Wicomico County Public Entities Consortium (WCPE)
Wicomico County, MD & Affiliated Groups; Wicomico County Public Schools; City of Salisbury
THE PREFERRED PROVIDER NETWORK ADVANTAGE

As a member of The Wicomico County Public Entities Consortium you have access to two medical options using the CareFirst BlueCross BlueShield Preferred Provider Network. The Preferred Provider Network gives you access to a quality network of practitioners and hospitals within Maryland. The BlueCard® PPO program provides access to a national network.

- No need to enroll with a primary care physician
- No permission required to see a specialist

If an in-network specialist is not available to provide services, the in-network physician may refer you to an out-of-network specialist. In-network benefits will apply if the referring in-network physician reports the referral and receives approval through the Referral Service Unit. Whenever in-network benefits are applied to an out-of-network, non-participating provider, you will still be responsible for any balance remaining after Plan payment.

EXCLUSIVE PROVIDER OPTION (EPO)

In Network benefits are provided when you use Preferred Providers. In-network providers must render all services.

IN-NETWORK	OUT-OF-NETWORK
• You choose a network practitioner, specialist or hospital • You have low out-of-pocket costs You are responsible for: • per visit copayments	Most Benefits are NOT covered Out-of-Network, you must use In-Network Providers. See benefit summary for details

PREFERRED PROVIDER OPTION (PPO)

Using a Preferred Provider network practitioner will keep your out-of-pocket costs to a minimum and you won't have to file a claim form. You will pay more out of your own pocket when you use practitioners who do not belong to the Preferred Provider Network. You may be required to pay a deductible and a greater portion of the cost of medical treatment. You may also need to file a claim.

IN-NETWORK	OUT-OF-NETWORK	
• You choose a network practitioner, specialist or hospital • You have lower out-of-pocket costs	• You choose any practitioner, specialist or hospital • You have higher out-of-pocket costs	
	Participating Provider	**Non-participating Provider**
You are responsible for: • per visit copayments	You are responsible for: • deductibles • coinsurance	You are responsible for: • direct payment to provider for provider's total charge. (your actual liability equals the difference between plan payment and provider's billed charges) • Plan payment will be sent to you excluding deductible and coinsurance based on plan's "allowed benefit".

To find participating Preferred Providers in Maryland call 1-800-872-5310 or reach us on the World Wide Web at: http://www.carefirst.com

To find participating BlueCard PPO healthcare providers outside of Maryland, Call BlueCard Access at: 1-800-810-BLUE (2583)
OR Reach us on the World Wide Web at:
Inside U.S.: http://www.bcbs.com/coverage/bluecard/bluecard-when-traveling.html
Outside U.S.: http://www.bcbs.com/coverage/bluecard/bluecard-worldwide.html

