BlueChoice Advantage Summary of Benefits

Asbury Communities—Platinum Plan

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.	
NETWORK		
Provider	Care received by a BlueChoice, BluePreferred, or BlueCard PPO provider	Care received by a non-participating provider
ANNUAL DEDUCTIBLE (Benefit period)[4]		
Individual	$500	$2,000
Family	$1,000	$4,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[5]		
Medical[6]	$5,500 Individual/$11,000 Family	$9,000 Individual/$18,000 Family
Prescription Drug[6]	Combined with in-network out-of-pocket maximum	All drug costs are subject to in-network out-of-pocket maximum
LIFETIME MAXIMUM BENEFIT		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	No charge*
Adult Physical Examination (including routine GYN visit)	No charge*	No charge*
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*
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	$20 PCP/$40 Specialist per visit	Deductible, then 50% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans)	$80 per visit	Deductible, then 50% of Allowed Benefit
Lab	$20 per visit	Deductible, then 50% of Allowed Benefit
X-ray	$40 per visit	Deductible, then 50% of Allowed Benefit
Allergy Testing	$20 PCP/$40 Specialist per visit	Deductible, then 50% of Allowed Benefit
Allergy Shots	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Physical, Speech and Occupational Therapy[7] (limited to 90 visits/injury/benefit period)	$40 per visit	Deductible, then 50% of Allowed Benefit
Chiropractic (limited to 20 visits/benefit period)	$40 per visit	Deductible, then 50% of Allowed Benefit
Acupuncture (limited to 20 visits/benefit period)	$40 per visit	Deductible, then 50% of Allowed Benefit
EMERGENCY SERVICES		
Urgent Care Center	$75 per visit	Deductible, then 50% of Allowed Benefit
Emergency Room—Facility Services	Deductible, then $200 per visit (waived if admitted)	In-network deductible, then $200 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 10% of Allowed Benefit	Deductible, then 50% 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 $100 per visit	Deductible, then 50% of Allowed Benefit
Outpatient Physician Services	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Inpatient Facility Services	Deductible, then $300 per admission	Deductible, then 50% of Allowed Benefit
Inpatient Physician Services	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Hospice (180 Lifetime days Inpatient/ Outpatient combined)	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Skilled Nursing Facility	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	No charge*
Delivery and Facility Services	Deductible, then $300 per admission	Deductible, then 50% of Allowed Benefit
Nursery Care of Newborn	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Artificial and Intrauterine Insemination[8] (limited to 6 attempts per live birth)	Deductible, then 10% 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 50% of Allowed Benefit
Inpatient Physician Services	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Outpatient Facility Services	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Outpatient Physician Services	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Office Visits	$20 per visit	Deductible, then 50% of Allowed Benefit
Medication Management	$20 per visit	Deductible, then 50% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 10% of Allowed Benefit	Deductible, then 50% 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*
Hearing Aids for Adults	$40 per visit	Deductible, then 50% 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] Participating BlueChoice providers and outpatient facilities must use LabCorp® facilities for laboratory services to be covered in-network. For BlueChoice providers who refer you to a lab, you must use a LabCorp® facility for laboratory services to be covered under your in-network coverage. You may also use a participating BlueCard PPO laboratory and receive in-network benefits if the ordering physician and/or outpatient facility is not a BlueChoice participating provider.
[3] Out-of-Network: When covered services are rendered by a non-participating provider, 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] 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: 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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