BlueChoice HMO Open Access—Low Option Plan

Product Summary of Benefits

Anne Arundel County Public Schools

Services	In-network You Pay[1]
	Visit carefirst.com/doctor to locate providers
ANNUAL DEDUCTIBLE (Benefit period)[2]	
Individual	$4,500
Family	$9,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[3]	
Medical[4]	$6,350 Individual/$12,700 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 $30 PCP/$40 Specialist per visit
Imaging (MRA/MRS, MRI, PET & CAT scans)[5]	$40 per visit
Lab[5]	$40 per visit
X-ray[5]	$40 per visit
Allergy Testing	$30 PCP/$40 Specialist per visit
Allergy Shots	$30 PCP/$40 Specialist per visit
Physical, Speech and Occupational Therapy (limited to 30 visits combined/injury/ benefit period)	Deductible, then $40 per visit
Chiropractic (limited to 20 visits/benefit period)	Deductible, then $40 per visit
Acupuncture	Not covered (except when approved or authorized by Plan when used for anesthesia)
EMERGENCY CARE AND URGENT CARE	
Urgent Care Center	Deductible, then $100 per visit
Emergency Room—Facility Services	Deductible, then $300 per visit (waived if admitted)
Emergency Room—Physician Services	No charge* after deductible
Ambulance (if medically necessary)	No charge* after deductible
HOSPITALIZATION—Members are responsible for applicable physician and facility fees	
Outpatient Facility Services	Deductible, then 30% of Allowed Benefit
Outpatient Physician Services	Deductible, then 30% of Allowed Benefit
Inpatient Facility Services	Deductible, then 30% of Allowed Benefit
Inpatient Physician Services	Deductible, then 30% of Allowed Benefit
HOSPITAL ALTERNATIVES	
Home Health Care	Deductible, then 30% of Allowed Benefit
Hospice	Deductible, then 30% of Allowed Benefit
Skilled Nursing Facility	Deductible, then 30% of Allowed Benefit

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Services	In-network You Pay[1]
MATERNITY	
Preventive Prenatal and Postnatal Office Visits	No charge*
Delivery and Facility Services	Deductible, then 30% of Allowed Benefit
Nursery Care of Newborn	Deductible, then 30% of Allowed Benefit
Artificial and Intrauterine Insemination6 (limited to 6 attempts per live birth)	Deductible, then 50% of Allowed Benefit
In Vitro Fertilization Procedures[6] (limited to 3 attempts per live birth up to $100,000 lifetime maximum)	Deductible, then 50% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE USE DISORDER (Members are responsible for applicable physician and facility fees)	
Inpatient Facility Services	Deductible, then 30% of Allowed Benefit
Inpatient Physician Services	Deductible, then 30% of Allowed Benefit
Outpatient Facility Services	Deductible, then 30% of Allowed Benefit
Outpatient Physician Services	Deductible, then 30% of Allowed Benefit
Office Visits	Deductible, then $30 per visit
Medication Management	Deductible, then $30 per visit
MEDICAL DEVICES AND SUPPLIES	
Durable Medical Equipment	Deductible, then 50% of Allowed Benefit
Hearing Aids for ages 0-18 (limited to 1 hearing aid per hearing impaired ear every 3 years)	No charge*
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 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: When one family member meets the individual deductible, they can start receiving benefits as indicated above. 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 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] 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 (R. 4/08); MD/CFBC/ELIG (R.7/09); MD/CFBC/RX (R. 7/12) and any amendments.

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