CareFirst Administrators PPO

Services	In-Network	Out-of-Network
ANNUAL DEDUCTIBLE - ***You are required to satisfy two separate deductibles. Expenses for in-network services apply to the in-network deductible, and expenses for out-of-network services apply to the out-of-network deductible.***		
Individual	$250	$250
Individual plus 1	$500	$500
Individual plus 2 or more	$750	$750
ANNUAL OUT-OF-POCKET LIMIT - ***You are required to satisfy two separate out-of-pocket maximums. Expenses for in-network services apply to the in-network out-of-pocket maximum, and expenses for out-of-network services apply to the out-of-network out-of-pocket maximum. Out-of-network copays do not apply to the out-of-network out-of-pocket maximum. *Medical and Pharmacy out of pockets do not cross apply.***		
Individual	$2,000	$2,000
Individual plus 1	$4,000	$4,000
Individual plus 2 or more	$6,000	$6,000
LIFETIME MAXIMUM BENEFIT		
	Unlimited except where otherwise indicated.	
REFERRAL REQUIREMENT		
	None	None
NETWORK / HOW TO SEARCH FOR A PROVIDER		
Customer Service:	877-889-2478	
Network:	PPO Blue Card National Network	
Locate a Provider:	www.cfablue.com	
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months	Covered 100%; deductible waived*	Covered 100%; deductible waived
24 months-13 years	Covered 100%; deductible waived*	Covered 100%; deductible waived
14-17 years	Covered 100%; deductible waived*	Covered 100%; deductible waived
7 exams in first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 18.		
Adult Physical Examination	Covered 100%; deductible waived*	Covered 100%; deductible waived
1 exam per Calendar Year for members age 18 and older		
Routine GYN Visits	Covered 100%; deductible waived*	Covered 100%; deductible waived
Mammograms	Covered 100%; deductible waived*	Covered 100%; deductible waived
Cancer Screening (Pap Test and Prostate)	Covered 100%; deductible waived*	Covered 100%; deductible waived
Colorectal Cancer Screening For all members age 50 and over	Covered under Routine Adult Exams	Covered 100%; deductible waived
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	20%; after deductible	40%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	20%; after deductible	40%; after deductible
Advance Imaging (MRA/MRS, MRI, PET, & CAT scans)	20%; after deductible *(pre-authorization required)*	40%; after deductible *(pre-authorization required)*

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X-ray	20%; after deductible	40%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Lab Tests	20%; after deductible	40%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Allergy Testing	20%; after deductible	40%; after deductible
Allergy Shots	20%; after deductible	40%; after deductible
Outpatient Physical, Speech and Occupational Therapy *(Limited to 60 visits per calendar year - combined with Chiropractic)*	20%; after deductible	40%; after deductible
Outpatient Chiropractic *(Limited to 60 visits per Calendar Year - combined with Speech, PT and OT)*	20%; after deductible	40%; after deductible
Telemedicine - MDLIVE	20% of $38.00 *(Copay $7.60 per session)*	
EMERGENCY CARE AND URGENT CARE		
Physician's Office	20%; after deductible	40%; after deductible
Urgent Care Center	20%; after deductible	40%; after deductible
Non-Urgent Use of Urgent Care Provider	50%; after deductible	50%; after deductible
Hospital Emergency Room *(True Emergency only)*	20%; after deductible	20%; after deductible
Non-Emergency Care in an Emergency Room	50%; after deductible	50%; after deductible
Ambulance *(if medically necessary)*	20%; after deductible	20%; after deductible
HOSPITALIZATION		
Inpatient Facility Services	20%; after deductible *(pre-certification required)*	40%; after deductible *(pre-certification required)*
Outpatient Facility Services	20%; after deductible *(pre-certification required)*	40%; after deductible *(pre-certification required)*
Outpatient Surgery	20%; after deductible	40%; after deductible
MATERNITY		
Prenatal and Postnatal Office Visits	Covered 100%; deductible waived*	Covered 100%; deductible waived
Delivery and Facility Services - ***Pre-certification required for inpatient***	20%; after deductible *(pre-certification required)*	40%; after deductible *(pre-certification required)*
Nursery Care of Newborn	Covered 100%; deductible waived* *(pre-certification required if not discharged with mother)*	Covered 100%; deductible waived *(pre-certification required if not discharged with mother)*
	Please refer to plan documents for detailed coverage	
OTHER SERVICES		
Home Health Care	20%; after deductible *(pre-certification required)*	40%; after deductible *(pre-certification required)*
Limited to 60 days per Calendar Year		
Hospice	20%; after deductible *(pre-certification required)*	40%; after deductible *(pre-certification required)*
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		

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Skilled Nursing Facility - *(Limited to 60 visits per calendar year)*	20%; after deductible *(pre-certification required)*	40%; after deductible *(pre-certification required)*
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Bariatric Surgery - *(Limited to one surgery per lifetime)*	20%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Facility Services	20%; after deductible *(pre-certification required)*	40%; after deductible *(pre-certification required)*
Inpatient Physician Services	20%; after deductible *(pre-certification required)*	40%; after deductible *(pre-certification required)*
Outpatient Facility Services	20%; after deductible	40%; after deductible
Outpatient Physician Services	20%; after deductible	40%; after deductible
Office Visits	20%; after deductible	40%; after deductible
MISCELLANEOUS		
Durable Medical Equipment	20%; after deductible (*Pre-certification required for purchase or rental in excess of $1,500)*	40%; after deductible *(Pre-certification required for purchase or rental in excess of $1,500)*
Audiometric Exam and Hearing Aids	20%; after deductible	40%; after deductible
Aids For covered dependent children under age 19; subject to $1,400 non-disposable hearing aid maximum for each hearing impaired ear in any 36 months period.		
VISION		
Routine Exam (Optometrist or Ophthalmologist) *(limited to 1 exam/benefit period)*	Covered 100%; deductible waived*	Covered 100%; deductible waived
PHARMACY (True Rx) ***^ Medical and Pharmacy have separate Out of Pocket Maximums and do not cross apply***		
Retail *(Up to 30-90 day supply)*		
Generic	20%	40% of submitted cost after the applicable preferred copay
Formulary Brand-name	20%	
Non-Formulary Brand-name	40%	
Specialty	20%; $100 copay max	
Mail Order *(Up to 90 day supply)*	20% copay for generic drugs, 20% copay for formulary brand-name drugs, and 40% copay for non-formulary brand-name drugs up to a 31-90 day supply.	Not Applicable