BlueChoice HMO Referral Bronze 5750 Summary of Benefits

Non-Integrated Deductible

Services	In-Network You Pay[1]
	Visit www.carefirst.com/doctor to locate providers and facilities
FIRSTHELP—24/7 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 FirstHelp at 800-535-9700 to speak with a registered nurse about your health questions and treatment options.
WELLNESS PROGRAM & BLUE REWARDS	
Visit **www.carefirst.com/sharecare** 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 MEDICAL DEDUCTIBLE (Benefit Period)[2]	
Individual/Family	$5,750 Individual/$11,500 Family (separate)
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit Period)[3,4]	
Individual/Family	$7,900 Individual/$15,800 Family (separate)
PREVENTIVE SERVICES	
Well-Child Care (including exams & immunizations)	No charge*
Adult Physical Examination (including routine GYN visit)	No charge*
Breast Cancer Screening	No charge*
Pap Test	No charge*
Prostate Cancer Screening	No charge*
Colorectal Cancer Screening	No charge*
PCP AND SPECIALIST SERVICES	
FACILITY CHARGE[5]—In addition to the physician copays/coinsurances listed below, if a service is rendered on a hospital campus, ADD facility charge if applicable (also applies to Artificial Insemination and In Vitro Fertilization on page 2)	Deductible, then $50 per visit
Office Visits for Illness—PCP[5,6]	$40 per visit
Office Visits for Illness—Specialist[5,6]	Deductible, then $80 per visit
Allergy Testing[5]	Deductible, then $80 per visit
Allergy Shots[5]	Deductible, then $80 per visit
Physical, Speech, and Occupational Therapy[5] (limited to 30 visits/illness or injury/benefit period)	Deductible, then $80 per visit
Chiropractic[5] (limited to 20 visits/benefit period)	Deductible, then $80 per visit
Acupuncture[5]	Deductible, then $80 per visit
IMMEDIATE AND EMERGENCY SERVICES	
Convenience Care (retail health clinics such as CVS MinuteClinic or Walgreens Healthcare Clinic)	$40 per visit
Urgent Care Center (such as Patient First or ExpressCare)	$100 per visit
Hospital Emergency Room Services	
■ Facility	Deductible, then $500 per visit (waived if admitted)
■ Physician	Deductible, then $50 per visit
Ambulance (if medically necessary)	Deductible, then $80 per service

Services	In-Network You Pay[1]
DIAGNOSTIC SERVICES	
Labs[7]	
■ LabCorp	$40 per visit
■ Hospital (preauthorization required)	Deductible, then $150 per visit
X-ray	
■ Non-Hospital/Freestanding Facility	$160 per visit
■ Hospital (preauthorization required)	Deductible, then $200 per visit
Imaging	
■ Non-Hospital/Freestanding Facility	Deductible, then $300 per visit
■ Hospital (preauthorization required)	Deductible, then $750 per visit
SURGERY AND HOSPITALIZATION—(Members are responsible for both physician and facility fees)	
Outpatient Surgery (Non-Hospital)	
■ Facility	Deductible, then $300 per visit
■ Physician	Deductible, then $80 per visit
Outpatient Surgery (Hospital)	
■ Facility	Deductible, then $450 per visit
■ Physician	Deductible, then $80 per visit
Inpatient Surgery and Hospital Services	
■ Facility	Deductible, then $500 per day (5 day maximum payment per admission)
■ Physician	Deductible, then $80 per visit
HOSPITAL ALTERNATIVES	
Home Health Care	No charge*
Hospice	No charge*
Skilled Nursing Facility (limited to 100 days/benefit period)	Deductible, then $80 per day
MATERNITY	
Preventive Prenatal and Postnatal Office Visits	No charge*
Delivery and Facility Services	Deductible, then $500 per day (5 day maximum payment per admission)
Artificial and Intrauterine Insemination[5,8]	Deductible, then $40 per visit
In Vitro Fertilization Procedures[5,8]	Not covered
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for both physician and facility fees)	
Office Visits	$40 per visit
Outpatient Services	
■ Facility	Deductible, then $50 per visit
■ Physician	Deductible, then $80 per visit
Inpatient Services	
■ Facility	Deductible, then $500 per day (5 day maximum payment per admission)
■ Physician	Deductible, then $80 per visit
MEDICAL DEVICES AND SUPPLIES	
Durable Medical Equipment	Deductible, then 25% of Allowed Benefit
Hearings Aids (limited to one hearing aid per hearing-impaired ear every 36 months)	Deductible, then 25% of Allowed Benefit

