BlueChoice HMO Open Access Summary of Benefits

Services	In-network You Pay[1]
	Visit carefirst.com/doctor to locate providers
24-HOUR NURSE ADVICE LINE	
Free advice from a registered nurse. Visit **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.
ANNUAL DEDUCTIBLE (Benefit period)[2]	
Individual	None
Family	None
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[3]	
Medical[4]	$3,500 Individual/$9,400 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	$10 PCP/$20 Specialist per visit
Imaging (MRA/MRS, MRI, PET & CAT scans)[5]	No charge*
Lab[5]	No charge*
X-ray[5]	No charge*
Allergy Testing	$10 PCP/$20 Specialist per visit
Allergy Shots	$10 PCP/$20 Specialist per visit
Physical, Speech and Occupational Therapy[6] (limited to 60 visits/injury/benefit period)	$10 per visit
Chiropractic (limited to 20 visits/benefit period)	$10 per visit
Acupuncture	Not covered (except when approved or authorized by Plan when used for anesthesia)
EMERGENCY SERVICES	
Urgent Care Center	$20 per visit
Emergency Room—Facility Services	$100 per visit (waived if admitted)
Emergency Room—Physician Services	No charge*
Ambulance (if medically necessary)	No charge*
HOSPITALIZATION (Members are responsible for applicable physician and facility fees)	
Outpatient Facility Services	$50 per visit
Outpatient Physician Services	No charge*
Inpatient Facility Services	$100 per admission
Inpatient Physician Services	No charge*

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Services	In-network You Pay[1]
HOSPITAL ALTERNATIVES	
Home Health Care	No charge*
Hospice	No charge*
Skilled Nursing Facility	$100 per admission
MATERNITY	
Preventive Prenatal and Postnatal Office Visits	No charge*
Delivery and Facility Services	$100 per admission
Nursery Care of Newborn	No charge*
Artificial and Intrauterine Insemination[7] (limited to 6 attempts per live birth)	$20 per visit
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	$100 per admission
Inpatient Physician Services	No charge*
Outpatient Facility Services	No charge*
Outpatient Physician Services	No charge*
Office Visits	$10 per visit
Medication Management	$10 per visit
MEDICAL DEVICES AND SUPPLIES	
Durable Medical Equipment	50% of Allowed Benefit
Hearing Aids (for ages 0-18)	Not covered
VISION	
Routine Exam (limited to 1 visit/benefit period)	$10 per visit
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: When one family member meets the individual deductible, they can start receiving benefits. Each family member cannot contribute more than the individual deductible amount. The family deductible must be met before the remaining family members can start receiving benefits.
[3] For Family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit.
[4] Plan has separate out-of-pocket maximums for medical and drug expenses which accumulate independently.
[5] Members accessing laboratory services inside the CareFirst service area (Maryland, Washington, D.C. and Northern Virginia) must use LabCorp as their Lab Test facility and non-hospital/freestanding facility for X-rays and specialty imaging.
[6] There are no limits for children under age 21 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.

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: DC/CFBC/GC (R. 1/19); DC/CFBC/EOC (R. 6/09); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/ DOCS (R. 6/09); DC/BC-OOP/SOB (R. 6/09); DC/BC-OOP/SOB HDHP (R. 7/07); DC/CFBC/LG/INCENT (R. 1/19); DC/CFBC/RX3 (R. 1/18); DC/CFBC/ATTC (R. 1/10) and any amendments.