BlueChoice HMO Open Access HRA/HSA Summary of Benefits

Integrated Deductible

Services	In-Network You Pay[1]
	Visit www.carefirst.com/doctor to locate providers and facilities
24-HOUR NURSE ADVICE LINE	
Free advice from a registered nurse. Visit **www.carefirst.com/needcare** to learn more about your options for care.	When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health questions and treatment options.
WELLNESS PROGRAM & BLUE REWARDS	
Visit **www.carefirst.com/myaccount** for more information.	You have access to a comprehensive wellness program as part of your medical plan. You also have Blue Rewards, an incentive program where you can get rewarded for completing certain activities.
ANNUAL DEDUCTIBLE (Benefit period)[2]	
Individual	$1,500
Family	$3,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[3]	
Medical[4]	$3,000 Individual/$6,550 Family
Prescription Drug[4]	Combined with in-network medical out-of-pocket maximum
LIFETIME MAXIMUM BENEFIT	
Lifetime Maximum	None
PREVENTIVE SERVICES	
Well-Child Care (including exams & immunizations)	No charge*
Adult Physical Examination (including routine GYN visit)	No charge*
Breast Cancer Screening	No charge*
Pap Test	No charge*
Prostate Cancer Screening	No charge*
Colorectal Cancer Screening	No charge*
OFFICE VISITS, LABS AND TESTING	
Office Visits for Illness	Deductible, then $10 PCP/$20 Specialist per visit
Imaging (MRA/MRS, MRI, PET & CAT scans)[5]	No charge* after deductible
Lab[5]	No charge* after deductible
X-ray[5]	No charge* after deductible
Allergy Testing	Deductible, then $10 PCP/$20 Specialist per visit
Allergy Shots	Deductible, then $10 PCP/$20 Specialist per visit
Physical, Speech and Occupational Therapy[6] (limited to 30 visits/injury/benefit period)	Deductible, then $20 per visit
Chiropractic (limited to 20 visits/benefit period)	Deductible, then $20 per visit
Acupuncture	Not covered (except when approved or authorized by Plan when used for anesthesia)
EMERGENCY SERVICES	
Urgent Care Center	Deductible, then $20 per visit
Emergency Room—Facility Services	Deductible, then $100 per visit (waived if admitted)
Emergency Room—Physician Services	No charge* after deductible
Ambulance (if medically necessary)	No charge* after deductible

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Services	In-Network You Pay[1]
HOSPITALIZATION—(Members are responsible for both physician and facility fees)	
Outpatient Facility Services	No charge* after deductible
Outpatient Physician Services	Deductible, then $10 PCP/$20 Specialist per visit
Inpatient Facility Services	Deductible, then $250 per admission
Inpatient Physician Services	No charge* after deductible
HOSPITAL ALTERNATIVES	
Home Health Care	No charge* after deductible
Hospice	No charge* after deductible
Skilled Nursing Facility	No charge* after deductible
MATERNITY	
Preventive Prenatal and Postnatal Office Visits	No charge*
Delivery and Facility Services	Deductible, then $250 per admission
Nursery Care of Newborn	No charge* after deductible
Artificial and Intrauterine Insemination[7]	Not covered
In Vitro Fertilization Procedures[7]	Not covered
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for applicable physician and facility fees)	
Inpatient Facility Services	Deductible, then $250 per admission
Inpatient Physician Services	No charge* after deductible
Outpatient Facility Services	No charge* after deductible
Outpatient Physician Services	No charge* after deductible
Office Visits	No charge* after deductible
Medication Management	No charge* after deductible
MEDICAL DEVICES AND SUPPLIES	
Durable Medical Equipment	Deductible, then 25% of Allowed Benefit
Hearing Aids for ages 0-18	Not covered
VISION	
Routine Exam (limited to 1 visit/benefit period)	$10 per visit at participating vision provider
Eyeglasses and Contact Lenses	Discounts from participating vision centers

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Note: Allowed Benefit is the fee that participating providers in the network have agreed to accept for a particular service. The participating provider cannot charge the member more than this amount for any covered service. Example: Dr. Carson charges $100 to see a sick patient. To be part of CareFirst's network, he has agreed to accept $50 for the visit. The member will pay their copay/coinsurance and deductible (if applicable) and CareFirst will pay the remaining amount up to $50.

* No copayment or coinsurance.

1 When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.
2 For family coverage only: The family deductible must be met before any member starts receiving benefits as indicated above. The deductible may be met by one member or any combination of members.
3 For family coverage only: The family out-of-pocket maximum must be met before any member's services will be covered at 100% up to the Allowed Benefit. The out-of-pocket maximum may be met by one member or any combination of members.
4 Plan has an integrated medical and prescription drug out-of-pocket maximum.
5 Members accessing laboratory services inside the CareFirst Service area (Maryland, D.C., Northern Virginia) must use LabCorp as their Lab Test facility and a non-hospital/freestanding facility for X-rays and specialty Imaging.
6 Visit Limitation does not apply to children ages 2-10 when Physical, Speech and Occupational Therapy is for treatment of Autism Spectrum Disorder.
7 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. Preauthorization required.

Reminder: To enroll in HMO, HMO Referral and Plus plans, members must live or work within the CareFirst service area of Maryland, Washington, D.C. or Northern Virginia.

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

The benefits described are issued under form numbers: VA/CFBC/GC (R. 1/13); VA/CFBC/DOCS (R. 1/09); VA/CFBC/EOC (R. 1/09); VA/BC-OOP/SOB HDHP (R. 1/09); VA/CFBC/ATTC (R. 1/10); VA/CFBC/DOL APPEAL (R. 7/12); VA/CFBC/RX3 (R. 1/15) and any amendments.

CareFirst BlueChoice

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