BlueChoice HMO
Open Access HRA/HSA
Integrated Deductible

Summary of Benefits

Services	In-Network You Pay[1]
	Visit www.carefirst.com/doctor to locate providers
FIRSTHELP—24/7 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 FirstHelp at 800-535-9700 to speak with a registered nurse about your health questions and treatment options.
BLUE REWARDS	
Visit **www.carefirst.com/bluerewards** for more information	Blue Rewards is an incentive program where you can earn up to $300 for taking an active role in getting healthy and staying healthy.
ANNUAL DEDUCTIBLE (Benefit period)[2]	
Individual	$2,500
Family	$5,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[3]	
Medical[4]	$3,500 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	No charge* after deductible
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	No charge* after deductible
Allergy Shots	No charge* after deductible
Physical, Speech and Occupational Therapy[6] (limited to 30 visits/injury/benefit period)	No charge* after deductible
Chiropractic (limited to 20 visits/benefit period)	No charge* after deductible
Acupuncture	Not covered (except when approved or authorized by Plan when used for anesthesia)
EMERGENCY SERVICES	
Urgent Care Center	No charge* after deductible
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	In-Network You Pay[1]
HOSPITALIZATION (Members are responsible for applicable physician and facility fees)	
Outpatient Facility Services	No charge* after deductible
Outpatient Physician Services	No charge* after deductible
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] (limited to 6 attempts per live birth)	Deductible, then 50% Allowed Benefit
In Vitro Fertilization Procedures[7] (limited to 3 attempts per live birth up to $100,000 lifetime maximum)	Deductible, then 50% Allowed Benefit
MENTAL HEALTH AND SUBSTANCE ABUSE (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 (limited to 1 hearing aid per hearing impaired ear every 3 years)	No charge* after deductible
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

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. 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 who reside in the CareFirst service area must use LabCorp as their Lab Test facility and freestanding facilities for Imaging and X-rays.
[6] There are no limits for children until the end of the month in which the insured or enrollee turns 19 years of age when Physical, Speech or Occupational Therapy is included as part of Habilitative Services.
[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.

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: MD/CFBC/GC (R. 1/13); MD/CFBC/EOC (R. 4/08); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/DOCS (R. 4/08); MD/BC-OOP/SOB HDHP (9/06); (MD/CFBC/ELIG (R.7/09);   MD/CFBC/RX (R. 7/12) and any amendments.

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