BlueChoice HMO HSA/HRA $1,500

Summary of Benefits

Services	You Pay[1]
	Visit www.carefirst.com/doctors to locate providers
BLUE REWARDS	
Visit **www.carefirst.com/bluerewards** for more information	Blue Rewards is an incentive program where you can earn up to $300 per adult and $750 per family for taking an active role in getting healthy and staying healthy.
ANNUAL DEDUCTIBLE (BENEFIT PERIOD)[2]	
Individual	$1,500
Family	$3,000
ANNUAL OUT-OF-POCKET MAXIMUM (BENEFIT PERIOD)[3,4]	
Individual	$4,000
Family	$8,000
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	
Facility Charge: In addition to the physician copays/coinsurances listed below, if a service is rendered on a hospital campus, ADD facility charge	Deductible, then $50 per visit
Office Visits for Illness[5]	Deductible, then $20 PCP/$30 Specialist per visit
Convenience Care (Retail Health Clinics)	Deductible, then $20 per visit
Diagnostic Services[5,6]	Deductible, then $30 per visit
Lab and Tests[5,6]	Deductible, then $30 per visit
X-ray[5,6]	Deductible, then $30 per visit
Allergy Testing & Shots[5]	Deductible, then $30 per visit
Physical, Speech and Occupational Therapy (limited to 30 visits per injury or illness/benefit period)[5,7]	Deductible, then $30 per visit
Chiropractic (limited to 20 visits/condition/benefit period)[5]	Deductible, then $30 per visit
Acupuncture[5]	Deductible, then $30 per visit
EMERGENCY CARE AND URGENT CARE	
Urgent Care Center	Deductible, then $30 per visit
Hospital 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

Services	You Pay[1]
HOSPITALIZATION—MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES	
Outpatient Facility Surgery (Freestanding Facility)	Deductible, then $100 per visit
Outpatient Facility Surgery (Hospital Facility)	Deductible, then $200 per visit
Outpatient Physician Services	Deductible, then $30 per visit
Inpatient Facility Services	Deductible, then $250 per admission
Inpatient Physician Services	Deductible, then $20 per visit
HOSPITAL ALTERNATIVES	
Home Health Care	No charge* after deductible
Hospice	No charge* after deductible
Skilled Nursing Facility (limited to 100 days/benefit period)	Deductible, then $30 per admission
MATERNITY	
Preventive Prenatal and Postnatal Office Visits	No charge*
Delivery and Facility Services	Deductible, then $250 per visit
Nursery Care of Newborn	No charge* after deductible
Artificial Insemination[8]	Deductible, then $30 per visit
In Vitro Fertilization Procedures[8]	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE	
Inpatient Facility Services	Deductible, then $250 per admission
Inpatient Physician Services	Deductible, then $20 per visit
Outpatient Facility Services	Deductible, then $30 per visit
Outpatient Physician Services	Deductible, then $30 per visit
Office Visits	Deductible, then $20 per visit
Partial Hospitalization Facility Services	Deductible, then $30 per visit
Partial Hospitalization Physician Services	Deductible, then $30 per visit
Medication Management	Deductible, then $20 per visit
MEDICAL DEVICES AND SUPPLIES	
Durable Medical Equipment	Deductible, then 25% of Allowed Benefit
Hearing Aids (limited to minor children and limited to one hearing aid per hearing-impaired ear every 36 months)	No charge* after deductible
PRESCRIPTION DRUGS[9,10]	
Prescription Drug Deductible	Subject to combined medical and prescription drug deductible
Preventive Drugs	No charge*
Oral Chemo Drugs and Diabetic Supplies	No charge* after deductible
Generic Drugs	34-day supply-Deductible, then $10; 90-day supply-Deductible, then $20
Preferred Brand Drugs[11]	34-day supply-Deductible, then $45; 90-day supply-Deductible, then $90
Non-preferred Brand Drugs[12]	34-day supply-Deductible, then $65; 90-day supply-Deductible, then $130
Specialty Drugs	Deductible, then 50% coinsurance
PEDIATRIC VISION (UNDER 19)	
Routine Exam (limited to 1 visit/benefit period)	In-Network-No charge*; Out-of-Network-Total charge minus $40 reimbursement
Frames and Contact Lenses– Pediatric Collection Only	In-Network-No charge*; Out-of-Network-Reimbursements apply
Spectacle Lenses	In-Network-No charge*; Out-of-Network-Reimbursements apply

Services	You Pay[1]
PEDIATRIC DENTAL (UNDER 19)	
Dental Deductible	In-Network-$25; Out-of-Network-$50
Class I Preventive & Diagnostic Services Exams (2 per year), cleanings (2 per year), fluoride treatments (2 per year), sealants, bitewing X-rays (2 per year), full mouth X-ray (one every 3 years)	In-Network-No charge*; Out-of-Network-20% of Allowed Benefit
Class II Basic Services Fillings (amalgam or composite), simple extractions, non-surgical periodontics	In-Network-Deductible, then 20% of Allowed Benefit; Out-of-Network-Deductible, then 40% of Allowed Benefit
Class III Major Services–Surgical Surgical periodontics, endodontics, oral surgery	In-Network-Deductible, then 20% of Allowed Benefit; Out-of-Network-Deductible, then 40% of Allowed Benefit
Class IV Major Services–Restorative Crowns, dentures, inlays and onlays	In-Network-Deductible, then 50% of Allowed Benefit; Out-of-Network-Deductible, then 65% of Allowed Benefit
Class V Medically-Necessary Orthodontic Services	In-Network-50% of Allowed Benefit; Out-of-Network-65% of Allowed Benefit

Note: Allowed Benefit is the fee that providers in the network have agreed to accept for a particular service. The 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] All drug costs are subject to the in-network out-of-pocket maximum.
[5] If a service is rendered on a hospital campus you could receive two bills, one from the physician and one from the facility.
[6] Members who reside in the CareFirst service area must use LabCorp as their Lab Test facility and freestanding facilities for Diagnostic Services and X-rays.
[7] There are no limits for children ages 19 and under when Physical, Speech and Occupational Therapy is for treatment of Autism Spectrum Disorder.
[8] 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.
[9] Members are only able to use non-participating Pharmacies in cases of Emergency Services or out-of-area Urgent Care and are reimbursed based on the allowed amount minus the deductible, copay/coinsurance.
[10] Benefits for Specialty Drugs are only available when Specialty Drugs are purchased from and dispensed by a specialty Pharmacy in the Exclusive Specialty Pharmacy Network.
[11] If a Generic drug becomes available for a Preferred Brand drug, the Preferred Brand drug moves to the Non-preferred Brand drug tier.
[12] If a provider prescribes a Non-preferred Brand drug, and the Member selects the Non-preferred Brand drug when a Generic drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the Non-preferred Brand drug and the Generic drug up to the cost of the drug. This amount will not contribute to the Out-of-Pocket Maximum.

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.

The benefits described are issued under the following form numbers: MD/CFBC/GC (1/14) • MD/CFBC/HMO/EOC (1/14) • MD/CFBC/DOL APPEAL (R. 9/11) • MD/CFBC/SHOP/BCOA/DOCS (1/14) • MD/CFBC/BCOA CDH/1500 SOB (1/15)• MD/CFBC/ELIG (1/14) and any amendments.

CareFirst BlueChoice

www.carefirst.com