# 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 | |
| **FIRSTHELP—24/7 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 FirstHelp at 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

Family of health care plans