

Medi-Comp Plan

Medicare Eligibles/Retirees Over 65—January 2019

Product Line Services	Medi-Comp	
	Medicare Covers	Medi-Comp
Part A Hospital Deductible	60 days of inpatient hospital care, except for a \$1,340 deductible.	After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary
Inpatient Days 61-90	30 additional days of hospital inpatient care, except for a \$335 per day copayment.	After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary
Lifetime Reserve Days	60 additional "lifetime reserve" days of inpatient hospital care, except for a \$670 per day copayment.	After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary
Skilled Nursing Facility	100 days of inpatient care in a skilled nursing facility, except for the \$167.50 per day copayment for days 21-100.	After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary
Inpatient Medical/Surgery	80% of the Medicare-approved amount for in-hospital surgery and medical care, after the annual \$183 deductible has been met.	After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary
Outpatient Surgery	80% of the Medicare-approved amount for outpatient hospital visits and surgery, for medical conditions after the annual \$183 deductible has been met.	After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary
Emergency Services	80% of the Medicare-approved amount for minor surgery and emergency first aid provided in a physician's office or hospital outpatient department, after the annual \$183 deductible has been met.	After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary
Diagnostic Services	Covers clinical laboratory services at 100% of the Medicare-approved amount. 80% of the Medicare-approved amount for diagnostic X-rays or pathology examinations provided in a physician's office or hospital outpatient department, after the \$183 deductible has been met.	Medicare covers in full For outpatient minor surgery or accidental injury: After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary For all other cases: After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary
Radiation/Chemotherapy Services	80% of the Medicare-approved amount for radiation/chemotherapy services provided in an office or hospital outpatient department, after the \$183 deductible has been met.	After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary
Diabetic Self-Management	80% of the Medicare-approved amount for blood glucose monitors, testing strips, lancet devices, after the \$183 annual deductible has been met.	After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary

Medi-Comp Plan

Product Line	Medi-Comp	
Services	Medicare Covers	Medi-Comp
PREVENTIVE SERVICES		
Annual Physical	One Annual Wellness visit every 12 months. There is no coinsurance, copayment or deductible.	Covered by Medicare
Routine GYN	No coinsurance, copayment or deductible for Pap Smears, Pelvic and clinical breast exams. Covered once every 2 years. Covered once a year for women at high risk.	100% of the Allowed Benefit the year Medicare does not pay
Prostate Cancer Screening Exam	80% of the Medicare-approved amount for digital rectal exam for men age 50 and older after the \$183 annual deductible has been met. 100% for the PSA test; 80% for other related services. Covered once a year.	Pays 100% of Medicare Part B deductible and coinsurance.
Colorectal Cancer Screening Procedures	No coinsurance, copayment or deductible for screening colonoscopy or screening flexible sigmoidoscopy.	Covered by Medicare
Mammography Screening	No coinsurance, copayment or deductible. One baseline between ages 35–39. Once every 12 months for age 40 and older.	Covered by Medicare
Bone Mass Measurement	No coinsurance, copayment or deductible. Once every 24 months for persons at high risk for osteoporosis.	Covered by Medicare

Examples:

Medicare Claim \$5,000 Facility Charge	\$5,000.00 Medicare Allowed Amount	CareFirst Claim \$5,000 Facility Charge	\$5,000.00 Allowed Amount	Member Liability \$500
	\$1,340.00 Part A Deductible		\$4,500.00 90% of Allowed Benefit	
	\$3,660.00 Medicare Paid		-\$3,660.00 Medicare Paid Amount	
			\$ 840.00 CareFirst Payment Amount	
Medicare Claim \$500 Provider Charge	\$200.00 Medicare Allowed Amount	CareFirst Claim \$500 Provider Charge	\$200.00 Allowed Amount	Member Liability \$20
	\$183.00 Part B Deductible		\$180.00 90% of Allowed Benefit	
	\$ 17.00 Medicare Paid		-\$ 17.00 Medicare Paid Amount	
			\$163.00 CareFirst Payment Amount	
Medicare Claim \$250 Provider Charge	\$250.00 Medicare Allowed Amount	CareFirst Claim \$500 Provider Charge	\$30.00 Allowed Amount	Member Liability \$183
	\$183.00 Part B Deductible		\$27.00 90% of Allowed Benefit	
	\$ 67.00 Medicare Paid		-\$67.00 Medicare Paid Amount	
			\$ 0.00 CareFirst Payment Amount	

Out-of-pocket

After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if we were primary, up to a \$500 out-of-pocket. Reimbursement is then 100% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if we were primary for the remaining calendar year.

