

BlueChoice Opt-Out *Plus* • Open Access High Deductible Health Plan

Summary of Benefits

Services	In-Network You Pay	Out-of-Network You Pay
ANNUAL DEDUCTIBLE¹		
Individual	\$1,200	\$1,800
Individual & Child(ren)	\$2,400	\$3,600
Individual & Adult	\$2,400	\$3,600
Family	\$2,400	\$3,600
ANNUAL OUT-OF-POCKET LIMIT¹		
Individual	\$2,400	\$3,600
Individual & Child(ren)	\$4,800	\$7,200
Individual & Adult	\$4,800	\$7,200
Family	\$4,800	\$7,200
LIFETIME MAXIMUM BENEFIT	None	None
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months	No charge**	\$10 per visit
24 months-13 years (immunization visit)	No charge**	\$10 per visit
24 months-13 years (non-immunization visit)	No charge**	20% of Allowed Benefit*
14-17 years	No charge**	20% of Allowed Benefit*
Adult Physical Examination	No charge**	20% of Allowed Benefit*
Routine GYN Visits	No charge**	20% of Allowed Benefit*
Mammograms	No charge**	20% of Allowed Benefit*
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge**	20% of Allowed Benefit*
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	Deductible, then \$20 PCP/\$30 Specialist per visit	Deductible, then 20% of Allowed Benefit*
Diagnostic Services	Deductible, then \$30 or 50% of cost, whichever is less	Deductible, then 20% of Allowed Benefit*
X-ray and Lab Tests	Deductible, then \$30 or 50% of cost, whichever is less	Deductible, then 20% of Allowed Benefit*
Allergy Testing ²	Deductible, then \$20 PCP/\$30 Specialist per visit	Deductible, then 20% of Allowed Benefit*
Allergy Shots ²	Deductible, then \$20 PCP/\$30 Specialist per visit	Deductible, then 20% of Allowed Benefit*
Outpatient Physical, Speech and Occupational Therapy ³ (limited to 30 visits/condition/benefit period)	Deductible, then \$30 per visit	Deductible, then 30% of Allowed Benefit*
Outpatient Chiropractic ^{3,4} (limited to 20 visits/condition/benefit period)	Deductible, then \$30 per visit	Deductible, then 30% of Allowed Benefit*
EMERGENCY CARE AND URGENT CARE		
Physician's Office	Deductible, then \$20 PCP/\$30 Specialist per visit	Deductible, then 20% of Allowed Benefit*
Urgent Care Center	Deductible, then \$30 per visit	Covered as in-network
Hospital Emergency Room (limited to emergency services)	Deductible, then \$100 per visit (copay waived if admitted)	Covered as in-network
Ambulance (if medically necessary)	No charge** after deductible	Deductible, then 20% of Allowed Benefit*
HOSPITALIZATION		
Inpatient Facility Services	Deductible, then \$250 admission	Deductible, then 20% of Allowed Benefit*
Outpatient Facility Services	Deductible, then \$30 per visit	Deductible, then 20% of Allowed Benefit*
Inpatient Physician Visits	Deductible, then \$20 PCP/\$30 Specialist per visit	Deductible, then 20% of Allowed Benefit*
Outpatient Physician Services	Deductible, then \$30 per visit	Deductible, then 20% of Allowed Benefit*

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

* Out-of-network coinsurances are based on a percentage of the out-of-network Allowed Benefit. If services are rendered from a nonparticipating provider, member is responsible for 100% of charges above the Allowed Benefit. However, if services are rendered by a participating provider, member is only responsible for amount up to the 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. The Out-of-Pocket can be met in the same way. The Out-of-Network and In-Network deductibles, Out-of-Pocket maximum and Lifetime maximum are separate and do not contribute to each other.

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.

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 Opt-Out Plus Open Access, 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/OOP/OA (R. 11/11); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/BLCD (5/12) and any amendments.



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