CareFirst POS Summary—Active & Non-Medicare Retiree

Georgetown University

Effective January 1, 2025

Services	In-Network[1]	Out-of-Network[2]
ANNUAL DEDUCTIBLE (Calendar year)		
Individual	$250	$1,000
Individual & Child(ren)	$500	$2,000[3]
Individual & Adult	$500	$2,000[3]
Family	$500	$2,000[3]
ANNUAL COINSURANCE		
Individual	$2,000 (combined In- and Out-of-Network)	$5,000 (combined In- and Out-of-Network)
Individual & Child(ren)	$4,000[3] (combined In- and Out-of-Network)	$10,000[3] (combined In- and Out-of Network)
Individual & Adult	$4,000[3] (combined In- and Out-of-Network)	$10,000[3] (combined In- and Out-of- Network)
Family	$4,000[3] (combined In- and Out-of-Network)	$10,000[3] (combined In- and Out-of- Network)
ANNUAL OUT-OF-POCKET LIMIT[4] (INCLUDES DEDUCTIBLE, COINSURANCE, MEDICAL & RX COPAYMENTS)		
Individual	$6,000 (combined In- and Out-of-Network)	
Individual & Child(ren)	$12,000[3] (combined In- and Out-of-Network)	
Individual & Adult	$12,000[3] (combined In- and Out-of-Network)	
Family	$12,000[3] (combined In- and Out-of-Network)	
LIFETIME MAXIMUM		
Lifetime Maximum	None	
PREVENTIVE/WELL CARE (ROUTINE)		
Well Baby/Child Visits (0 through 17 years)	No Charge	100% of Allowed Benefit, no deductible
Immunizations for children as recommended by the Centers for Disease Control, U. S. Task Force of Preventive Care, and American Academy of Pediatrics	No Charge	100% of Allowed Benefit, no deductible
Annual Adult Physical Examination (age 18+) One per benefit period and Immunizations	No Charge	Not Covered
Routine GYN Services (including pap)	No Charge	100% of Allowed Benefit, no deductible
Screening Mammography	No Charge	100% of Allowed Benefit, no deductible
Cancer Screenings (Colonoscopy, Prostate and Colorectal)	No Charge	100% of Allowed Benefit, no deductible
INPATIENT HOSPITAL/FACILITY SERVICES (PREAUTHORIZATION REQUIRED)		
Room & Board (includes maternity and nursery charges) and Ancillary Services	90% of Allowed Benefit, after deductible	70% of Allowed Benefit, after deductible
Organ Transplants (Preauthorization Required) Covered as stated in the Evidence of Coverage	90% of Allowed Benefit, after deductible	70% of Allowed Benefit, after deductible
Skilled Nursing Facility (Preauthorization Required)	90% of Allowed Benefit, after deductible	70% of Allowed Benefit, after deductible
Hospice Care Inpatient or Home Hospice (Preauthorization Required) Includes Bereavement and Family Counseling, Respite Care (certain day limits apply)	90% of Allowed Benefit, after deductible	70% of Allowed Benefit, after deductible
INPATIENT PROFESSIONAL/PRACTITIONER SERVICES		
Physician Surgical Services	90% of Allowed Benefit, after deductible	70% of Allowed Benefit, after deductible
Anesthesia	90% of Allowed Benefit, after deductible	70% of Allowed Benefit, after deductible
Consultations & Physician Visits	90% of Allowed Benefit, after deductible	70% of Allowed Benefit, after deductible
Radiation Therapy, Chemotherapy and Renal Dialysis	90% of Allowed Benefit, after deductible	70% of Allowed Benefit, after deductible

Services	In-Network[1]	Out-of-Network[2]
OUTPATIENT HOSPITAL/FACILITY SERVICES		
Emergency Care Services: Emergency Room Facility Services (Inside and Outside the service area)	90% of Allowed Benefit, after deductible	Paid same as In-Network
Emergency Care Services: Emergency Room Physician Services (Inside and Outside the service area)	90% of Allowed Benefit, after deductible	Paid same as In-Network
Cardiac Rehabilitation (Outpatient Freestanding Clinic or Outpatient Hospital only) 90 days per benefit period	$40 copay Specialist per visit applies to Facility	70% of Allowed Benefit, after deductible
Home Health Care	90% of Allowed Benefit, after deductible	70% of Allowed Benefit, after deductible (90 visits per benefit period)
Outpatient Physical Therapy, Speech Therapy and Occupational Therapy (30 visits per condition per benefit period)	$40 copay Specialist per visit applies to Facility	70% of Allowed Benefit, after deductible
Minor/All Surgery (includes hospital based and freestanding surgical centers)	90% of Allowed Benefit, after deductible	70% of Allowed Benefit, after deductible
Preadmission Testing	90% of Allowed Benefit, after deductible	70% of Allowed Benefit, after deductible
Laboratory Tests, X-rays & Diagnostic Services[5]	$40 copay	70% of Allowed Benefit, after deductible
Advanced Imaging (MRIs, CT and PET scans)	$50 copay	70% of Allowed Benefit, after deductible
Diagnostic Mammogram	$40 copay	70% of Allowed Benefit, after deductible
OUTPATIENT/OFFICE PROFESSIONAL SERVICES		
Physician Office Visit—Primary Care Provider	$25 copay per visit	70% of Allowed Benefit, after deductible
Physician Office Visit—Specialist	$40 copay per visit	70% of Allowed Benefit, after deductible
Urgent Care Centers	$40 copay per visit	100% of Allowed Benefit after $40 copay
Minor/All Surgery	$25 copay PCP/$40 copay Specialist per visit	70% of Allowed Benefit, after deductible
Anesthesia	100% of Allowed Benefit	70% of Allowed Benefit, after deductible
Allergy testing	$25 copay PCP/$40 copay Specialist per visit	70% of Allowed Benefit, after deductible
Allergy injections and serum	$25 copay PCP/$40 copay Specialist per visit	70% of Allowed Benefit, after deductible
Laboratory Tests, X-rays & Diagnostic Services[5]	Office or Freestanding facility: $25 copay PCP/$40 copay Specialist per visit	70% of Allowed Benefit, after deductible
Advanced Imaging (MRIs, CT and PET Scans)	Office or Freestanding facility: $50 copay	70% of Allowed Benefit, after deductible
Outpatient Chiropractic (limited to 20 visits per benefit period)	$40 copay Specialist per visit	70% of Allowed Benefit, after deductible
Physical Therapy, Speech Therapy and Occupational Therapy (30 visits per condition per benefit period)	$40 copay Specialist per visit	70% of Allowed Benefit, after deductible
Hearing Aids (covered for dependent children up to age 26) One hearing aid for each hearing impaired ear once every 36 months	100% of Allowed Benefit	Not Covered
Acupuncture (limited to 20 visits per benefit period)	$40 copay Specialist per visit	70% of Allowed Benefit, after deductible
Artificial and Intrauterine Insemination (limited to 6 attempts per live birth)[6]	$40 copay Specialist per visit	Not Covered
In Vitro Fertilization[6]	Not Covered	Not Covered
Emergency Services Office— Evaluation/examination not rendered in a hospital emergency room/department	$25 copay PCP/$40 copay Specialist per visit	100% of Allowed Benefit after $25 copay PCP/$40 copay Specialist per visit
Ambulance (if medically necessary)	$50 copay	Paid same as In-Network
MATERNITY		
Pre and Postnatal Office Visits[7]	$25 PCP/$40 Specialist per visit	70% of Allowed Benefit, after deductible

