

HealthyBlue Plus \$1,500

Summary of Benefits

Services	In-Network	Out-of-Network
HEALTHY REWARD		
Visit www.carefirst.com/healthyblue for more information.	Earn \$300 per adult and up to \$700 per family toward reducing your deductible for completing 3 simple steps.	
ANNUAL DEDUCTIBLE (BENEFIT PERIOD)¹		
Individual	\$1,500	\$3,000
Family	\$3,000	\$6,000
ANNUAL OUT-OF-POCKET MAXIMUM (BENEFIT PERIOD)²		
Individual	\$5,500	\$7,500
Family	\$11,000	\$15,000
LIFETIME MAXIMUM		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	No charge*
Adult Physical Examination	No charge*	No charge* after deductible
Routine GYN Visits	No charge*	No charge* after deductible
Mammograms	No charge*	No charge*
Pap Test	No charge*	No charge* after deductible
Cancer Screening (Prostate and Colorectal)	No charge*	No charge* after deductible
OFFICE VISITS, LABS & TESTING		
Facility fee for services rendered in a hospital setting ³	\$50 per visit	Deductible, then \$100 per visit
Office Visits for Illness ³	No charge* PCP/\$30 Specialist per visit	Deductible, then \$50 per visit
Diagnostic Services/Lab Tests (LabCorp only) ³	No charge*	Deductible, then \$50 per visit
X-ray (Freestanding Facility only)	No charge*	Deductible, then \$50 per visit
Allergy Testing & Shots ³	\$30 per visit	Deductible, then \$50 per visit
Outpatient Physical, Speech and Occupational Therapy ³	\$30 per visit	Deductible, then \$50 per visit
Outpatient Spinal Manipulation ³ (limited to 20 visits/condition/benefit period)	\$30 per visit	Deductible, then \$50 per visit
EMERGENCY CARE AND URGENT CARE		
Urgent Care Center	\$50 per visit	Paid as in-network
Hospital Emergency Room (waived if admitted)	\$200 per visit	Paid as in-network
Emergency Room—Professional Services	No charge*	Paid as in-network
Ambulance (if medically necessary)	\$50 per visit	Paid as in-network
HOSPITALIZATION		
Outpatient Facility Non-Surgery (Hospital Facility) ³	\$50 per visit	Deductible, then \$100 per visit
Outpatient Facility Surgery (Freestanding Facility)	\$100 per visit	Deductible, then \$500 per visit
Outpatient Facility Surgery (Hospital Facility)	Deductible, then \$500 per visit	Deductible, then \$750 per visit
Outpatient Physician Services	No charge* after deductible	Deductible, then \$50 per visit
Inpatient Facility Services	Deductible, then \$500 per admission	Deductible, then \$750 per admission
Inpatient Physician Services	No charge* after deductible	Deductible, then \$50 per visit
HOSPITAL ALTERNATIVES		
Home Health Care	Deductible, then \$30 per visit	Deductible, then \$50 per visit
Hospice	Deductible, then \$30 per visit	Deductible, then \$50 per visit
Skilled Nursing Facility (limited to 100 days/benefit period)	Deductible, then \$30 per admission	Deductible, then \$50 per admission

Services	In-Network You Pay	Out-of-Network You Pay
MATERNITY		
Prenatal and Postnatal Office Visits	No charge*	Deductible, then \$50 per visit
Delivery and Facility Services	Deductible, then \$500 per admission	Deductible, then \$750 per admission
Nursery Care of Newborn	No charge* after deductible	Deductible, then \$50 per visit
Artificial Insemination ^{3,4}	Deductible, then \$30 per visit	Deductible, then \$50 per visit
In Vitro Fertilization Procedures	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Facility Services	Deductible, then \$500 per admission	Deductible, then \$750 per admission
Inpatient Physician Services	No charge* after deductible	Deductible, then \$50 per visit
Outpatient Facility Services	No charge*	Deductible, then \$50 per visit
Outpatient Physician Services	No charge*	Deductible, then \$50 per visit
Office Visits ³	No charge*	Deductible, then \$50 per visit
Partial Hospitalization Facility Services	No charge*	Deductible, then \$50 per visit
Partial Hospitalization Physician Services	No charge*	Deductible, then \$50 per visit
Medication Management ³	No charge*	Deductible, then \$50 per visit
MISCELLANEOUS		
Durable Medical Equipment	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Acupuncture ³	\$30 per visit	Deductible, then \$50 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	Deductible, then 20% of Allowed Benefit
PRESCRIPTION DRUGS		
Preferred Preventive Drugs	No charge*	
Generic Drugs	No charge*	
Preferred Brand Name Drugs	34-day supply-\$45; 90-day supply-\$90	
Non-Preferred Brand Name Drugs	34-day supply-\$65; 90-day supply-\$130	
Specialty Drugs	50% coinsurance	
PEDIATRIC VISION (UNDER 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 (UNDER 19)		
Dental Deductible	\$25	\$50
Class I Preventive & Diagnostic Services	No charge*	20% of Allowed Benefit
Class II Basic Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Class III Major Services—Surgical	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Class IV Major Services—Restorative	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

* No copayment 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 member contract.

- Notes: ■ Upon enrollment you must select a Primary Care Provider (PCP). For the most current listing, go to www.carefirst.com or call the Member Services number on your ID card for assistance, or to request a printed 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.
 - When the Allowed Benefit is less than the copay listed, the member payment will be the Allowed Benefit.

Policy Form Numbers: MD/CFBC/GC (1/14) • MD/CFBC/ADV IN/EOC (1/14) • MD/CFBC/DOL APPEAL (R. 9/11) • MD/CFBC/IN/DOCS (1/14) • MD/CFBC/HB+-ADV IN/1500 SOB (1/14) • MD/CFBC/HB/WELLNESS (R. 7/13) • MD/CFBC/ELIG (1/14) • MD/CF/GC (1/14) • MD/CF/ADV OON/EOC (1/14) • MD/GHMSI/DOL APPEAL (R. 9/11) • MD/CF/OON/DOCS (1/14) • MD/CF/HB+-ADV OON/1500 SOB (1/14) • MD/CF/ELIG (1/14) • CFMI/GC (1/14) • CFMI/ADV OON/EOC (1/14) • CFMI/DOL APPEAL (R. 9/11) • CFMI/OON/DOCS (1/14) • CFMI/HB+-ADV OON/1500 SOB (1/14) • CFMI/ELIG (1/14) and any amendments.

HealthyBlue



www.carefirst.com

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are independent licensees of the BlueCross and BlueShield Association. ®Registered trademark of the Blue Cross and Blue Shield Association. ®Registered trademark of CareFirst of Maryland, Inc.