

BlueChoice Opt-Out *Plus* Open Access

Summary of Benefits

Services	In-Network You Pay	Out-of-Network You Pay
ANNUAL DEDUCTIBLE (Benefit period)^{3,8}		
Individual	\$500	\$1,000
Individual & Child(ren) ⁵	\$1,000	\$2,000
Individual & Adult	\$1,000	\$2,000
Family	\$1,000	\$2,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)^{4,7}		
Individual	\$2,500	\$2,500
Individual & Child(ren) ⁵	\$5,000	\$5,000
Individual & Adult	\$5,000	\$5,000
Family	\$5,000	\$5,000
LIFETIME MAXIMUM BENEFIT	No Limit	\$1,000,000/Member
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months	\$20 per visit	20% of Allowed Benefit*
24 months-13 years (immunization visit)	\$20 per visit	20% of Allowed Benefit*
24 months-13 years (non-immunization visit)	\$20 per visit	20% of Allowed Benefit*
14-17 years	\$20 per visit	20% of Allowed Benefit*
Adult Physical Examination	\$20 PCP/\$30 Specialist per visit	Not covered
Routine GYN Visits	\$20 PCP/\$30 Specialist per visit, then deductible	Deductible, then 20% of Allowed Benefit*
Mammograms	No charge ² (limited to one examination per benefit period)	20% of Allowed Benefit*
Cancer Screening ⁶ (Pap Test, Prostate and Colorectal)	\$20 PCP/\$30 Specialist per visit	Deductible, then 20% of Allowed Benefit*
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	\$20 PCP/\$30 Specialist per visit, then deductible	Deductible, then 20% of Allowed Benefit*
Diagnostic Services ⁶	\$20 PCP/\$30 Specialist per visit, then deductible	Deductible, then 20% of Allowed Benefit*
X-ray and Lab Tests	No charge ²	Deductible, then 20% of Allowed Benefit*
Allergy Testing ⁶	\$20 PCP/\$30 Specialist per visit	Deductible, then 20% of Allowed Benefit*
Allergy Shots ⁶	\$20 PCP/\$30 Specialist per visit	Deductible, then 20% of Allowed Benefit*
Outpatient Physical, Speech and Occupational Therapy	\$30 per visit, then deductible (limited to 30 visits/condition/benefit period)	Deductible, then 20% of Allowed Benefit*
Outpatient Spinal Manipulation	\$30 per visit, then deductible (limited to 20 visits/benefit period)	Deductible, then 20% of Allowed Benefit*
EMERGENCY CARE AND URGENT CARE		
Physician's Office	\$20 PCP/\$30 Specialist per visit, then deductible	Paid as in-network
Urgent Care Center	\$30 per visit, then deductible	Paid as in-network
Hospital Emergency Room (limited to emergency services)	\$100 per visit, then deductible (waived if admitted)	Paid as in-network
Ambulance (if medically necessary)	No charge ² after deductible is met	Deductible, then 20% of Allowed Benefit*
HOSPITALIZATION		
Inpatient Facility Services	No charge ² after deductible is met	Deductible, then 20% of Allowed Benefit*
Outpatient Facility Services	No charge ² after deductible is met	Deductible, then 20% of Allowed Benefit*
Inpatient Physician Services	No charge ² after deductible is met	Deductible, then 20% of Allowed Benefit*
Outpatient Physician Services	\$20 PCP/\$30 Specialist per visit, then deductible	Deductible, then 20% of Allowed Benefit*

