BlueChoice Advantage Summary of Benefits

Hagerstown Community College

Services	In-network You Pay[1,2]	Out-of-network You Pay[1,3]
	Visit carefirst.com/doctor to locate providers	
24/7 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.	
ANNUAL DEDUCTIBLE (Benefit period)[2]		
Individual	$550	$550
Family	$900	$900
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[3]		
Medical[4]	$3,500 Individual/$6,500 Family	$3,500 Individual/$6,500 Family
Prescription Drug[4]	Combined with medical in-network 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*	Deductible, then 40% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	No charge*	Deductible, then 40% of Allowed Benefit
Breast Cancer Screening	No charge*	Deductible, then 40% of Allowed Benefit
Pap Test	No charge*	Deductible, then 40% of Allowed Benefit
Prostate Cancer Screening	No charge*	Deductible, then 40% of Allowed Benefit
Colorectal Cancer Screening	No charge*	Deductible, then 40% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans)[5]	Deductible, then 10% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Lab[5]	Deductible, then 10% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
X-ray[5]	Deductible, then 10% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Allergy Testing	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Allergy Shots	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Physical, Speech and Occupational Therapy	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Chiropractic	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Acupuncture	Not covered (except when approved or authorized by Plan when used for anesthesia)	Not covered (except when approved or authorized by Plan when used for anesthesia)
Video Visits	Covered at 100% of Allowed benefit with no deductible or copay	Covered at 100% of Allowed benefit with no deductible or copay
Provider Sponsored Telemedicine	Deductible, then 80% of Allowed Benefit	Deductible, then 60% of Allowed Benefit
Provider Telephonic Consultations	Not covered	Not covered
EMERGENCY SERVICES		
Urgent Care Center	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Emergency Room—Facility Services	Deductible, then 20% of Allowed Benefit (waived if admitted)	In-network deductible, then 20% of Allowed Benefit (waived if admitted)
Emergency Room—Physician Services	Deductible, then 20% of Allowed Benefit	In-network deductible, then 20% of Allowed Benefit
Ambulance (if medically necessary)	Deductible, then 20% of Allowed Benefit	In-network deductible, then 20% of Allowed Benefit

BlueChoice Advantage Summary of Benefits

Services	In-network You Pay[1,2]	Out-of-network You Pay[1,3]
HOSPITALIZATION (Members are responsible for applicable physician and facility fees)		
Outpatient Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Outpatient Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Inpatient Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Inpatient Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 40 visits per benefit period)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Hospice (Inpatient—limited to 30 days; Outpatient—limited to 180 days during Hospice eligibility period)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Skilled Nursing Facility (limited to 120 days/benefit period)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then 40% of Allowed Benefit
Delivery and Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Nursery Care of Newborn	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Artificial and Intrauterine Insemination[7]	Not covered	Not covered
In Vitro Fertilization Procedures[7] (limited to 3 attempts per live birth up to $100,000 lifetime maximum)	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE USE DISORDER (Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Inpatient Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Outpatient Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Outpatient Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Office Visits	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Medication Management	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Hearing Aids for ages 0-18 (limited to 1 hearing aid per hearing impaired ear every 3 years)	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 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 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 separate out-of-pocket maximums for medical and drug expenses which accumulate independently.

[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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