Prescription drugs

Covered through the CVS Caremark SilverScript Program. Refer to the 2019 Retirees' Healthcare Enrollment Guide.

Note: Medicare's deductibles and/or coinsurance amounts are subject to change effective 1/1/2019. As of the print date, we do not have the information from Medicare for 2019. Should Medicare's deductibles and/or coinsurance change 1/1/2019, CareFirst will increase the amount covered to reflect the change in the deductibles and/or coinsurance.

Medical Benefits Options

Medicare Eligibles/Retirees Over 65—January 2019

Product Line	HMO
Product Name	BlueChoice HMO Open Access
Services	
NETWORK	BLUECHOICE
COPAYS	\$10 PCP / \$15 Specialist copay
ANNUAL DEDUCTIBLE	
Individual	None
Individual & Child	None
Individual & Adult	None
Family	None
ANNUAL OUT-OF-POCKET MAXIMUM	
Medical	\$2,000 Ind. / \$6,000 Family
LIFETIME MAXIMUM BENEFIT	Unlimited except on fertility services
PREVENTIVE SERVICES	
Well-Child Care	
0–24 months	No Charge
24 months–13 years (immunization visit)	No Charge
24 months–13 years (non-immunization visit)	No Charge
14–17 years	No Charge
Adult Physical Examination	No Charge
Routine GYN Visits	No Charge
Mammograms	No Charge
Cancer Screening (Pap Test, Prostate and Colorectal)	No Charge
OFFICE VISITS, LABS AND TESTING	
Office Visits for Illness	\$10 PCP / \$15 Specialist copay
Diagnostic Services	\$10 PCP / \$15 Specialist copay
X-ray and Lab Tests	No copay (LabCorp)
Allergy Testing	\$10 PCP / \$15 Specialist copay (if office visit copay paid, additional copay not required)
Allergy Shots	\$10 PCP / \$15 Specialist copay (if office visit copay paid, additional copay not required)
Outpatient Physical, Speech and Occupational Therapy (Office Setting)	\$15 copay; (limited to 30 visits combined/condition/benefit period)
Outpatient Chiropractic	\$15 copay; (limited to 20 visits/condition/benefit period)
EMERGENCY CARE AND URGENT CARE	
Physician's Office	\$10 PCP / \$15 Specialist copay
Urgent Care Center	\$10 PCP / \$15 Specialist copay
Hospital Emergency Room	\$75 copay (waived if admitted)
Ambulance (if medically necessary)	No charge

Medical Benefits Options

Product Line	HMO
Product Name	BlueChoice HMO Open Access
Services	
HOSPITALIZATION	
Inpatient Facility Services	No charge
Outpatient Facility Services	No charge
Inpatient Physician Services	No charge
Outpatient Physician Services	\$10 PCP / \$15 Specialist copay
HOSPITAL ALTERNATIVES	
Home Health Care	No charge
Hospice	No charge
Skilled Nursing Facility (limited to 365 days/benefit period)	No charge
MATERNITY	
Preventive Prenatal and Postnatal Office Visits	No charge
Delivery and Facility Services	No charge
Nursery Care of Newborn	No charge
Artificial Insemination—Subject to State Mandate (limited to 6 attempts per live birth)	50% of the AB
InVitro Fertilization Procedures—Subject to State Mandate (limited to 3 attempts per live birth & \$100,000 lifetime max)	50% of the AB
MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)—SUBJECT TO FEDERAL MANDATE	
Inpatient Facility Services (requires Pre-authorization)	No charge
Inpatient Physician Services	No charge
Outpatient Services (MH & SA)	\$10 copay (office)
Partial Hospitalization	No charge
Medication Management Visit	\$10 copay
MISCELLANEOUS	
Durable Medical Equipment	100% AB
Diabetic Supplies	Covered under Prescription Drug plan
Acupuncture	\$15 copay (limited to 24 visits/benefit period)
Hearing Aids for Children and Adults (limited to one hearing aid/ per ear every 36 months)	100% AB per aid/per ear; member may be balanced billed up to the total charge
Outpatient Surgery (office)	\$10 PCP / \$15 Specialist copay
Chemotherapy/Radiation Therapy (office)	\$15 copay
Renal Dialysis	No charge
Cardiac Rehab (subject to Medical Policy review)	No charge
PRESCRIPTION DRUGS	Covered through the CVS Caremark SilverScript Program. Refer to the 2019 Retirees' Healthcare Enrollment Guide.
DEPENDENT AGE LIMIT	To age 26, end of month