

BlueChoice HMO • Open Access High Deductible Health Plan

Summary of Benefits

Services	In-Network You Pay
ANNUAL DEDUCTIBLE¹	
Individual	\$1,200
Individual & Child(ren)	\$2,400
Individual & Adult	\$2,400
Family	\$2,400
ANNUAL OUT-OF-POCKET MAXIMUM¹	
Individual	\$2,400
Individual & Child(ren)	\$4,800
Individual & Adult	\$4,800
Family	\$4,800
LIFETIME MAXIMUM BENEFIT	None
PREVENTIVE SERVICES	
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*
Breast Cancer Screening/Mammograms	No charge*
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge*
OFFICE VISITS, LABS AND TESTING	
Office Visits for Illness	Deductible, then \$20 PCP/ \$30 Specialist per visit
Diagnostic Services	Deductible, then \$30 or 50% of cost; whichever is less
X-ray and Lab Tests	Deductible, then \$30 or 50% of cost; whichever is less
Allergy Testing ²	Deductible, then \$20 PCP/ \$30 Specialist per visit
Allergy Shots ²	Deductible, then \$20 PCP/ \$30 Specialist per visit
Outpatient Physical, Speech and Occupational Therapy ³ (limited to 30 visits/benefit period)	Deductible, then \$30 per visit
Outpatient Spinal Manipulation ^{3,4} (limited to 20 visits/benefit period)	Deductible, then \$30 per visit
EMERGENCY CARE AND URGENT CARE	
Physician's Office	Deductible, then \$20 PCP/ \$30 Specialist per visit
Urgent Care Center	Deductible, then \$30 per visit
Hospital Emergency Room	Deductible, then \$100 per visit (waived if admitted)
Ambulance (if medically necessary)	No charge* after deductible is met
HOSPITALIZATION⁵	
Inpatient Facility Services	Deductible, then \$250 per admission
Outpatient Facility Services	Deductible, then \$30 per visit
Inpatient Physician Services	Deductible, then \$20 PCP/ \$30 Specialist per visit
Outpatient Physician Services	Deductible, then \$30 per visit

Services	In-Network You Pay
HOSPITAL ALTERNATIVES⁵	
Home Health Care	No charge* after deductible is met
Hospice	No charge* after deductible is met
Skilled Nursing Facility (limited to 100 days/benefit period) ³	Deductible, then \$30 per day
MATERNITY	
Prenatal and Postnatal Office Visits	Deductible, then \$20 per visit
Delivery and Facility Services ⁵	Deductible, then \$250 per admission
Nursery Care of Newborn ⁶	No charge* after deductible is met
Initial Office Consultation(s) for Infertility Services/Procedures	Deductible, then \$30 Specialist per visit
Artificial Insemination ⁷	Deductible, then 50% of Allowed Benefit (after diagnosis is confirmed)
In Vitro Fertilization Procedures ⁷	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE⁵	
Inpatient Facility Services (limited to 60 days/benefit period)	Deductible, then \$250 per admission
Inpatient Physician Services	Deductible, then \$20 PCP/\$30 Specialist per visit
Outpatient Services (MH & SA)	Deductible, then 30% of Allowed Benefit
Partial Hospitalization ³ (each day counts as 1/2 day toward inpatient limit)	Deductible, then \$250 per admission
Medication Management Visit	Deductible, then \$20 PCP/\$30 Specialist per visit
MISCELLANEOUS	
Durable Medical Equipment ⁵	No charge* after deductible is met
Acupuncture	Deductible, then \$30 Specialist per visit
Transplants ^{5,8}	Covered as stated in the Evidence of Coverage
Hearing Aids for ages 0-18 (limited to 1 hearing aid per hearing impaired ear every 3 years) ³	No charge* after deductible is met
VISION	
Routine Exam (limited to 1 visit/benefit period)	Not covered
Eyeglasses and Contact Lenses	Not covered
PRESCRIPTION DRUGS	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 drug benefit summary for copay amounts.)

¹ 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.

² If office copayment has been paid additional office copayment not required for this service.

³ 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.

⁴ Consultation for chiropractic services is the same as office visit for illness.

⁵ Preauthorization required.

⁶ Newborns must be enrolled within 31 days of birth.

⁷ 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.

⁸ Please refer to your Evidence of Coverage to determine your coverage level.

* No copayments or coinsurance.

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.

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/CFBC/MSGR/HSA/SOB/ENHANCE (R. 1/09); 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/DOCS APPEAL (R. 9/11); MD/CFBC/BLCD (5/12) and any amendments.



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