employee Benefits and Retirement to obtain enrollment brochures and a copy of the applicable Benefit Guide or Certificate of Coverage. After you enroll, you will receive a copy of the Benefit Guide or Certificate of Coverage for the health plan that you have selected. Please retain this information for your records.*

What is a “Primary Care Physician (PCP)”?

All of the options require the selection of a Primary Care Physician (PCP) to obtain the highest level of coverage. A PCP is typically a general practitioner, a family practitioner, an internist, or a pediatrician. You and each covered member of your family must choose a PCP from the plan's provider directory. The most current provider directory information is available from each plan's Web site, from Member Services, or you may call the Office of Employee Benefits and Retirement to obtain a paper copy of the directory.

Your PCP provides your medical care or refers you to a specialist, as necessary. Your PCP will get to know your medical history and your individual health care needs.

Primary Care Physicians make sure that you are not receiving unnecessary medical treatment and that the medications that you are taking are safe and effective. There are generally no claim forms to complete or submit. Call the Member Services number on your medical plan identification card for information on changing your PCP.



Your Medical Options – Highlights *(continued)*

Option 1

CareFirst BlueCross BlueShield Triple Choice MPOS

How the Plan Works

The CareFirst Plan offers three levels of coverage in one health plan. When you need to see a doctor, you have the flexibility to see the physician of your choice. Your choice determines whether benefits will be paid at the Level 1, 2, or 3 amounts each time you seek medical services.

Choosing a Provider

To receive the highest level of benefits, you will need to choose a Primary Care Physician (PCP) to coordinate all of your health care needs. To find a PCP who is part of the CareFirst network, consult the MPOS Provider Directory by visiting CareFirst’s Web site at www.carefirst.com or contact Member Services at (410) 581-3625.

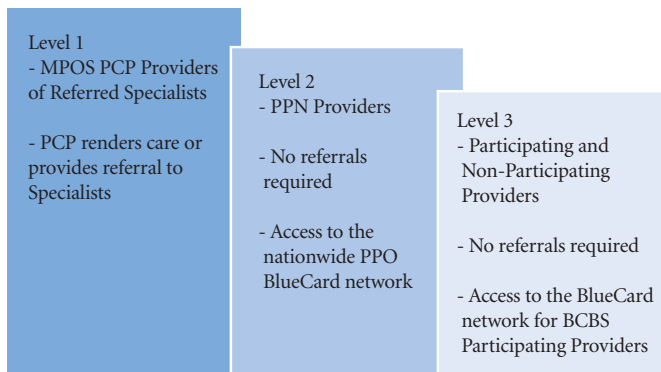
When You Need Care

Benefit levels are determined each time you need a medical service. This level also determines the out-of-pocket expenses you will have to pay. It’s your choice.

Level 1 Benefits: provide the highest level of plan coverage when you use network providers (from the MPOS directory) and have your PCP coordinate all your medical care.

Level 2 Benefits: provide the second highest level of plan coverage when you seek medical care from any provider in the national Preferred Provider Organization (PPO) without the coordination of your PCP.

Level 3 Benefits: provide a lower level of benefits coverage in exchange for the freedom to seek care from any provider you choose. If you receive care from a doctor or hospital not in the MPOS or Preferred Provider networks, your care will be covered under this option.



What Applies to My Out-of-Pocket?

- Deductibles
- Copayments for all covered services
- Coinsurance for all covered services

What Does Not Apply to My Out-of-Pocket?

- Portion of any provider charge that is in excess of the Allowed Benefit.
- Charges for any service which are not covered under the coverage or which exceed the maximum number of covered visits/days.
- Amounts incurred for failure to comply with the Utilization Management Program requirements.

BlueCard® Program

As a member of CareFirst, you have access to the BlueCard program. If you or your dependents are traveling for work, school or vacation, your CareFirst benefits travel with you. BlueCard allows you and your dependents to access any Blue Cross and Blue Shield Preferred Provider throughout the United States.

To find out if a provider or hospital participates with BlueCard, simply call (800) 810-BLUE, or visit the BlueCross BlueShield Web site at www.bluecares.com.

Online Access Through My Account

CareFirst is pleased to offer My Account, a web site that allows you to directly access your health benefit information online. You can obtain answers to many questions regarding your health insurance coverage and costs, including your date of eligibility, who is included on your policy and the status of your current and previous claims, as well as your current deductible and maximums – all conveniently online. Visit www.carefirst.com/myaccount to register.