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OPTIONS FOR MEDICAL BENEFITS
YOU MAY CHOOSE ONE OF THESE OPTIONS

	EPO OPTION		PPO OPTION	
	EPO IN-NETWORK	EPO OUT-OF-NETWORK ** (OON)	PPN IN-NETWORK	PPN OUT-OF-NETWORK **
TYPE OF SERVICE	**PLAN PAYMENT**	**PLAN PAYMENT**	**PLAN PAYMENT**	**PLAN PAYMENT**
BENEFIT PERIOD	CALENDAR YEAR		CALENDAR YEAR	
DEDUCTIBLE	NOT APPLICABLE		No deductible if service is rendered by a preferred provider	$200 individual $600 family
OUT-OF-POCKET LIMIT	NOT APPLICABLE		$1200 individual	$3600 family
LIFETIME MAXIMUM	UNLIMITED		$1,000,000	
Copayments for certain services	➢ Office Visit ➢ $15 per visit ➢ Hospital Facility $35 per visit ➢ Practitioner (at the hospital) $25 per visit	NO BENEFIT OON	➢ Office Visit ➢ $15 per visit ➢ Hospital Facility $35 per visit ➢ Practitioner (at the hospital) $25 per visit	You are responsible for deductible & coinsurance amounts for services rendered by participating providers. **
TYPE OF SERVICE	**PLAN PAYMENT**	**PLAN PAYMENT**	**PLAN PAYMENT**	**PLAN PAYMENT**
HOSPITAL INPATIENT PREADMISSION REVIEW/APPROVAL REQUIRED ➢ Semi-private room or intensive care unit ➢ Operating room/special treatment room ➢ All medically necessary services ➢ Includes Medical, Surgical, Maternity, Physical Rehab, Psychiatric and Substance abuse Admissions ➢ Extended Care Facility Benefits (when used as an alternative to acute inpatient days)	100% of "AB"	NO BENEFIT OON	100% of "AB" If a member is admitted without pre-admission review, covered benefits will be reduced by 20%	80% of "AB" after deductible If a member is admitted without pre-admission review, covered benefits will be reduced by 20%
OUTPATIENT SURGERY				
➢ Outpatient Facility Services	100% of "AB" after $35 copay	NO BENEFIT OON	100% of "AB" after $35 copay	80% of “AB” after deductible
➢ Practitioner in Outpatient Facility	100% of "AB" after $25 copay	NO BENEFIT OON	100% of "AB" after $25 copay	80% of “AB” after deductible
➢ Practitioner in Office	100% of "AB" after $15 copay	NO BENEFIT OON	100% of "AB" after $15 copay	80% of “AB” after deductible
PHYSICIAN SERVICES				
➢ Office visits, home visits, second surgical opinion	100% of "AB" after $15 copay	NO BENEFIT OON	100% of "AB" after $15 copay	80% of "AB" after deductible
➢ Inpatient Care/Physical Rehabilitation	100% of "AB"	NO BENEFIT OON	100% of "AB"	80% of "AB" after deductible
➢ Surgeon, In-Hospital visits	100% of "AB"	NO BENEFIT OON	100% of "AB"	80% of “AB” after deductible
➢ Assistant Surgeon, Anesthesiologist	100% of "AB"	Paid at in-network benefit**	100% of "AB"	Paid at in-network benefit **

“AB”= ALLOWED BENEFIT **** Non-Participating providers can bill you up to total charges.**

Certain outpatient services require approval to begin or continue outpatient treatment including private duty nursing; home health care; hospice services; artificial insemination and invitro fertilization.

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OPTIONS FOR MEDICAL BENEFITS
YOU MAY CHOOSE ONE OF THESE OPTIONS

	EPO OPTION		PPO OPTION	
	EPO IN-NETWORK	EPO OUT-OF-NETWORK ** (OON)	PPN IN-NETWORK	PPN OUT-OF-NETWORK **
TYPE OF SERVICE	PLAN PAYMENT	PLAN PAYMENT	PLAN PAYMENT	PLAN PAYMENT
MATERNITY (Outpatient)				
➢ Physician and medical services	100% of "AB"	NO BENEFIT OON	100% of "AB"	80% of "AB" after deductible
➢ Invitro Fertilization IVF benefits are limited three attempts per live birth; and, a lifetime maximum benefit of $100,000. Pre Approval Required	100% of "AB"	NO BENEFIT OON	100% of "AB"	80% of "AB" after deductible
➢ Artificial Insemination Pre Approval Required	100% of "AB"	NO BENEFIT OON	100% of "AB"	80% of "AB" after deductible
URGENT CARE **Emergency accident, trauma & medical emergency.**				
➢ Outpatient Facility Services	100% of "AB" after $35 copay	NO BENEFIT OON	100% of "AB" after $35 copay	80% of "AB" after deductible
➢ Practitioner in Outpatient Facility	100% of "AB" after $25 copay	NO BENEFIT OON	100% of "AB" after $25 copay	80% of "AB" after deductible
➢ Practitioner in Office	100% of "AB" after $15 copay	NO BENEFIT OON	100% of "AB" after $15 copay	80% of "AB" after deductible
HOSPITAL OUTPATIENT NON-SURGICAL				
➢ Outpatient Facility Services	100% of "AB" after $35 copay	NO BENEFIT OON	100% of "AB" after $35 copay	80% of "AB" after deductible
➢ Practitioner in Outpatient Facility	100% of "AB" after $25 copay	NO BENEFIT OON	100% of "AB" after $25 copay	80% of "AB" after deductible
OUTPATIENT DIAGNOSTIC - LAB				
➢ Physician Office/Independent Lab	100% of the "AB"	NO BENEFIT OON	100% of "AB" after $15 copay	Paid at in-network benefit **
➢ Outpatient (Facility)	100% of the "AB	Paid at in-network benefit **	100% of "AB" after $15 copay	Paid at in-network benefit **
➢ Outpatient Professional Component billing – charge for "reading"	100% of the "AB	Paid at in-network benefit **	100% of the "AB	Paid at in-network benefit **
Mammogram Screening ***GUIDELINES APPLY***	Paid the same as diagnostic	Paid the same as diagnostic	Paid the same as diagnostic	Paid the same as diagnostic
WELL CARE				
➢ Adult Routine Physical Exam	100% of "AB" after appropriate copay	NO BENEFIT OON	100% of "AB" after appropriate copay	80% of "AB" after deductible
➢ Routine GYN Exam	100% of "AB" after appropriate copay	NO BENEFIT OON	100% of "AB" after appropriate copay	80% of "AB" after deductible
➢ Well Child Visits guidelines apply	100% of "AB" after appropriate copay	NO BENEFIT OON	100% of "AB" after appropriate copay	80% of "AB" **NO** deductible
RADIATION THERAPY, CHEMOTHERAPY & RENAL DIALYSIS			100% of "AB" after	
➢ Outpatient Facility Services ➢ Practitioner in Outpatient Facility	100% of the "AB" 100% of the "AB"	NO BENEFIT OON NO BENEFIT OON	$35 member copay $25 member copay	80% of "AB" after deductible
➢ Practitioner in Office	100% of the "AB"	NO BENEFIT OON	$15 member copay	