Services	In-Network You Pay	Out-of-Network You Pay
HOSPITAL ALTERNATIVES		
Home Health Care	No charge ² after deductible is met	Deductible, then 20% of Allowed Benefit*
Hospice	No charge ² after deductible is met	Deductible, then 20% of Allowed Benefit*
Skilled Nursing Facility	No charge ² after deductible is met	Deductible, then 20% of Allowed Benefit*
MATERNITY		
Prenatal and Postnatal Office Visits	\$20 PCP/\$30 Specialist per visit, then deductible (up to 10 times the copay per pregnancy)	Deductible, then 20% of Allowed Benefit*
Delivery and Facility Services	No charge ² after deductible is met	Deductible, then 20% of Allowed Benefit*
Nursery Care of Newborn	No charge ² after deductible is met	Deductible, then 20% of Allowed Benefit*
Initial Office Consultation(s) for Infertility Services/Procedures	\$30 Specialist per visit	Deductible, then 20% of Allowed Benefit*
Artificial and Intrauterine Insemination ¹	Deductible, then 50% of Allowed Benefit	Deductible, then 20% of Allowed Benefit*
In Vitro Fertilization Procedures ¹ (limited to 3 attempts/live birth up to \$100,000 lifetime maximum)	Deductible, then 50% of Allowed Benefit	Deductible, then 20% of Allowed Benefit*
MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)		
Inpatient Facility Services	No charge ² after deductible is met	Deductible, then 20% of Allowed Benefit*
Inpatient Physician Services	No charge ² after deductible is met (limited to 1 visit/day during covered admission)	Deductible, then 20% of Allowed Benefit* (limited to 1 visit/day during covered admission)
Outpatient Services (MH and SA) Visits 1-5 Visits 6-30 Visits 31 and over	Deductible, then 20% of Allowed Benefit* Deductible, then 35% of Allowed Benefit* Deductible, then 50% of Allowed Benefit*	Deductible, then 20% of Allowed Benefit* Deductible, then 35% of Allowed Benefit* Deductible, then 50% of Allowed Benefit*
Partial Hospitalization	\$30 per day, then deductible (limited to 60 days/benefit period)	Deductible, then 20% of Allowed Benefit*
Medication Management Visit	\$20 PCP/\$30 Specialist per visit, then deductible	Deductible, then 20% of Allowed Benefit*
MISCELLANEOUS		
Durable Medical Equipment	Deductible, then 25% of Allowed Benefit (limited to in-network plan payment of \$7,500/benefit period)	Deductible, then 20% of Allowed Benefit*
Acupuncture	Not covered (except when approved or authorized by CareFirst when used for anesthesia)	Not covered (except when approved or authorized by CareFirst when used for anesthesia)
Transplants	Covered as stated in the Evidence of Coverage	Covered as stated in the Evidence of Coverage
Hearing Aids for ages 0-18	No charge ² (limited to \$1,400 max per hearing aid every 3 years)	No charge ² (limited to \$1,400 max per hearing aid every 3 years)
VISION		
Routine Exam (limited to 1 visit/benefit period)	\$10 per visit at CareFirst BlueChoice designated vision center; \$25 at CareFirst physician offices	Not covered (limited to 1 visit/benefit period)
Eyeglasses and Contact Lenses	Discounts from participating vision centers	Not covered

¹ 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. However, assisted reproduction (AI & IVF) services performed as treatment options for infertility are only available under the terms of the members contract. Preauthorization required.

² No copayments or coinsurance.

³ If you have Individual and Adult or Individual and Child(ren) coverage, each Member must satisfy his/her own deductible by meeting the individual deductible. If you have family coverage, all Members' individual deductibles will be combined to meet the family deductible; however, no individual Member may contribute more than the individual deductible amount.

⁴ If you have Individual and Adult or Individual and Child(ren) coverage, each Member must satisfy his/her own out-of-pocket maximum by meeting the individual out-of-pocket maximum. If you have family coverage, all Members' individual out-of-pocket maximums will be combined to meet the family out-of-pocket maximum; however, no individual Member may contribute more than the individual out-of-pocket amount.

⁵ Please refer to your Evidence of Coverage to determine your coverage level.

⁶ If office copayment has been paid, additional copayment not required for this service.

⁷ The actual out-of-pocket limit may vary based on the types of coverage selected by your employer.

⁸ Copayment or portion of deductible may be required at the point of sale while in the deductible period. Member will never be required to pay more than CareFirst's Allowed Benefit for service rendered.

^{*} Out-of-network coinsurances are based on a percentage of the out-of-network Allowed Benefit. If services are received from a non-participating provider, the member is responsible for 100% of charges above the Allowed Benefit. However, if services are received from a participating provider, the member is only responsible for amount up to the Allowed Benefit.

Note: Upon enrollment in CareFirst BlueChoice, you will need to select a Primary Care Physician (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/GC (R. 10/07); MD/BC-OOP/SOB (R. 7/03); MD/CFBC/DOCS (R. 7/03); MD/CFB/ELIG (R. 1/08); MD/CFBC/EOC (R. 7/03) • CCH/NCA COC/MD; MD/CF/ATTC (R. 1/08); DOCS/M; MD/CMM/SOB (R. 8/04); MD/CF/RX3 (R. 1/04) and any amendments or riders.



www.carefirst.com

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