HealthyBlue Advantage HSA/HRA Silver 2000 Summary of Benefits

Integrated Deductible

Services	In-Network You Pay[1]	Out-of-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)[2,3]		
Individual/Family	$2,000 Individual/$4,000 Family (aggregate)	$4,000 Individual/$8,000 Family (aggregate)
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit Period)[2,4,5]		
Individual/Family	$6,550 Individual/$13,100 Family (separate)	$9,000 Individual/$18,000 Family (separate)
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	No charge*
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
PCP AND SPECIALIST SERVICES		
FACILITY CHARGE[6]—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	Deductible, then $150 per visit
Office Visits for Illness—PCP[6,7]	No charge* after deductible	Deductible, then $65 per visit
Office Visits for Illness—Specialist[6,7]	Deductible, then $45 per visit	Deductible, then $65 per visit
Allergy Testing[6]	Deductible, then $45 per visit	Deductible, then $65 per visit
Allergy Shots[6]	Deductible, then $45 per visit	Deductible, then $65 per visit
Physical, Speech, and Occupational Therapy[6] (limited to 30 visits/illness or injury/benefit period)	Deductible, then $45 per visit	Deductible, then $65 per visit
Chiropractic[6] (limited to 20 visits/benefit period)	Deductible, then $45 per visit	Deductible, then $65 per visit
Acupuncture[6]	Deductible, then $45 per visit	Deductible, then $65 per visit

Services	In-Network You Pay[1]	Out-of-Network You Pay[1]
IMMEDIATE AND EMERGENCY SERVICES		
Convenience Care (retail health clinics such as CVS MinuteClinic or Walgreens Healthcare Clinic)	No charge* after deductible	Deductible, then $65 per visit
Urgent Care Center[8] (such as Patient First or ExpressCare)	Deductible, then $50 per visit	In-network deductible, then $50 per visit
Hospital Emergency Room Services[8]		
■ Facility	Deductible, then $200 per visit (waived if admitted)	In-network deductible, then $200 per visit (waived if admitted)
■ Physician	Deductible, then $45 per visit	In-network deductible, then $45 per visit
Ambulance (if medically necessary)[8]	Deductible, then $45 per service	In-network deductible, then $45 per service
DIAGNOSTIC SERVICES		
Labs[9]		
■ Non-Hospital/Freestanding Facility	No charge* after deductible	Deductible, then $50 per visit
■ Hospital	Deductible, then $75 per visit	Deductible, then $125 per visit
X-ray		
■ Non-Hospital/Freestanding Facility	No charge* after deductible	Deductible, then $50 per visit
■ Hospital	Deductible, then $100 per visit	Deductible, then $150 per visit
Imaging		
■ Non-Hospital/Freestanding Facility	Deductible, the $100 per visit	Deductible, then $150 per visit
■ Hospital	Deductible, then $300 per visit	Deductible, then $400 per visit
SURGERY AND HOSPITALIZATION—(Members are responsible for both physician and facility fees)		
Outpatient Surgery (Non-Hospital)		
■ Facility	Deductible, then $100 per visit	Deductible, then $200 per visit
■ Physician	Deductible, then $45 per visit	Deductible, then $65 per visit
Outpatient Surgery (Hospital)		
■ Facility	Deductible, then $200 per visit	Deductible, then $300 per visit
■ Physician	Deductible, then $45 per visit	Deductible, then $65 per visit
Inpatient Surgery and Hospital Services		
■ Facility	Deductible, then $500 per admission	Deductible, then $600 per admission
■ Physician	Deductible, then $45 per visit	Deductible, then $65 per visit
HOSPITAL ALTERNATIVES		
Home Health Care	No charge* after deductible	Deductible, then $65 per visit
Hospice	No charge* after deductible	Deductible, then $65 per admission
Skilled Nursing Facility (limited to 100 days/benefit period)	Deductible, then $45 per admission	Deductible, then $65 per admission
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then $65 per visit
Delivery and Facility Services	Deductible, then $500 per admission	Deductible, then $600 per admission
Artificial and Intrauterine Insemination[6,10]	No charge* after deductible	Deductible, then $65 per visit
In Vitro Fertilization Procedures[6,10]	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for both physician and facility fees)		
Office Visits	No charge* after deductible	Deductible, then $65 per visit
Outpatient Services		
■ Facility	Deductible, then $50 per visit	Deductible, then $65 per visit
■ Physician	Deductible, then $45 per visit	Deductible, then $65 per visit
Inpatient Services		
■ Facility	Deductible, then $500 per admission	Deductible, then $600 per admission
■ Physician	Deductible, then $45 per visit	Deductible, then $65 per visit

