

# BlueChoice HMO

## Open Access HSA

### Summary of Benefits

| Services   | In-Network You Pay                                      |
|--|---|
| <b>ANNUAL DEDUCTIBLE<sup>1</sup></b>   |   |
| Individual   | \$1,500   |
| Individual & Child(ren)  | \$3,000   |
| Individual & Adult   | \$3,000   |
| Family   | \$3,000   |
| <b>ANNUAL OUT-OF-POCKET LIMIT<sup>1</sup></b>  |   |
| Individual   | \$3,000   |
| Individual & Child(ren)  | \$6,000   |
| Individual & Adult   | \$6,000   |
| Family   | \$6,000   |
| <b>LIFETIME MAXIMUM BENEFIT</b>  | None  |
| <b>PREVENTIVE SERVICES</b>   |   |
| Well-Child Care  |   |
| 0-24 months  | No charge*  |
| 24 months-13 years (immunization visit)  | No charge*  |
| 24 months-13 years (non-immunization visit)  | No charge*  |
| 14-17 years  | No charge*  |
| Adult Physical Examination   | No charge*  |
| Routine GYN Visits   | No charge*  |
| Mammograms   | No charge*  |
| Cancer Screening<br>(Pap Test, Prostate and Colorectal)  | No charge*  |
| <b>OFFICE VISITS, LABS AND TESTING</b>   |   |
| Office Visits for Illness  | Deductible, then \$25 PCP/\$40 Specialist per visit     |
| Diagnostic Services  | Deductible, then \$40 or 50% of cost, whichever is less |
| X-ray and Lab Tests  | Deductible, then \$40 or 50% of cost, whichever is less |
| Allergy Testing <sup>3</sup>   | Deductible, then \$25 PCP/\$40 Specialist per visit     |
| Allergy Shots <sup>3</sup>   | Deductible, then \$25 PCP/\$40 Specialist per visit     |
| Outpatient Physical, Speech and Occupational Therapy <sup>4</sup><br>(limited to 30 visits/condition/benefit period) | Deductible, then \$40 per visit                         |
| Outpatient Chiropractic <sup>4,5</sup><br>(limited to 20 visits/condition/benefit period)                            | Deductible, then \$40 per visit                         |
| <b>EMERGENCY CARE AND URGENT CARE</b>  |   |
| Physician's Office   | Deductible, then \$25 PCP/\$40 Specialist per visit     |
| Urgent Care Center   | Deductible, then \$40 per visit                         |
| Hospital Emergency Room  | Deductible, then \$100 per visit (waived if admitted)   |
| Ambulance (if medically necessary)   | No charge after deductible*                             |
| <b>HOSPITALIZATION<sup>6</sup></b>   |   |
| Inpatient Facility Services  | Deductible, then \$500 per admission                    |
| Outpatient Facility Services   | Deductible, then \$40 per visit                         |
| Inpatient Physician Visits   | Deductible, then \$30 per visit                         |
| Outpatient Physician Services  | Deductible, then \$25 PCP/ \$40 Specialist per visit    |

| Services   | In-Network You Pay   |
|--|--|
| <b>HOSPITAL ALTERNATIVES<sup>6</sup></b>   |  |
| Home Health Care   | No charge after deductible*  |
| Hospice  | No charge after deductible*  |
| Skilled Nursing Facility<br>(limited to 100 days/benefit period) <sup>4</sup>                | Deductible, then \$40 per day  |
| <b>MATERNITY</b>   |  |
| Prenatal and Postnatal Office Visits   | Deductible, then \$30 per visit  |
| Delivery and Facility Services <sup>6</sup>  | Deductible, then \$500 per admission   |
| Nursery Care of Newborn <sup>2</sup>   | No charge after deductible*  |
| Initial Office Consultation(s) for Infertility<br>Services/Procedures                        | Deductible, then \$40 Specialist per visit   |
| Artificial Insemination <sup>7</sup>   | Deductible, then 50% of the allowed benefit (after diagnosis is confirmed)   |
| In Vitro Fertilization Procedures <sup>7</sup>   | Not covered  |
| <b>MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)<sup>6</sup></b>                               |  |
| Inpatient Facility Services  | Deductible, then \$500 per admission   |
| Inpatient Physician Services   | Deductible, then \$30 per visit  |
| Outpatient Services (MH & SA)  | Deductible, then \$40 per visit  |
| Partial Hospitalization <sup>4</sup><br>(each day counts as 1/2 day towards inpatient limit) | Deductible, then \$40 per visit  |
| Medication Management Visit  | Deductible, then \$25 PCP/\$40 Specialist per visit  |
| <b>MISCELLANEOUS</b>   |  |
| Durable Medical Equipment <sup>6</sup>   | No charge after deductible*  |
| Acupuncture  | Deductible, then \$25 PCP/ \$40 Specialist per visit   |
| Transplants <sup>6,8</sup>   | Deductible, then covered as stated in Evidence of Coverage   |
| Hearing Aids for ages 0-18<br>(limited to one hearing aid every 3 years) <sup>4</sup>        | Deductible, then \$40  |
| <b>VISION</b>  |  |
| Routine Exam (Optometrist or Ophthalmologist)<br>(limited to 1 visit/benefit period)         | \$10 per visit at a participating provider   |
| Eyeglasses and Contact Lenses  | Discounts at a participating Vision provider   |
| <b>PRESCRIPTION DRUGS</b>  | You pay 100% of the discounted cost of your prescription drugs up to your annual deductible; then you pay the regular prescription drug copays until you meet your annual out of pocket maximum. Refer to your prescription summary for copay amounts. |

<sup>1</sup> The deductible can be met entirely by one Member or by combining eligible expenses of two or more members. The out-of-pocket can be met in the same way.

<sup>2</sup> Newborns must be enrolled within 31 days of birth.

<sup>3</sup> If office copayment has been paid additional office copayment not required for this service.

<sup>4</sup> CareFirst BlueChoice may be providing your BlueChoice benefits on either a contract or calendar year basis. Please refer to your benefits contract to determine which method applies to your group benefit plan.

<sup>5</sup> Consultation for chiropractic services is the same as office visit for illness.

<sup>6</sup> Preauthorization required.

<sup>7</sup> Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment option for infertility. However, assisted reproduction (AI) services performed as treatment option for infertility are only available under the terms of the members contract. Preauthorization required.

<sup>8</sup> Please refer to your Evidence of Coverage to determine your coverage level.

\* No copayments or coinsurance.

HSA plans must be sold with an integrated Rx benefit.

All copayments apply towards the deductible and out-of-pocket limit.

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](http://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.

Policy Form Numbers: MD/CFBC/MSGR/GRP APP (R. 9/09); MD/CFBC/MSGR/EOC (R. 7/08); MD/CFBC/MSGR/GC (R. 9/09); MD/BC/AMEND DOCS OPEN ACCESS MSGR (R. 6/09); MD/CFBC/MSGR/GS (9/09); MD/CFBC/MSGR/DOCS (7/07); MD/CFBC/MSGR/HSA/SOB/CORE (R. 1/09); MD/CFBC/DOL APPEAL (R. 6/06); MD/CFBC/MSGR/BLUECARD (7/07) and any amendments.