Health Information on the Internet

Visit our own online, interactive guide for health related topics. Called *My Care First*, this site offers information on nutrition, fitness, chronic illnesses, stress, mental health and much more. You’ll also find support if you’re trying to lose weight, quit smoking or manage a chronic illness. Check it out at www.carefirst.com to learn how you can maintain a healthier lifestyle.

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E-Health Newsletter

CareFirst members have access to an online health newsletter called Health News. Information includes: ‘Find a Doctor’, Options discount program, *My Care First* health and wellness articles, and a link to the eHealthy Cooking video of the month.

Prescription Drug Coverage for CareFirst Members

Prescription drug coverage is provided through Express Scripts (ESI). A separate identification card will be mailed directly to your home for use at participating pharmacies throughout the country. To obtain the name of a pharmacy that is conveniently located in your area, visit their Web site at www.express-scripts.com or call Member Services.

How are Prescriptions Covered?

- See the prescription drug services section on the Medical Options At-a-Glance chart on pages 24-25 for details.
- The use of generic drugs, if available, is mandatory. If you obtain a brand name drug when a generic is available, regardless of the circumstances, you will pay more.
- The following drugs or drug classifications will only be covered with submission of the appropriate diagnosis by your physician: Lupron, Retin-A after age 25, Dexadrine after age 25, Accutane after age 25, genetically engineered drugs, injectable drugs, and growth hormone therapy. **Note:** *This list is subject to modification.*

Is a Mail Order Program Offered?

Yes. The ESI mail order program provides you with the convenience of receiving up to a 90-day supply of prescription maintenance medications at your home. You can order refills using ESI’s automated touch-tone refill system or by using their Web site at www.cfpharmacy.com. Your medications will be delivered by the U.S. Postal Service or UPS within seven business days of receipt at ESI. To obtain further information about the mail order program, call ESI at (800) 233-7139. Order forms are available from the Office of Employee Benefits and Retirement.

Note: If you change your address, contact the Office of Payroll at BCPS. BCPS will update all address information with each vendor with the exception of CFI mail order. You must contact the mail order number directly to change your mailing address.

Option 2

Health Maintenance Organizations (HMOs)

The plans offered by Kaiser Permanente and Keystone Health Plan Central are HMOs. HMOs provide comprehensive medical care (including extensive preventive care and wellness benefits) through a network of participating hospitals, physicians, and other health care providers. You must use the network of providers and follow the Plan’s referral requirements to receive benefits. When you need care, contact your primary care physician to schedule an appointment or to receive a referral for specialty care. Your primary care physician will also arrange for any hospitalization you may need at an affiliated hospital best suited to treat your condition.



Medical Options At-a-Glance Chart

(Summary Plan Document Prevails; visit www.bcbs.org/offices/benefits for full details)

