BlueChoice Advantage POS Network Summary of Benefits

Montgomery County Government

Plan Features	HIGH OPTION		STANDARD OPTION	
	In-Network Benefits Cost to Member[1,2]	Out-of-Network Benefits Cost to Member[1,3]	In-Network Benefits Cost to Member[1,2]	Out-of-Network Benefits Cost to Member[1,3]
Provider Network	Visit **carefirst.com/mcg** to locate providers			
24-HOUR NURSE ADVICE LINE—FREE ADVICE FROM A REGISTERED NURSE				
Visit **carefirst.com/mcg** to learn more about your options for care.	When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health questions and treatment options.			
ANNUAL DEDUCTIBLE (BENEFIT PERIOD)[4]				
Individual	None	$300	None	$300
Family	None	$600	None	$600
ANNUAL OUT-OF-POCKET MAXIMUM (BENEFIT PERIOD)[5]				
Medical	$1,000 Individual/ $2,000 Family	$2,000 Individual/ $4,000 Family	$1,000 Individual/ $2,000 Family	$2,000 Individual/ $4,000 Family
LIFETIME MAXIMUM BENEFIT				
Lifetime Maximum	None	None	None	None
PREVENTIVE SERVICES				
Well-Child Care (including exams & immunizations)	$10 per visit	Deductible, then 20% of Allowed Benefit	$15 per visit	Deductible, then 20% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	$10 per visit	Deductible, then 20% of Allowed Benefit	$15 per visit	Deductible, then 20% of Allowed Benefit
Breast Cancer Screening**	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Pap Test**	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Prostate Cancer Screening**	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Colorectal Cancer Screening**	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING				
Office Visits for Illness	$10 per visit	Deductible, then 20% of Allowed Benefit	$15 per visit	Deductible, then 20% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans)[7]	No charge*	No charge*	No charge*	No charge*
Lab[6] (at approved locations)	No charge*	No charge*	No charge*	No charge*
X-ray[6] (at approved locations)	No charge*	No charge*	No charge*	No charge*
Allergy Shots	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Physical, Speech and Occupational Therapy (limited to 90 visits/injury/ benefit period)	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Chiropractic	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Acupuncture	$10 per visit	Dedutible, then 20% of Allowed Benefit	$30 per visit	Deductible, then 20% of Allowed Benefit
EMERGENCY SERVICES				
Urgent Care Center	No charge*	No charge*	No charge*	No charge*
Emergency Room— Facility Services	$25 per visit (waived if admitted)	$25 per visit (waived if admitted)	$35 per visit (waived if admitted)	$35 per visit (waived if admitted)
Ambulance (if medically necessary)	No charge*	No charge*	No charge*	No charge*

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	In-Network Benefits Cost to Member[1,2]	Out-of-Network Benefits Cost to Member[1,3]	In-Network Benefits Cost to Member[1,2]	Out-of-Network Benefits Cost to Member[1,3]
HOSPITALIZATION (MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES)				
Outpatient Facility Services	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Inpatient Facility Services	No charge*	Deductible, then 20% of Allowed Benefit	No charge* after $150 per admission	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
HOSPITAL ALTERNATIVES				
Home Health Care (90-visit maximum in-network)	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Hospice (Inpatient—limited to 30 days; Outpatient—unlimited during Hospice eligibility period)	No charge*	No charge*	No charge*	No charge*
Skilled Nursing Facility (limited to 100 days/benefit period)	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
MATERNITY				
Preventive Prenatal and Postnatal Office Visits	$10 per visit	Deductible, then 20% of Allowed Benefit	$30 per visit	Deductible, then 20% of Allowed Benefit
Delivery and Facility Services	No charge*	Deductible, then 20% of Allowed Benefit	No charge* after $150 per admission	Deductible, then 20% of Allowed Benefit
Nursery Care of Newborn	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Artificial and Intrauterine Insemination[7] (limited to 6 attempts per live birth)	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
In Vitro Fertilization Procedures[7] (limited to 3 attempts per live birth up to $100,000 lifetime maximum)	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for applicable physician and facility fees)				
Inpatient Facility Services	No charge*	Deductible, then 20% of Allowed Benefit	No charge* after $150 per admission	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Outpatient Facility Services	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Office Visits	$10 per visit	Deductible, then 20% of Allowed Benefit	$15 per visit	Deductible, then 20% of Allowed Benefit
Medication Management	$10 per visit	Deductible, then 20% of Allowed Benefit	$15 per visit	Deductible, then 20% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES				
Durable Medical Equipment	No charge*	No charge*	No charge*	No charge*
Hearing Aids for ages 0–18 (limited to 1 hearing aid per hearing impaired ear every 3 years)	No charge*	No charge*	No charge*	No charge*
Adult Hearing Screenings and Hearing Aids	Blue365 members receive a complimentary hearing screening and discounted prices on hearing aids.			

Note: Allowed Benefit is the fee that participating providers in the network have agreed to accept for a particular service. The participating provider cannot charge the member more than this amount for any covered service. Example: Dr. Carson charges $100 to see a sick patient. To be part of CareFirst's network, he has agreed to accept $50 for the visit. The member will pay their copay/coinsurance and deductible (if applicable) and CareFirst will pay the remaining amount up to $50.

* No copayment or coinsurance.
** Copay applies if office visit is not billed.
[1] When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.
[2] In-Network: When covered services are rendered in Maryland, Washington D.C. and/or Northern Virginia, collectively known as the CareFirst BlueChoice service area, by a provider in the CareFirst BlueChoice Provider network, care is reimbursed at the in-network level. In-network benefits are based on the CareFirst BlueChoice Allowed Benefit. The CareFirst BlueChoice Allowed Benefit is generally the contracted rates or fee schedules that CareFirst BlueChoice providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueChoice, Inc., however, in certain circumstances, an allowance may be established by law. Outside of the CareFirst BlueChoice service area, when covered services are rendered by a provider in the preferred provider network, care is also covered at the in-network level. These in-network benefits are based on the contracted rates or fee schedules that preferred providers have agreed to accept as payment for covered services that are established by the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.
[3] Out-of-Network: When covered services are rendered by a provider that is not in the CareFirst BlueChoice network in Maryland, Washington D.C. or Northern Virginia, or is not in the preferred provider network outside of CareFirst BlueChoice service area, the care is reimbursed as out-of-network. Out-of-network benefits are based on the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that are established by CareFirst BlueChoice, or the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.
[4] For family coverage only: When one family member meets the individual deductible, they can start receiving benefits. Each family member cannot contribute more than the individual deductible amount. The family deductible must be met before the remaining family members can start receiving benefits.
[5] For Family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit.
[6] If you receive laboratory services inside the CareFirst Service area (Maryland, D.C., Northern Virginia) members should use LabCorp to receive In-Network benefits. Services performed by any other provider, while inside the CareFirst Service area will be considered out-of-network. If you receive laboratory services outside of Maryland, D.C. or Northern Virginia, you may use any participating BlueCard PPO laboratory and receive in-network benefits.
[7] Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. Preauthorization required.

CareFirst BlueChoice

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