Services	In-Network You Pay[1]
PRESCRIPTION DRUGS[9]	
Formulary List	Visit **www.carefirst.com/acarx** to locate Formulary List
Annual Prescription Drug Deductible	$250 per person (waived for generic drugs)
Preventive Drugs	No charge*
Oral Chemo Drugs and Diabetic Supplies	No charge*
Generic Drugs	30-day supply $20; 90-day supply $40 (maintenance drugs only)
Preferred Brand Drugs[10]	30-day supply Deductible, then $75; 90-day supply Deductible, then $150 (maintenance drugs only)
Non-preferred Brand Drugs[11]	30-day supply Deductible, then $150; 90-day supply Deductible, then $300 (maintenance drugs only)
Preferred Specialty Drugs (must be filled through Exclusive Specialty Pharmacy Network)	30-day supply Deductible, then $100 maximum; 90-day supply Deductible, then $200 maximum (maintenance drugs only)
Non-Preferred Specialty Drugs (must be filled through Exclusive Specialty Pharmacy Network)	30-day supply Deductible, then $150 maximum; 90-day supply Deductible, then $300 maximum (maintenance drugs only)
PEDIATRIC VISION—(Through the end of the calendar year in which the dependent turns 19)	
Routine Exam (limited to 1 visit/benefit period)	In-network-No charge*; Out-of-network-Total charge minus $40 reimbursement
Frames and Contact Lenses—Pediatric Collection Only	In-network-No charge*; Out-of-network-Reimbursements apply
Spectacle Lenses	In-network-No charge*; Out-of-network-Reimbursements apply
PEDIATRIC DENTAL—(Through the end of the calendar year in which the dependent turns 19)	
Annual Dental Deductible	In-network-$25; Out-of-network-$50
Class I Preventative & Diagnostic Services—Exams (2 per year). Cleanings (2 per year), fluoride treatments (2 per year), sealants, bitewing X-rays (2 per year), full mouth X-ray (one every 3 years)	In-network-No charge*; Out-of-network-20% of Allowed Benefit
Class II Basic Services—Fillings (amalgam or composite), simple extractions, non-surgical periodontics	In-network-Deductible, then 20% of Allowed Benefit; Out-of-network-Deductible, then 40% of Allowed Benefit
Class III Major Services—Surgical periodontics, endodontics, oral surgery	In-network-Deductible, then 20% of Allowed Benefit; Out-of-network-Deductible, then 40% of Allowed Benefit
Class IV Major Services—Restorative Crowns, dentures, inlays and onlays	In-network-Deductible, then 50% of Allowed Benefit; Out-of-network-Deductible, then 65% of Allowed Benefit
Class V Medically Necessary Orthodontic Services	In-network-50% of Allowed Benefit; Out-of-network-65% of Allowed Benefit

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Note: Allowed Benefit is the fee that providers in the network have agreed to accept for a particular 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 Separate - 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.
3 Separate - 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. The out-of-pocket maximum includes deductibles, copays and coinsurance.
4 All drug costs are subject to the in-network out-of-pocket maximum.
5 If a service is rendered on a hospital campus you could receive two bills, one from the physician and one from the facility.
6 "Telemedicine services" refers to the use of a combination of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Use of audio-only telephone, electronic mail message (e-mail), or facsimile transmission (FAX) is not considered a telemedicine service.
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.
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 forinfertility. Preauthorization required.
9 Benefits for Specialty Drugs are only available when Specialty Drugs are purchased from and dispensed by a specialty Pharmacy in the Exclusive Specialty Pharmacy Network.
10 If a Generic drug becomes available for a Preferred Brand drug, the Preferred Brand drug moves to the Non-preferred Brand drug tier.
11 If a provider prescribes a Non-preferred Brand drug, and the Member selects the Non-preferred Brand drug when a Generic drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the Non-preferred Brand drug and the Generic drug up to the cost of the drug. This amount will not contribute to the Out-of-Pocket Maximum.

Note: Upon enrollment in CareFirst BlueChoice, you will need to select a Primary Care Provider (PCP). To select a PCP, go to www.carefirst.com for the most current listing of PCPs from our online provider directory. You may also call the Member Services toll free phone number on the front of your CareFirst BlueChoice ID card for assistance in selecting a PCP or obtaining a printed copy of the CareFirst BlueChoice provider directory.
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 (1/14) • MD/CFBC/SG/2016 GC AMEND (1/16) • MD/CFBC/SG/HMO-POS/EOC (1/17) • MD/CFBC/DOL APPEAL (R. 9/11) • MD/CFBC/SHOP/HMO DOCS (R. 1/17) • MD/CFBC/SHOP/HMO REF CDH/BRZ 5500 (1/19) • MD/CFBC/SG/HMO REF/BRZ 5750 (1/19) • MD/CFBC/SG/HMO REF/SIL 4000 (1/19) • MD/CFBC/SG/HMO REF/SIL 2000 (1/19) • MD/CFBC/SG/HMO REF/GOLD 1000 (1/19) • MD/CFBC/SG/HMO REF/GOLD 500 (1/19) • MD/CFBC/SG/HMO REF/GOLD 0 (1/19) • MD/CFBC/SG/HMO REF/PLAT 0 (1/19) • MD/CFBC/SG/HMO-POS IN/INCENT (R. 1/19) • MD/CFBC/ELIG (1/14) and any amendments.

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