September 1, 2009 – August 31, 2010

Plan Name		CareFirst BlueCross BlueShield		Triple Choice MPOS	Kaiser Permanente (for MD residents only)	Keystone Health Plan Central (for PA residents only)
Plan Facts	Member Services	CareFirst (Medical) 800-525-5392 Express Scripts (Prescription) 877-852-4061 ComPsych (Mental Health) 877-595-5283			800-777-7902	800-622-2843 Nurse Line 866-243-1238
	Group Number	RM61			7434-6	00509145
Benefit Levels		Level 1 MARYLAND POINT OF SERVICE PCP RENDERED OR REFERRED	Level 2 PREFERRED PROVIDER NETWORK (PPN) OR BLUE CARD PPO NETWORK NO PCP REFERRAL	Level 3 PARTICIPATING OR NON-PARTICIPATING NO PCP REFERRAL	HMO	HMO
Calendar Year Deductible (Jan 1 - Dec 31)						
- Individual		\$150	\$200	\$300	None	None
- Family		\$300	\$400	\$600	None	None
Coinsurance		95%	85%	75%	N/A	N/A
Calendar Year Out-of-Pocket Maximum						
- Individual		\$500	\$1,000	\$1,500	None	None
- Family		\$1,000	\$2,000	\$3,000	None	None
Lifetime Maximum		Unlimited	\$1,000,000 for level 2 and level 3 combined	\$1,000,000 for level 2 and level 3 combined	Unlimited	Unlimited
PROFESSIONAL SERVICES						
Office Visits						
- PCP		100% after \$10 copay	100% after \$20 copay	75% of allowed benefit after deductible	100% after \$5 copay	100% after \$5 copay
- Specialist		100% after \$20 copay (referral required)	100% after \$30 copay	75% of allowed benefit after deductible	100% after \$5 copay (referral required)	100% after \$5 copay (referral required)
Physical/Speech/Occupational Therapy Office Visit		100% after \$20 copay; maximum 100 visits (referral required)	100% after \$30 copay	75% of allowed benefit after deductible	100% after \$5 copay (maximum 30 visits or 90 days per contract year)	100% for 60 visits of therapy per year (combined limit for skilled nursing and rehabilitation facility)
Chiropractic Office Visit		100% after \$20 copay	100% after \$30 copay	75% of allowed benefit after deductible	Discounts available- no referral	Acute care only – limited benefit (referral required)
Diagnostic Laboratory Tests, X-Rays		100%	100%	100% of allowed benefit	100%	100%
Allergy Shots/Other Covered Injections		100%	100%	100%	100% after \$5 copay	100% after \$5 copay
Allergy Serum		95% after deductible	85% after deductible	75% after deductible	100%	100%
Allergy Testing		95% after deductible	85% after deductible	75% after deductible	100%	100%
PREVENTIVE CARE						
Well Child Visit/Immunization		100% after \$10 copay	100% after \$20 copay	75% of allowed benefit after deductible	100% to age 5	\$0 copay (ages 11-18 annually)
Routine Gynecological Exam (no referral required)		100% after \$10 copay	100% after \$10 copay	75% of allowed benefit after deductible	100%	\$0 copay
Routine Pap Smear (no referral required)		100%	100%	100% of allowed benefit	100%	\$0 copay
Routine Mammogram (once per 12 months)		100%	100%	100% of allowed benefit	100%	100% after age 40
Routine Adult Physical		100% after \$10 copay (available once every 2 years)	100% after \$20 copay (available once every 2 years)	75% of allowed benefit after deductible (available once every 2 years)	100% (once per calendar year)	\$0 copay (ages 19-29 once; ages 30-49 once every 4 years; ages 50+ once a year)
PSA Testing		100%	100%	100%	100%	100%
HOSPITAL SERVICES (Inpatient & Outpatient)						
Semi-Private Room and Board		95% after deductible	85% after deductible	75% of allowed benefit after deductible	100%	100%
Lab Tests and X-Rays		100%	100%	100% of allowed benefit	100%	100%
Home Health Care		100%	100%	100% of allowed benefit	100%	100% (maximum 100 visits per calendar year)
Skilled Nursing Facility/Rehab Facility Care		95% after deductible (120 day maximum)	85% after deductible (120 day maximum)	75% of allowed benefit after deductible, 120 day maximum	100% (maximum of 100 days per plan year)	100%
Physician/Surgical Services		95% after deductible	85% after deductible	75% after deductible	100%	100%
Anesthesia Services		95% after deductible	85% after deductible	75% after deductible	100%	100%
Medical Consultations		95% after deductible	85% after deductible	75% after deductible	100%	100%