Services	In-Network[1]	Out-of-Network[2]
BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER (PREAUTHORIZATION REQUIRED FOR INPATIENT ADMISSIONS)		
Inpatient Facility Services	90% of Allowed Benefit, after deductible	70% of Allowed Benefit, after deductible
Inpatient Physician Services	90% of Allowed Benefit, after deductible	70% of Allowed Benefit, after deductible
Outpatient Facility Services	90% of Allowed Benefit, after deductible	70% of Allowed Benefit, after deductible
Outpatient Physician Services	$25 copay applies to PCP or Specialist per visit	70% of Allowed Benefit, after deductible
Office Visits	$25 copay applies to PCP or Specialist per visit	70% of Allowed Benefit, after deductible
Partial Hospitalization Facility Services & Physician Services	90% of Allowed Benefit, after deductible	70% of Allowed Benefit, after deductible
Medication Management Visit	$25 copay applies to PCP or Specialist per visit	70% of Allowed Benefit, after deductible
Halfway House	90% of Allowed Benefit, after deductible	70% of Allowed Benefit, after deductible
MISCELLANEOUS		
Durable Medical Equipment & Medical Supplies	90% of Allowed Benefit, after deductible	70% of Allowed Benefit, after deductible
Diabetes Equipment	100% of Allowed Benefit, no deductible	70% of Allowed Benefit, after deductible
Diabetes Supplies	Covered under Prescription Drug Card	Covered under Prescription Drug Card
Routine Vision Exam (limited to 1 visit/ benefit period) Benefits are not included for eye refractions	$10 copay per visit at participating vision providers	Up to $33 allowance toward exam
Eyeglasses and Contact Lenses	Discounts from Participating Davis Vision centers	Discounts from Participating Davis Vision centers

This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

[1] 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 Blue Choice Allowed Benefit is generally the contracted rate 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 BlueCross and BlueShield Plan, however, in certain circumstances, an allowance may be established by law.

[2] 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 the 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 rate or fee schedule that are established by CareFirst BlueChoice, or the local BlueCross and BlueShield Plan, however, in certain circumstances, an allowance may be established by law. When services are rendered by non-participating or non-preferred providers, the member may be responsible for charges in excess of the Allowed Benefit. The difference between the Allowed Benefit and the charge for which the member is responsible will not contribute to the Out-of-Pocket Limit.

[3] For purposes of determining the deductible amounts for those with coverage other than Individual, when one family member meets the individual deductible, they can start receiving benefits as indicated. For purposes of determining the out-of-pocket maximums for those with coverage other than Individual, when one family member meets the individual out-of-pocket amount, their services will be covered at 100% up to the Allowed Benefit. One family member cannot contribute more than the individual deductible amount or individual out-of-pocket amount.

[4] Out-of-Network coinsurance amounts are based on a percentage of the Out-of-Network Allowed Benefit. When Out-of-Network services are rendered by a non-participating provider, the member is responsible for 100% of the charge. The difference between the Allowed Benefit and the charge does not contribute to the Out-of-Pocket limit.

[5] Members must use a LabCorp facility for any laboratory services in order to obtain coverage in-network when in the Maryland, Washington, D.C. and Northern Virginia service area. Services performed at a facility in Maryland, D.C., or Northern Virginia that is not part of the LabCorp network will be considered out-of-network. Any lab work performed in an outpatient hospital setting requires prior authorization.

[6] 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 as covered under the terms of the members contract. Preauthorization required.

[7] In-network preventive prenatal and postnatal office visits will be covered to the same extent as other In-network preventive office visits.

The deductible and out-of-pocket amounts are calculated based on the Allowed Benefit for Covered Services.

CareFirst BlueChoice

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