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	EPO IN-NETWORK	EPO OUT-OF-NETWORK ** (OON)	PPN IN-NETWORK	PPN OUT-OF-NETWORK **
TYPE OF SERVICE	PLAN PAYMENT	PLAN PAYMENT	PLAN PAYMENT	PLAN PAYMENT
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY	50 visits per calendar year (for each modality)		Unlimited visits per calendar year	Unlimited visits per calendar year
➢ Outpatient Facility Services ➢ Practitioner in Outpatient Facility	$35 member copay $25 member copay	NO BENEFIT OON	$35 member copay $25 member copay	80% of “AB” after deductible
➢ Practitioner in Office	$15 member copay	NO BENEFIT OON	$15 member copay	
RESPIRATORY & INHALATION THERAPY				
➢ Outpatient Facility Services ➢ Practitioner in Outpatient Facility	$35 member copay $25 member copay	NO BENEFIT OON	$35 member copay $25 member copay	80% of “AB” after deductible
➢ Practitioner in Office	$15 member copay	NO BENEFIT OON	$15 member copay	
OUTPATIENT CARDIAC REHAB: limited to JCAH approved program following inpatient admission				
➢ Outpatient Facility Services ➢ Practitioner in Outpatient Facility	$35 member copay $25 member copay	NO BENEFIT OON	$35 member copay $25 member copay	80% of “AB” after deductible
OUTPATIENT PSYCHIATRIC & SUBSTANCE ABUSE. TREATMENT AUTHORIZATION IS REQUIRED				
➢ Halfway House/Partial Hospitalization	60 days-see benefit contract	NO BENEFIT OON	60 days-see benefit contract	60 days-see benefit contract
➢ Outpatient Visits ➢ No Annual Visit Maximum	**NO** deductible, visits: 1-5 = 80%; 6-30 = 65% 31+ = 50% Of “AB”	NO BENEFIT OON	**NO** deductible, visits: 1-5 = 80%; 6-30 = 65% 31+ = 50% Of “AB”	After deductible, visits: 1-5 = 80%; 6-30 = 65% 31+ = 50% Of “AB”
TRANSPLANTS				
➢ **KIDNEY, CORNEA, BONE MARROW TRANSPLANTS**	Covered as surgical procedure	NO BENEFIT OON	Covered as surgical procedure	Covered as surgical procedure
➢ **LIVER, HEART, PANCREAS, LUNG TRANSPLANTS (reinsured-limitations apply)**	Precertification required, 100% of "AB"	NO BENEFIT OON	Precertification required, 100% of "AB"	Precertification required, 100% of "AB", no deductible
OTHER SERVICES				
➢ **CHIROPRACTIC SERVICES**	20 visits per calendar year at 100% of "AB" after appropriate copay	NO BENEFIT OON	Unlimited visits per calendar year 100% of "AB" after appropriate copay	Unlimited visits per calendar year 80% of “AB” after deductible
➢ **DURABLE MEDICAL EQUIPMENT, PROSTHESES, MEDICAL & OSTOMY SUPPLIES (guidelines apply)**	100% of "AB"	NO BENEFIT OON	100% of "AB"	80% of “AB” after deductible
➢ **ORTHOTICS AND BRACES**	100% of "AB"	NO BENEFIT OON	100% of "AB"	80% of “AB” after deductible
➢ **ACUPUNCTURE (guidelines apply)**	20 visits per calendar year at 100% of "AB" after appropriate copay	NO BENEFIT OON	Unlimited visits per calendar year 100% of "AB" after appropriate copay	Unlimited visits per calendar year 80% of “AB” after deductible