Medical Options At-a-Glance Chart *(continued)*

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	Group Number	RM61			7434-6	00509145
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HOSPITAL SERVICES (Inpatient & Outpatient) (CONT.)						
ICU/CCU		95% after deductible	85% after deductible	75% after deductible	100%	100%
Hospice Care		100%	100%	100% of allowed benefit	100%, maximum of 6 months	100%, maximum \$50,000 per member
Dialysis/Radiation/Chemotherapy ¹ (Inpatient)		95% after deductible	85% after deductible	75% after deductible	100%	100%
Dialysis/Radiation/Chemotherapy ¹ (Outpatient)		100%	100%	100%	100% after \$5 copay	100% after \$5 copay
Physical/Speech/Occupational Therapy (Inpatient)		95% after deductible	85% after deductible	75% after deductible	100%	100%; combined limit for skilled nursing and rehabilitation facility
Physical/Speech/Occupational Therapy (Outpatient)		95% (100 visits per benefit period)	95% (100 visits per benefit period)	95% (100 visits per benefit period)	100% after \$5 copay	100% for medically necessary short term treatment
Outpatient Diagnostic Services		100%	100%	100%	100%	100%
SUPPLIES						
Durable Medical Equipment		100%; Hearing aids for adults and children; 1 per ear every 36 months to \$1,400 max per ear	100%; Hearing aids for adults and children; 1 per ear every 36 months to \$1,400 max per ear	100% of allowed benefit; Hearing aids for adults and children; 1 per ear every 36 months to \$1,400 max per ear	100% of allowed benefit for basic DME; Hearing aids for adults and children 1 per ear every 36 months to \$1,000 max per ear.	100% of allowed benefit; Hearing aids for adults and children 1 per ear every 36 months to \$800 max per ear
Prosthetic Devices and Orthopedic Braces		100%	100%	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Diabetic Supplies		Covered by pharmacy benefit	Covered by pharmacy benefit	Covered by pharmacy benefit	80% of allowed benefit for most supplies	100% through pharmacy benefit
EMERGENCY SERVICES						
Emergency Room if admitted if discharged		100% 100% after \$35 copay*	100% 100% after \$35 copay*	100% of allowed benefit 100% of allowed benefit after \$35 copay*	100% 100% after \$35 copay	100% 100% after \$25 copay
Ambulance (Air Ambulance if medically necessary)		100%	100%	100% of allowed benefit	100% if medically necessary	100% if medically necessary
MATERNITY/INFERTILITY SERVICES²						
Pre- and Postnatal Care and Delivery		95% after deductible	95% after deductible	75% after deductible	100%	100% after \$5 copay for first visit only
Sterilization/Reverse Sterilization		95% after deductible	85% after deductible	75% after deductible	Applicable cost share based upon place of service	100% for sterilization, reversal not covered
Elective Abortions in Inpatient and Outpatient Facility		95% after deductible	95% after deductible	75% after deductible	Applicable cost share based upon place of service	100%, exclusions apply
Artificial Insemination (requires pre-authorization)		95% after deductible	95% after deductible	75% after deductible	Applicable cost share based upon place of service	50% of allowed benefit, \$2,500 lifetime maximum when medically necessary
InVitro Fertilization (requires pre-authorization)		95% after deductible	95% after deductible	75% after deductible	50% of allowed benefit lifetime maximum of \$100,000 per member	50% of allowed benefit, lifetime maximum of \$100,000 per member
MENTAL HEALTH AND SUBSTANCE ABUSE³						
<i>Pre-authorization Required</i>		Mental Health and Substance Abuse All inpatient and outpatient covered services require pre-admission review and pre-treatment		Provided by ComPsych certification. Call ComPsych at (877) 595-5283	Yes	Yes
Mental Health Inpatient Services		(70 days combined in- and out-of-network calendar year maximum); In-network: 100% of Out-of-network: 75% of allowed amount, no deductible or out-of-pocket		allowed amount, no deductible applies maximum applies	100%	100%, maximum 30 days per calendar year, 90 days per lifetime <i>Note: additional benefits may be available depending on the diagnosis</i>

*No copay required for accidents treated within 72 hours and medical emergencies paid at 100% of the Allowed Benefit.

