BlueChoice Advantage PPO Summary of Benefits

Capital Vision Services—ODs

Non-Integrated Deductible

Services	In-network You Pay[1,2]	Out-of-network You Pay[1,3]
	Visit carefirst.com/doctor to locate providers	
24-HOUR NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **carefirst.com/needcare** 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.	
WELLBEING PROGRAM & BLUE REWARDS		
Visit **carefirst.com/myaccount** for more information.	You have access to a comprehensive wellness program as part of your medical plan. You also have Blue Rewards, an incentive program where you can get rewarded for completing certain activities.	
ANNUAL DEDUCTIBLE (Benefit period)[4]		
Individual	$1,500	$3,500
Family	$3,000	$7,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[5]		
Medical[6]	$4,000 Individual/$8,000 Family	$8,000 Individual/$16,000 Family
Prescription Drug[6]	Combined with in-network out-of-pocket maximum	All drug costs are subject to in-network out-of-pocket maximum
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	50% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	No charge*	50% of Allowed Benefit
Breast Cancer Screening	No charge*	50% of Allowed Benefit
Pap Test	No charge*	50% of Allowed Benefit
Prostate Cancer Screening	No charge*	50% of Allowed Benefit
Colorectal Cancer Screening	No charge*	50% of Allowed Benefit
PCP AND SPECIALIST SERVICES		
FACILITY CHARGE[7]—In addition to the physician copays/coinsurances listed below, if a service is rendered on a hospital campus, ADD facility charge if applicable	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Office Visits for Illness—PCP[7,8]	$30 per visit	Deductible, then 50% of Allowed Benefit
Convenience Care (retail health clinics such as CVS MinuteClinic or Walgreens Healthcare Clinic)	$30 per visit	Deductible, then 50% of Allowed Benefit
Office Visits for Illness—Specialist[7,8]	$60 per visit	Deductible, then 50% of Allowed Benefit
Allergy Testing[7]	$30 PCP/$60 Specialist per visit	Deductible, then 50% of Allowed Benefit
Allergy Shots[7]	$30 PCP/$60 Specialist per visit	Deductible, then 50% of Allowed Benefit
Physical, Speech, and Occupational Therapy[7,9] (limited to 60 visits/injury/benefit period)	$60 per visit	Deductible, then 50% of Allowed Benefit
Chiropractic Services[7] (limited to 20 visits/benefit period)	$60 per visit	Deductible, then 50% of Allowed Benefit
Acupuncture[7] (limited to 20 visits/benefit period)	$60 per visit	Deductible, then 50% of Allowed Benefit
EMERGENCY SERVICES		
Urgent Care Center[10] (such as Patient First or Express Care)	$60 per visit	$60 per visit
Hospital Emergency Room Services[10]		
▪ Facility	$500 per visit (waived if admitted)	$500 per visit (waived if admitted)
▪ Physician	No charge*	No charge*
Ambulance[10] (if medically necessary)	Deductible, then 30% of Allowed Benefit	In-network deductible, then 30% of Allowed Benefit

BlueChoice Advantage PPO Summary of Benefits

Services	In-network You Pay[1,2]	Out-of-network You Pay[1,3]
DIAGNOSTIC SERVICES		
Labs[11]		
▪ Non-Hospital/Freestanding Facility	$30 PCP/$60 Specialist per visit	Deductible, then 50% of Allowed Benefit
▪ Hospital	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
X-ray[11]		
▪ Non-Hospital/Freestanding Facility	$30 PCP/$60 Specialist per visit	Deductible, then 50% of Allowed Benefit
▪ Hospital	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Imaging[11]		
▪ Non-Hospital/Freestanding Facility	$30 PCP/$60 Specialist per visit	Deductible, then 50% of Allowed Benefit
▪ Hospital	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
HOSPITALIZATION (Members are responsible for both physician and facility fees)		
Outpatient Surgical Center Services		
▪ Facility	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
▪ Physician	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Outpatient Hospital Surgical Services		
▪ Facility	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
▪ Physician	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Inpatient Hospital Services		
▪ Facility	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
▪ Physician	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 90 days per benefit period)	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Hospice (limited to 180 lifetime days inpatient/outpatient combined)	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Skilled Nursing Facility (limited to 60 days/benefit period)	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then 50% of Allowed Benefit
Delivery and Facility Services	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Artificial and Intrauterine Insemination[7,12]	Not covered	Not covered
In Vitro Fertilization Procedures[7,12]	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE USE DISORDER (Members are responsible for both physician and facility fees)		
Office Visits	$30 per visit	Deductible, then 50% of Allowed Benefit
Outpatient Services		
▪ Facility	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
▪ Physician	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Inpatient Services		
▪ Facility	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
▪ Physician	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Hearing Aids for adults	Not covered	Not covered
Hearing Aids for children 18 years and younger	No charge*	No charge*
VISION		
Routine Exam (limited to 1 visit/benefit period)	$10 per visit at participating vision provider	Total charge minus $33 Allowed Benefit
Eyeglasses and Contact Lenses	Discounts from participating vision centers	Not covered

Note: Allowed Benefit is the fee that participating, in-network providers have agreed to accept for a particular covered service. The 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, 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] Plan has an integrated medical and prescription drug out-of-pocket maximum.

[7] If a service is rendered on a hospital campus you could receive two bills, one from the physician and one from the facility.

[8] "Telemedicine services" refers to the use of a combination of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Use of audio-only telephone, electronic mail message (e-mail), or facsimile transmission (FAX) is not considered a telemedicine service.

[9] Visit Limitation does not apply to children ages 2-10 when Physical, Speech and Occupational Therapy is for treatment of Autism Spectrum Disorder.

[10] If the out-of-network benefit is listed as contributing toward the in-network deductible, then it also contributes toward the in-network out-of-pocket maximum.

[11] Members accessing laboratory services inside the CareFirst Service area (Maryland, D.C., Northern Virginia) must use LabCorp as their Lab Test facility and a non-hospital/freestanding facility for X-rays and specialty Imaging for In-Network benefits. Services performed by any other provider, while inside the CareFirst Service area will be considered Out-of-Network. Members accessing laboratory, X-rays, and specialty Imaging services outside of Maryland, D.C. or Northern Virginia, may use any participating BlueCard PPO facility and receive in-network benefits.

[12] 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: VA/CFBC/GC (R. 1/13); VA/CFBC/HPN EOC (R. 10/11); VA/CFBC/LG/POS/DOCS (6/16); VA/CFBC/LG/POS/SOB (6/16); VA/CFBC/ADV/BLCRD (1/17); VA/CFBC/ADV/MEM/BLCRD (1/17); VA/BCOO/VISION (R.1/12); VA/CFBC/RX3 (R. 1/18); VA/CFBC/ATTC (R. 1/10) and any amendments.

CareFirst

Family of health care plans