Services	In-Network You Pay[1]	Out-of-Network You Pay[1]
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 25% of Allowed Benefit	Deductible, then 45% of Allowed Benefit
Hearing Aids (limited to one hearing aid per hearing-impaired ear every 36 months)	Deductible, then 25% of Allowed Benefit	Deductible, then 45% of Allowed Benefit
PRESCRIPTION DRUGS[11,12]		
Formulary List	Visit **www.carefirst.com/acarx** to locate Formulary List	
Annual Prescription Drug Deductible	Subject to combined medical and prescription drug deductible	
Preventive Drugs	No charge*	
Oral Chemo Drugs and Diabetic Supplies	HSA - No charge* after deductible; HRA - No charge*	
Generic Drugs	30-day & 90-day (maintenance drugs only) supplies No charge* after deductible	
Preferred Brand Drugs[13]	30-day supply Deductible, then $45; 90-day supply Deductible, then $90 (maintenance drugs only)	
Non-preferred Brand Drugs[14]	30-day supply Deductible, then $65; 90-day supply Deductible, then $130 (maintenance drugs only)	
Preferred Specialty Drugs (must be filled through Exclusive Specialty Pharmacy Network)	30-day supply Deductible, then 50% up to $100 maximum; 90-day supply Deductible, then 50% up to $200 maximum (maintenance drugs only)	
Non-Preferred Specialty Drugs (must be filled through Exclusive Specialty Pharmacy Network)	30-day supply Deductible, then 50% up to $150 maximum; 90-day supply Deductible, then 50% up to $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)	No charge*	Total charge minus $40 reimbursement
Frames and Contact Lenses—Pediatric Collection Only	No charge*	Reimbursements apply
Spectacle Lenses	No charge*	Reimbursements apply
PEDIATRIC DENTAL—(Through the end of the calendar year in which the dependent turns 19)		
Annual Dental Deductible	$25	$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)	No charge*	20% of Allowed Benefit
Class II Basic Services—Fillings (amalgam or composite), simple extractions, non-surgical periodontics	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Class III Major Services—Surgical periodontics, endodontics, oral surgery	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Class IV Major Services—Restorative Crowns, dentures, inlays and onlays	Deductible, then 50% of Allowed Benefit	Deductible, then 65% of Allowed Benefit
Class V Medically Necessary Orthodontic Services	50% of Allowed Benefit	65% of Allowed Benefit

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 In- and out-of-network deductible and out-of-pocket maximums do not contribute to each other.
3 Aggregate - 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.
4 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.
5 All drug costs are subject to the in-network out-of-pocket maximum.
6 If a service is rendered on a hospital campus you could receive two bills, one from the physician and one from the facility.
7 "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.
8 If the out-of-network benefit is listed as contributing toward the in-network deductible, then it also contributes toward the in-network out-of-pocket maximum.
9 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.
10 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.
11 Except for emergency services or out-of-area urgent care, if a member goes to a non-participating pharmacy, the member is responsible for the copay/coinsurance for the drugplus the difference between the allowed charge and the actual charge for that drug (called balance billed amount). The balance billed amount does not contribute to the out-ofpocketmaximum.
12 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.
13 If a Generic drug becomes available for a Preferred Brand drug, the Preferred Brand drug moves to the Non-preferred Brand drug tier.
14 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.

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/CF/GC (1/14) • MD/CF/SG/2018 GC AMEND (1/18) • MD/CF/POS OON/EOC (R. 1/17) • MD/GHMSI/DOL APPEAL (R. 9/11) • MD/CF/SG/POS OON/DOCS (R. 1/17) • MD/CF/SG/POS OON CDH/SIL 2000 (1/19) • MD/CF/SG/POS OON/GOLD 1500 (1/19) • MD/CF/SG/POS OON/PLAT 500 (1/19) • MD/CF/ELIG (1/14) and any amendments.
MD/CF/GC (1/14) • MD/CF/SG/2018 GC AMEND (1/18) • MD/CF/POS OON/EOC (R. 1/17) • MD/GHMSI/DOL APPEAL (R. 9/11) • MD/CF/SG/POS OON/DOCS (R. 1/17) • MD/CF/SG/POS OON CDH/SIL 2000 (1/19) • MD/CF/SG/POS OON/GOLD 1500 (1/19) • MD/CF/SG/POS OON/PLAT 500 (1/19) • MD/CF/ELIG (1/14) and any amendments.
CFMI/GC (1/14) • CFMI/SG/2018 GC AMEND (1/18) • CFMI/POS OON/EOC (R. 1/17) • CFMI/DOL APPEAL (R. 9/11) • CFMI/SG/POS OON/DOCS (R. 1/17) • CFMI/SG/POS OON CDH/SIL 2000 (1/19) • CFMI/SG/POS OON/GOLD 1500 (1/19) • CFMI/SG/POS OON/PLAT 500 (1/19) • CFMI/ELIG (1/14) and any amendments.

CareFirst
Family of health care plans

SUM4351-1P (9/18) ■ MD ■ 2019 2-50 ACA Compliant (Can be sold as HDHP)