Medical Options At-a-Glance Chart *(continued)*

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MENTAL HEALTH AND SUBSTANCE ABUSE³ (Continued)		Mental Health and Substance Abuse Provided by ComPsych				Mental Health and Substance Abuse Provided by ComPsych	
Mental Health Outpatient Services	(100 visits combined in- and out-of-network In-network: \$30 copay for individual therapy, \$20 copay for group therapy, no deductible Out-of-network: Visit 1-20: 65% of allowed amount, no deductible or out-of-		calendar year maximum); or out-of-pocket maximum applies; Visits 21-100: 50% of allowed amount, pocket maximum applies		100% after \$20 copay for individual visits; \$10 copay for group therapy visits		\$25 copay, maximum 20 visits per calendar year <i>Note: additional benefits may be available depending on the diagnosis</i>
Substance Abuse Inpatient Services	(120 days/visits combined in- Detox- 7 days maximum per calendar year; Rehab residential facility- In-network: 100% of allowed benefit, Out-of-network: 75% of allowed benefit, no deductible		and out-of- network lifetime maximum; 30 days maximum per calendar year); no deductible applies or out-of-pocket maximum applies		100%		100%, maximum 30 days per calendar year; lifetime maximum 90 days, detox limited up to 7 days; 4 detox admissions per lifetime
Substance Abuse Outpatient Services	(Rehab outpatient facility- 120 visits up to \$3,000 per calendar year; Additional benefits- up to In-network: Detox- \$30 copy for individual Rehab- \$30 copay for individual visits, \$20 copay for group therapy, no Out-of-network: Detox- 75% of allowed benefit; Visits 21-120: 50% of allowed benefit, no		\$3,000 per calendar year subject to approval). visits, \$20 copay for group therapy; deductible or out-of-pocket maximum applies; Rehab- Visits 1-20: 65% of allowed benefit, deductible or out-of-pocket maximum applies		100% after \$20 copay for individual visits; \$10 copay for group therapy visits		100% 60 full-session visits per calendar year, lifetime maximum 120 days. Additional treatment available. \$25 copay full session and \$15 copay partial visit
OTHER SERVICES							
Kidney, Cornea, Bone Marrow Transplants	95% after deductible	85% after deductible	75% after deductible	100%	100%		
Heart, Heart-Lung, Lung, Pancreas, Liver Transplants (requires pre-authorization)	95% after deductible, \$1,000,000 maximum	95% after deductible, \$1,000,000 maximum	95% after deductible, \$1,000,000 maximum	100%	100%		
Organ Transplant Procurement	100%, \$50,000 maximum	100%, \$50,000 maximum	100%, \$50,000 maximum	100% covered if recipient is the member	100%, covered if recipient is the member		
Organ Transplant Travel	100%, \$150 per day up to \$10,000 maximum	100%, \$150 per day up to \$10,000 maximum	100%, \$150 per day up to \$10,000 maximum	Limited benefit	Up to \$10,000 if use of specific services		
Cardiac Rehabilitation	95% after deductible	85% after deductible	75% after deductible	100% after \$5 copay	100%		
PRESCRIPTION DRUG SERVICES		Prescription services provided through Copays are per fill at participating pharmacies up to a		Express Scripts. 30-day supply.	Copays are per fill up to a 60-day supply. Mandatory generic – \$5 Brand – \$5 At a participating community pharmacy: Mandatory generic – \$15	Services provided at Keystone participating pharmacy	
Retail	Mandatory generic – \$8 Formulary brand – \$20 Non-formulary brand – \$35					\$5 generic/\$15 brand up to 30-day supply; generic prescription program	
Mail Order	Copays are per fill for maintenance prescriptions up to a Mandatory generic – \$15 Formulary Brand – \$40 Non-Formulary Brand – \$40		90-day supply.		Copays are per fill for maintenance prescriptions up to a 90-day supply. Mandatory generic – \$5 Brand – \$5	\$10 generic/\$30 brand up to 90-day supply	
VISION	Routine vision services not covered	Routine vision services not covered	Routine vision services not covered		\$5 copayment for routine exam; discount on lenses & frames available	PCP screening only	
DENTAL	Not covered	Not covered	Not covered		None	None	
COMMENTS	• Reimbursement available for CareFirst BlueCross BlueShield providers	• Reimbursement available for BlueCross BlueShield PPO providers across the U.S.	• Reimbursement available for any participating BlueCross BlueShield providers across the U.S.	• Chiropractic care, acupuncture & massage therapy discount available. No referral required. my.kp.org/mida/bcps or www.kp.org		Nurse Line (866) 243-1238	
	Options Program - offers discounted • Acupuncture • Spas • Massage Therapy • Yoga Go to www.carefirst.com and click		services for: • Chiropractic Care • Fitness center and personal trainers on <i>Options Discount Program</i>			Please visit our Web site at www.capbluecross.com for various discounts.	

References from Benefit Chart

¹ Federally Required Information on Mastectomy Services for All Medical Plans

Under all the medical plans, coverage is provided for a person receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy, for:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes.)

This coverage is provided in consultation with the attending physician and patient. These benefits are subject to the same deductibles and coinsurance amounts that apply to other benefits provided under your medical plan.



² Important Notice About Maternity Coverage and Newborn Length of Stay

Under federal law, group health plans and health insurance issuers offering group insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to:

- Less than 48 hours following a normal vaginal delivery or
- Less than 96 hours following a cesarean section

However, the plan or health insurance issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or the newborn earlier.

In addition, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or the newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. Please contact your health plan's member services unit.

³ Using the Employment Assistance Program (EAP)

Did you know that BCPS offers the EAP free of charge?

The program is a confidential service designed to help you and your family resolve personal problems that may affect your health, family life, or job performance.

Up to 10 EAP visits are provided by ComPsych. The EAP is available 24 hours a day, 7 days a week. Program counselors are available for consultations during business hours and are on call for emergencies. To speak to a counselor or make an appointment, call (877) 595-5283 or visit their Web site at: www.guidanceresources.com (password: Baltimore).