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	EPO IN-NETWORK	EPO OUT-OF-NETWORK ** (OON)	PPN IN-NETWORK	PPN OUT-OF-NETWORK **
TYPE OF SERVICE	PLAN PAYMENT	PLAN PAYMENT	PLAN PAYMENT	PLAN PAYMENT
➢ **TREATMENT OF TMJ SYNDROME**	guidelines apply, 100% of "AB" after appropriate copay	NO BENEFIT OON	guidelines apply, 100% of "AB" after appropriate copay	guidelines apply, 80% of "AB" after deductible
➢ **WHOLE BLOOD, if not replaced**	100% of "AB"	NO BENEFIT OON	100% of "AB"	80% of "AB" after deductible
➢ **ALLERGY SERUM**	Covered as prescription drug	Covered as prescription drug	Covered as prescription drug	Covered as prescription drug
➢ **ALLERGY TESTING & INJECTIONS**	100% of "AB" after appropriate copay	NO BENEFIT OON	100% of "AB" after appropriate copay	80% of "AB" after deductible
➢ **AMBULANCE – ground, air if medically necessary**	100% of "AB"	100% of "AB" no deductible	100% of "AB"	100% of "AB" no deductible
➢ **HOME CARE & HOSPICE SERVICES - Agency services, guidelines apply**	100% of "AB"	NO BENEFIT OON	100% of "AB"	80% of "AB" no deductible

Prescription Drug Program

The three tier Prescription Drug Program is offered as part of your health care benefits. This program covers both non-maintenance and maintenance prescription drugs dispensed by a retail pharmacy or designated mail service pharmacy. This program is based on the CareFirst BlueCross BlueShield preferred drug list, which is made up of certain brand name prescription drugs (Tier 2) and all generic prescription drugs (Tier 1). A copy of this list can be found at www.carefirst.com/rx.

Prior Authorization: Some prescription drugs require Prior Authorization. Prior Authorization is a tool used to ensure that you will achieve the maximum clinical benefit from the use of specific targeted drugs. Your physician or pharmacist must call to begin the prior authorization process. For the most up-to-date prior authorization list, visit the prescription drug web site at www.carefirst.com/rx.

Maintenance Drugs are taken for several months to treat chronic conditions such as diabetes, high blood pressure and asthma. If the drug you are taking is on the maintenance list you can receive a 90 day supply of the "Maintenance" medication.

If you use **mail order** you can receive a 90 day supply of "Maintenance" medication for one (1) copay

OR

You can receive a 90 day supply for two (2) copays at a retail pharmacy.

$0 Deductible no annual maximum	
Retail Pharmacy	**34-day supply**
Tier 1: Generic Drugs	$5 copayment
Tier 2: Preferred Brand Drugs	$25 copayment
Tier 3: Non-Preferred Brand Drugs	$40 copayment
Maintenance Drugs Mail Order- Walgreens	**90-day supply**
Tier 1: Generic Drugs	$5 copayment
Tier 2: Preferred Brand Drugs	$25 copayment
Tier 3: Non-Preferred Brand Drugs	$40 copayment
Maintenance Drugs Retail	**90-day supply**
Tier 1: Generic Drugs	$10 copayment
Tier 2: Preferred Brand Drugs	$50 copayment
Tier 3: Non-Preferred Brand Drugs	$80 copayment

- Prior to filling or refilling your prescription check the website to make sure your drug is still in the same "tier".
- Not all prescription drugs are listed. If you cannot find a particular drug, or if you have questions, please call our pharmacy claims processor, Argus Health Systems, Inc. (Argus) at (800) 241-3371.
- The preferred drug list is subject to change as new generic and brand name drugs become available.

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