

BlueChoice Advantage Summary of Benefits

Frederick County Public Schools

Medicare-eligible Retirees

Services	In-network Member Pays ^{1,2}	Out-of-network Member Pays ^{1,3}
	Visit carefirst.com/frederick to locate providers and facilities	
24-HOUR NURSE ADVICE LINE		
Free advice from a registered nurse. Visit carefirst.com/frederick 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 MEDICARE DEDUCTIBLE (Benefit period) ⁴		
Individual	\$0 after annual Medicare deductible	
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period) ⁵		
Medical ⁶	\$500 Individual	\$500 Individual
LIFETIME MAXIMUM BENEFIT		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	After annual Medicare deductible, then 20% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	No charge*	After annual Medicare deductible, then 20% of Allowed Benefit
Breast Cancer Screening	No charge*	After annual Medicare deductible, then 20% of Allowed Benefit
Pap Test	No charge*	After annual Medicare deductible, then 20% of Allowed Benefit
Prostate Cancer Screening	No charge*	After annual Medicare deductible, then 20% of Allowed Benefit
Colorectal Cancer Screening	No charge*	After annual Medicare deductible, then 20% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	No charge* after annual Medicare deductible	After annual Medicare deductible, then 20% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans) ⁶	No charge* after annual Medicare deductible	After annual Medicare deductible, then 20% of Allowed Benefit
Lab ⁶	No charge* after annual Medicare deductible	After annual Medicare deductible, then 20% of Allowed Benefit
X-ray ⁶	No charge* after annual Medicare deductible	After annual Medicare deductible, then 20% of Allowed Benefit
Allergy Testing	No charge* after annual Medicare deductible	After annual Medicare deductible, then 20% of Allowed Benefit
Allergy Shots	No charge* after annual Medicare deductible	After annual Medicare deductible, then 20% of Allowed Benefit
Physical, Speech and Occupational Therapy ⁷ (limited to 100 visits combined with PT, ST, OT and Spinal Manipulation/benefit period)	No charge* after annual Medicare deductible	After annual Medicare deductible, then 20% of Allowed Benefit
Chiropractic (limited to 100 visits combined with PT, ST, OT and Spinal Manipulation/benefit period)	No charge* after annual Medicare deductible	After annual Medicare deductible, then 20% of Allowed Benefit
Acupuncture	No charge* after annual Medicare deductible	After annual Medicare deductible, then 20% of Allowed Benefit
EMERGENCY SERVICES		
Urgent Care Center	No charge* after annual Medicare deductible	No charge* after annual Medicare deductible
Emergency Room—Facility Services	No charge* after annual Medicare deductible	No charge* after annual Medicare deductible
Emergency Room—Physician Services	No charge* after annual Medicare deductible	No charge* after annual Medicare deductible
Ambulance (if medically necessary)	No charge* after annual Medicare deductible	No charge* after annual Medicare deductible

Services	In-network Member Pays ^{1,2}	Out-of-network Member Pays ^{1,3}
HOSPITALIZATION (Members are responsible for applicable physician and facility fees)		
Outpatient Facility Services	No charge* after annual Medicare deductible	After annual Medicare deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge* after annual Medicare deductible	After annual Medicare deductible, then 20% of Allowed Benefit
Inpatient Facility Services	No charge*	20% of Allowed Benefit
Inpatient Physician Services	No charge* after annual Medicare deductible	After annual Medicare deductible, then 20% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care (Benefits are limited to 90 days of unlimited home health care visits from a Home Health Agency or 40 home health aide visits per calendar year. This includes services for Outpatient Private Duty Nursing)	No charge*	No charge*
Hospice	No charge*	No charge*
Skilled Nursing Facility	No charge*	20% of Allowed Benefit
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	After annual Medicare deductible, then 20% of Allowed Benefit
Delivery and Facility Services	No charge*	20% of Allowed Benefit
Nursery Care of Newborn	No charge*	20% of Allowed Benefit
Artificial and Intrauterine Insemination ⁸ (limited to 6 attempts per live birth)	No charge*	20% of Allowed Benefit
In Vitro Fertilization Procedures ⁸ (limited to 3 attempts per live birth up to \$100,000 lifetime maximum)	No charge*	20% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE USE DISORDER (Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	No charge*	20% of Allowed Benefit
Inpatient Physician Services	No charge* after annual Medicare deductible	After annual Medicare deductible, then 20% of Allowed Benefit
Outpatient Facility Services	No charge* after annual Medicare deductible	After annual Medicare deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge* after annual Medicare deductible	After annual Medicare deductible, then 20% of Allowed Benefit
Office Visits	No charge* after annual Medicare deductible	After annual Medicare deductible, then 20% of Allowed Benefit
Medication Management	No charge* after annual Medicare deductible	After annual Medicare deductible, then 20% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	No charge* after annual Medicare deductible	After annual Medicare deductible, then 20% of Allowed Benefit
Hearing Aids—Covered under age 18	No charge* after annual Medicare deductible	After annual Medicare deductible, then 20% of Allowed Benefit

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.

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,

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 There are no limits for children until the end of the month in which the insured or enrollee turns 19 years of age when Physical, Speech or Occupational Therapy is included as part of Habilitative Services.

⁸ 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.

Not all services and procedures are covered by your benefits contract. This summary is for comparison purposes only and does not create rights not given through the benefit plan.

The benefits described are issued under form numbers: MD/CFBC/GC (R. 1/13); MD/CFBC/HPN/EOC (R. 6/10); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/PPN/DOCS (R. 6/10); MD/CFBC/PPN SOB (R. 6/10); MD/CFBC/ELIG (R. 7/09); MD/CFBC/RX (R. 7/12) and any amendments.



CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst MedPlus is the business name of First Care, Inc. CareFirst BlueCross BlueShield Medicare Advantage is the business name of CareFirst Advantage, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., The Dental Network, Inc., First Care, Inc., CareFirst BlueChoice, Inc., and CareFirst Advantage, Inc. are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.