Gold Plan Summary of Benefits

Kennedy Krieger

Services	In-network You Pay[1,2]	Out-of-network You Pay[1,3]
	Visit carefirst.com/doctor to locate providers	
Provider	Care received by a CareFirst BlueChoice Advantage, BluePreferred, or BlueCard PPO provider	Care received by a non-participating provider
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		
Visit **carefirst.com/myaccount** for more information.	You have access to a comprehensive well-being program as part of your medical plan.	
ANNUAL DEDUCTIBLE (Benefit period)[4]		
Individual	$600	$1,200
Family	$1,200	$2,400
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[5]		
Medical[6]	$3,000 Individual/$6,000 Family	$5,000 Individual/$10,000 Family
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	Deductible, then 30% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	No charge*	Deductible, then 30% of Allowed Benefit
Breast Cancer Screening	No charge*	No charge*
Pap Test	No charge*	No charge*
Prostate Cancer Screening	No charge*	No charge*
Colorectal Cancer Screening	No charge*	No charge*
PCP AND SPECIALIST SERVICES		
Office Visits for Illness—PCP[7,8]	$20 per visit	Deductible, then 30% of Allowed Benefit
Convenience Care (retail health clinics such as CVS Minute Clinic and Other participating Retail Health Clinics)	$5 per visit	$5 per visit
Office Visits for Illness—Specialist[7,8]	$35 per visit	Deductible, then 30% of Allowed Benefit
Allergy Testing[7]	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Allergy Shots[7]	No charge*	Deductible, then 30% of Allowed Benefit
Physical, Speech, and Occupational Therapy[7,9]	$20 per visit	Deductible, then 30% of Allowed Benefit
Chiropractic Services[7]	$35 per visit	Deductible, then 30% of Allowed Benefit
Acupuncture[7]	$35 per visit	Deductible, then 30% of Allowed Benefit
EMERGENCY SERVICES		
Urgent Care Center[10] (such as Patient First or Express Care)	$20 per visit	Deductible, then 30% of Allowed Benefit
Hospital Emergency Room Services[10]		
▪ Facility	$50 per visit, plus Deductible, then 10% of Allowed Benefit, (waived if admitted)	$50 per visit, plus Deductible, then 10% of Allowed Benefit, (waived if admitted)
▪ Physician	Deductible, then 10% of Allowed Benefit	Deductible, then 10% of Allowed Benefit
Ambulance[10] (if medically necessary)	$50 per visit, plus 10% of Allowed Benefit	$50 per visit, plus 10% of Allowed Benefit

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DIAGNOSTIC SERVICES		
Labs[11]		
▪ Non-Hospital/Freestanding Facility	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
▪ Hospital	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
X-ray[11]		
▪ Non-Hospital/Freestanding Facility	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
▪ Hospital	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Imaging[11]		
▪ Non-Hospital/Freestanding Facility	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
▪ Hospital	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
HOSPITALIZATION—(Members are responsible for both physician and facility fees)		
Outpatient Surgical Center Services		
▪ Facility	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
▪ Physician	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Outpatient Hospital Surgical Services		
▪ Facility	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
▪ Physician	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Inpatient Hospital Services		
▪ Facility (limited to 3 admission copays per year)	$200 copay per visit, plus Deductible, then 10% of Allowed Benefit	$200 copay per visit, plus Deductible, then 30% of Allowed Benefit
▪ Physician	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Hospice	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Skilled Nursing Facility (limited to 3 admission copays per year)	$200 copay per visit, plus Deductible, then 10% of Allowed Benefit	$200 copay per visit, plus Deductible, then 30% of Allowed Benefit
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then 30% of Allowed Benefit
Delivery and Facility Services	$200 copay, plus Deductible, then 10% of Allowed Benefit	$200 copay, plus Deductible, then 30% of Allowed Benefit
Artificial and Intrauterine Insemination[7,12] (limited to up to $20,000 lifetime maximum combined with IVF including non-iatrogenic related cryopreservation)	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
In Vitro Fertilization Procedures[7,12] (limited to up to $20,000 lifetime maximum combined with AI including non-iatrogenic related cryopreservation)	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for both physician and facility fees)		
Office Visits	$20 per visit	Deductible, then 30% of Allowed Benefit
Outpatient Services		
▪ Facility	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
▪ Physician	$20 copay per visit	Deductible, then 30% of Allowed Benefit
Inpatient Services		
▪ Facility (limited to 3 admission copays per year)	$200 copay, plus Deductible, then 10% of Allowed Benefit	$200 copay, plus Deductible, then 30% of Allowed Benefit
▪ Physician	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Hearing Aids (limited to one hearing aid per ear up to $2,000 per ear every 36 months)	No charge*	No charge*

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VISION		
Routine Exam (limited to $100 maximum benefit every two years)	No charge*	No charge*
Eyeglasses and Contact Lenses (limited to $150 maximum benefit every two years)	No charge*	No charge*

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 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, including audio-only telephone conversation between a health care provider and the Member when required by law, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Use of e-mail, online questionnaires or Fax is not considered a telemedicine service.

[9] 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.

[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.

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: In-Network: MD/CFBC/GC (R. 1/13); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/LG/POS IN/EOC (1/19); MD/CFBC/LG/POS IN/DOCS (1/19); MD/CFBC/LG/POS IN/SOB (1/19); MD/CFBC/ELIG (R. 7/09); MD/CFBC/RX (R. 1/18); MD/CFBC/INCENT (1/19) Out-of-Network: CFMI/51+/GC (R. 1/13); CFMI/LG/POS OON/EOC (1/19); CFMI/DOL APPEAL (R. 9/11); CFMI/LG/POS OON/DOCS (1/19); CFMI/LG/POS OON/SOB (1/19); CFMI/51+/ELIG (R. 1/10) Out-of-Network: MD/CF/GC (R. 1/13); MD/CF/LG/POS OON/EOC (1/19); MD/GHMSI/DOL APPEAL (R. 9/11); MD/CF/LG/POS OON/DOCS (1/19); MD/CF/LG/POS OON/SOB (1/19); MD/CF/ATTC (R. 7/09) and any amendments.

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