

BlueChoice HMO HSA/HRA \$1,500

Summary of Benefits

Services	In-Network You Pay
ANNUAL DEDUCTIBLE (BENEFIT PERIOD)¹	
Individual	\$1,500
Family	\$3,000
ANNUAL OUT-OF-POCKET MAXIMUM (BENEFIT PERIOD)²	
Individual	\$4,000
Family	\$8,000
LIFETIME MAXIMUM BENEFIT	
Lifetime Maximum	None
PREVENTIVE SERVICES	
Well-Child Care (including exams & immunizations)	No charge*
Adult Physical Examination	No charge*
Routine GYN Visits	No charge*
Breast Cancer Screening	No charge*
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge*
OFFICE VISITS, LABS AND TESTING	
Facility fee for services rendered in a hospital setting ³	Deductible, then \$50 per visit
Office Visits for Illness ³	Deductible, then \$20 PCP/\$30 Specialist per visit
Diagnostic Services/Lab Tests (LabCorp only) ³	Deductible, then \$30 per visit
X-ray (Freestanding Facility only)	Deductible, then \$30 per visit
Allergy Testing & Shots ³	Deductible, then \$30 per visit
Outpatient Physical, Speech and Occupational Therapy ³ (limited to 30 visits/illness or injury/benefit period)	Deductible, then \$30 per visit
Outpatient Chiropractic ³ (limited to 20 visits/condition/benefit period)	Deductible, then \$30 per visit
EMERGENCY CARE AND URGENT CARE	
Urgent Care Center	Deductible, then \$30 per visit
Hospital Emergency Room	Deductible, then \$100 per visit (waived if admitted)
Emergency Room—Professional Services	No charge* after deductible
Ambulance (if medically necessary)	No charge* after deductible
HOSPITALIZATION	
Outpatient Facility Non-Surgery (Hospital Facility) ³	Deductible, then \$50 per visit
Outpatient Facility Surgery (Freestanding Facility)	Deductible, then \$100 per visit
Outpatient Facility Surgery (Hospital Facility)	Deductible, then \$200 per visit
Outpatient Physician Services	Deductible, then \$30 per visit
Inpatient Facility Services	Deductible, then \$250 per admission
Inpatient Physician Services	Deductible, then \$20 PCP/\$30 Specialist per visit
HOSPITAL ALTERNATIVES	
Home Health Care	No charge* after deductible
Hospice	No charge* after deductible
Skilled Nursing Facility (limited to 100 days/benefit period)	Deductible, then \$30 per admission

Note: Plan has an integrated medical and prescription drug deductible.

Services	In-Network You Pay
MATERNITY	
Prenatal and Postnatal Office Visits ³	No charge*
Delivery and Facility Services	Deductible, then \$250 per admission
Nursery Care of Newborn	No charge* after deductible
Artificial Insemination ^{3,4} (limited to 6 attempts/live birth)	Deductible, then \$30 per visit
In Vitro Fertilization Procedures ⁴	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE	
Inpatient Facility Services	Deductible, then \$250 per admission
Inpatient Physician Services	Deductible, then \$20 PCP/\$30 Specialist per visit
Outpatient Facility Services	Deductible, then \$30 per visit
Outpatient Physician Services	Deductible, then \$30 per visit
Office Visits ³	Deductible, then \$20 per visit
Partial Hospitalization Facility Services	Deductible, then \$30 per visit
Partial Hospitalization Physician Services	Deductible, then \$30 per visit
Medication Management ³	Deductible, then \$20 per visit
MISCELLANEOUS	
Durable Medical Equipment	Deductible, then 25% of Allowed Benefit
Acupuncture ³	Deductible, then \$30 per visit
Hearing Aids (limited to minor children and limited to one hearing aid per hearing-impaired ear every 36 months)	No charge* after deductible
PRESCRIPTION DRUGS	
Preferred Preventive Drugs	No charge*
Generic Drugs	34-day supply-Deductible, then \$10; 90-day supply-Deductible, then \$20
Preferred Brand Name Drugs	34-day supply-Deductible, then \$45; 90-day supply-Deductible, then \$90
Non-Preferred Brand Name Drugs	34-day supply-Deductible, then \$65; 90-day supply-Deductible, then \$130
Specialty Drugs	Deductible, then 50% coinsurance
PEDIATRIC VISION (UNDER 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 (UNDER 19)	
Dental Deductible	In-Network-\$25; Out-of-Network-\$50
Class I Preventive & Diagnostic Services	In-Network-No charge*; Out-of-Network-20% of Allowed Benefit
Class II Basic Services	In-Network-Deductible, then 20% of Allowed Benefit; Out-of-Network-Deductible, then 40% of Allowed Benefit
Class III Major Services–Surgical	In-Network-Deductible, then 20% of Allowed Benefit; Out-of-Network-Deductible, then 40% of Allowed Benefit
Class IV Major Services–Restorative	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

* No copayments or coinsurance.

¹ The deductible can be met entirely by one Member or by combining eligible expenses of two or more members. There is no Individual Deductible with Family Coverage. The Family Deductible must be reached before CareFirst BlueChoice pays benefits for any Member who has other than Individual Coverage. Please refer to your Evidence of Coverage to determine your coverage level.

² The Out-of-Pocket Maximum can be met entirely by one Member or by combining eligible expenses of two or more members. There is no Individual Out-of-Pocket Maximum with Family Coverage. The Family Out-of-Pocket Maximum must be reached before CareFirst BlueChoice pays benefits for any Member who has other than Individual Coverage. Please refer to your Evidence of Coverage to determine your coverage level.

³ An additional facility copay and/or coinsurance may apply to services rendered in a hospital setting.

⁴ 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. However, assisted reproduction (AI & IUI) services performed as treatment options for infertility are only available under the terms of the members contract.

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

The benefits described are issued under the following form numbers: MD/CFBC/GC (1/14) • MD/CFBC/HMO/EOC (1/14) • MD/CFBC/DOL APPEAL (R. 9/11) • MD/CFBC/SHOP/BCOA/DOCS (1/14) • MD/CFBC/BCOA CDH/1500 SOB (1/14) • MD/CFBC/ELIG (1/14) and any amendments.



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