BlueChoice Advantage HSA D2 Summary of Benefits

Westat

Integrated Deductible

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
	Visit www.carefirst.com/doctor to locate providers and facilities	
24-HOUR NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **www.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 **www.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	$3,200	$4,500
Family	$5,000	$9,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[5]		
Medical[6]	$4,000 Individual/$8,000 Family	$6,000 Individual/$12,000 Family
Prescription Drug[6]	Combined with in-network medical out-of-pocket maximum	All drug costs are subject to in-network out-of-pocket maximum
LIFETIME MAXIMUM BENEFIT		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	No charge* after deductible
Adult Physical Examination (including routine GYN visit)	No charge*	No charge* after deductible
Breast Cancer Screening	No charge*	No charge*
Pap Test	No charge*	No charge* after deductible
Prostate Cancer Screening	No charge*	No charge* after deductible
Colorectal Cancer Screening	No charge*	No charge* after deductible
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	PCP: No charge* after deductible Specialist: Deductible, then $30 per visit	Deductible, then $50 per visit
Imaging (MRA/MRS, MRI, PET & CAT scans)[7]	No charge* after deductible	Deductible, then $50 per visit
Lab[7]	No charge* after deductible	Deductible, then $50 per visit
X-ray[7]	No charge* after deductible	Deductible, then $50 per visit
Allergy Testing	PCP: No charge* after deductible Specialist: Deductible, then $30 per visit	Deductible, then $50 per visit
Allergy Shots	PCP: No charge* after deductible Specialist: Deductible, then $30 per visit	Deductible, then $50 per visit
Physical, Speech and Occupational Therapy[8] (limited to 30 visits/injury/benefit period)	Deductible, then $30 per visit	Deductible, then $50 per visit
Chiropractic (limited to 20 visits/benefit period)	Deductible, then $30 per visit	Deductible, then $50 per visit
Acupuncture	Not covered	Not covered

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EMERGENCY SERVICES		
Urgent Care Center	Deductible, then $50 per visit	In-network deductible, then $50 per visit
Emergency Room—Facility Services	Deductible, then $200 per visit (waived if admitted)	In-network deductible, then $300 per visit (waived if admitted)
Emergency Room—Physician Services	No charge* after deductible	No charge* after in-network deductible
Ambulance (if medically necessary)	Deductible, then $50 per service	In-network deductible, then $50 per service
HOSPITALIZATION—(Members are responsible for applicable physician and facility fees)		
Outpatient Facility Services	Deductible, then $300 per visit	Deductible, then $500 per visit
Outpatient Physician Services	No charge* after deductible	Deductible, $50 per visit
Inpatient Facility Services	Deductible, then $300 per admission	Deductible, then $500 per admission
Inpatient Physician Services	No charge* after deductible	Deductible, then $50 per admission
HOSPITAL ALTERNATIVES		
Home Health Care	Deductible, then $30 per visit	Deductible, then $50 per visit
Hospice (Inpatient—limited to 30 days; Outpatient—unlimited during Hospice eligibility period)	Deductible, then $30 per visit	Deductible, then $50 per visit
Skilled Nursing Facility (limited to 60 days/benefit period)	Deductible, then $30 per visit	Deductible, then $50 per visit
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then $50 per visit
Delivery and Facility Services	Deductible, then $300 per admission	Deductible, then $500 per visit
Nursery Care of Newborn	No charge* after deductible	Deductible, then $50 per visit
Artificial and Intrauterine Insemination[9] (limited to 6 attempts per live birth)	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
In Vitro Fertilization Procedures[9] (limited to 3 attempts per live birth up to $100,000 lifetime maximum)	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	Deductible, then $300 per admission	Deductible, then $500 per admission
Inpatient Physician Services	No charge* after deductible	Deductible, then $50 per admission
Outpatient Facility Services	No charge* after deductible	Deductible, then $50 per visit
Outpatient Physician Services	No charge* after deductible	Deductible, then $50 per visit
Office Visits	PCP: No charge* after deductible Specialist: Deductible, then $30 per visit	Deductible, then $50 per visit
Medication Management	PCP: No charge* after deductible Specialist: Deductible, then $30 per visit	Deductible, then $50 per visit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then $30 copay	Deductible, then $50 copay
Hearing Aids (limited to 1 hearing aid per hearing impaired ear every 3 years)	No charge* after deductible	No charge* after deductible
VISION		
Routine Exam (limited to 1 visit/benefit period)	$10 per exam 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 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, in certain circumstances, an allowance may be established by law.

4 For family coverage only: The family deductible must be met before any member starts receiving benefits. The deductible may be met by one member or any combination of members.

5 For family coverage only: The family out-of-pocket maximum must be met before any member's services will be covered at 100% up to the Allowed Benefit. The out-of-pocket maximum may be met by one member or any combination of members.

6 Plan has an integrated medical and prescription drug out-of-pocket maximum.

7 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.

8 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.

9 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: 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/RX (R. 1/18); MD/CFBC/ELIG (R. 7/09); MD/CFBC/LG/INCENT (R.1/19) and any amendments. 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) and any amendments. 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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Family of health care plans