HealthyBlue HMO HSA/HRA $2,000

Summary of Benefits

Services	You Pay
HEALTHY REWARD	
Visit www.carefirst.com/healthyblue for more information.	Earn $300 per adult and up to $700 per family toward reducing your deductible for completing 3 simple steps.
ANNUAL DEDUCTIBLE (BENEFIT PERIOD)[1]	
Individual	$2,000
Family	$4,000
ANNUAL OUT-OF-POCKET MAXIMUM (BENEFIT PERIOD)[2]	
Individual	$6,350
Family	$12,700
LIFETIME MAXIMUM	
Lifetime Maximum	None
PREVENTIVE SERVICES	
Well-Child Care (including exams & immunizations)	No charge*
Adult Physical Examination	No charge*
Routine GYN Visits	No charge*
Mammograms	No charge*
Pap Test	No charge*
Cancer Screening (Prostate and Colorectal)	No charge*
OFFICE VISITS, LABS & TESTING	
Facility fee for services rendered in a hospital setting[3]	Deductible, then $50 per visit
Office Visits for Illness[3]	Deductible, then no charge* PCP/$30 Specialist per visit
Diagnostic Services/Lab Tests (LabCorp only)[3]	No charge* after deductible
X-ray (Freestanding Facility only)[3]	No charge* after deductible
Allergy Testing & Shots[3]	Deductible, then $30 per visit
Outpatient Physical, Speech and Occupational Therapy[3]	Deductible, then $30 per visit
Outpatient Chiropractic[3]	Deductible, then $30 per visit
EMERGENCY CARE AND URGENT CARE	
Urgent Care Center	Deductible, then $50 per visit
Hospital Emergency Room (waived if admitted)	Deductible, then $200 per visit
Emergency Room–Professional Services	No charge* after deductible
Ambulance (if medically necessary)	Deductible, then $50 per service
HOSPITALIZATION	
Outpatient Facility Non-Surgery (Hospital Facility)	Deductible, then $50 per visit
Outpatient Facility Surgery (Freestanding Facility)	Deductible, then $100 per visit
Outpatient Facility Surgery (Hospital Facility)	Deductible, then $300 per visit
Outpatient Physician Services	No charge* after deductible
Inpatient Facility Services	Deductible, then $300 per admission
Inpatient Physician Services	No charge* after deductible
HOSPITAL ALTERNATIVES	
Home Health Care (limited to 90 visits/episode of care)	Deductible, then $30 per visit
Hospice (limited to 60 days inpatient and 180 days outpatient/hospice eligibility period)	Deductible, then $30 per visit
Skilled Nursing Facility (limited to 60 days/admission)	Deductible, then $30 per admission

Note: Plan has an integrated medical and prescription drug deductible.

Services	You Pay
MATERNITY	
Prenatal and Postnatal Office Visits[3]	No charge*
Delivery and Facility Services	Deductible, then $300 per admission
Nursery Care of Newborn	No charge* after deductible
Artificial Insemination[4]	Not covered
In Vitro Fertilization Procedures[4]	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE	
Inpatient Facility Services	Deductible, then $300 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[3]	No charge* after deductible
Partial Hospitalization Facility Services	No charge* after deductible
Partial Hospitalization Physician Services	No charge* after deductible
Medication Management[3]	No charge* after deductible
MISCELLANEOUS	
Durable Medical Equipment	No charge* after deductible
Acupuncture[3]	Not covered (except when approved or authorized by Plan when used for anesthesia)
Hearing Aids	Not covered
PRESCRIPTION DRUGS[5]	
Preventive Drugs	No charge*
Generic Drugs	HealthyBlue Select Generics-No charge*; All other Generics-No charge* after deductible
Preferred Brand Drugs	34-day supply-Deductible, then $45; 90-day supply-Deductible, then $90
Non-Preferred Brand Drugs	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
PEDIATRIC DENTAL (UNDER 19)	
Dental Deductible	In-Network: $25; Out-of-Network: $50
Class I Preventive & Diagnostic Services	In-Network: No charge*; Out-of-Network: 20% of Allowed Benefit
Class II Basic Services	In-Network: Deductible, then 20% of Allowed Benefit; Out-of-Network: Deductible, then 40% of Allowed Benefit
Class III Major Services–Surgical	In-Network: Deductible, then 20% of Allowed Benefit; Out-of-Network: Deductible, then 40% of Allowed Benefit
Class IV Major Services–Restorative	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

* No copayment or coinsurance.

[1] The deductible can be met entirely by one Member or by combining eligible expenses of two or more members. There is no Individual Deductible with Family Coverage. The Family Deductible must be reached before CareFirst BlueChoice pays benefits for any Member who has other than Individual Coverage. Please refer to your Evidence of Coverage to determine your coverage level.

[2] The Out-of-Pocket Maximum can be met entirely by one Member or by combining eligible expenses of two or more members. There is no Individual Out-of-Pocket Maximum with Family Coverage. The Family Out-of-Pocket Maximum must be reached before CareFirst BlueChoice pays benefits for any Member who has other than Individual Coverage. Please refer to your Evidence of Coverage to determine your coverage level.

[3] An additional facility copay and/or coinsurance may apply to services rendered in a hospital setting.

[4] 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.

[5] 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.

Notes:
- Upon enrollment you must select a Primary Care Provider (PCP). For the most current listing, go to www.carefirst.com or call the Member Services number on your ID card for assistance, or to request a printed 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.
- When the Allowed Benefit is less than the copay listed, the member payment will be the Allowed Benefit.

Policy Form Numbers: ON SHOP-DC/CFBC/SHOP/GC (1/14); DC/CFBC/SHOP/EOC (1/14); DC/CFBC/SHOP/EXC/DOCS (1/14); DC/CFBC/SHOP/HB HMO/2000/SOB (1/14); DC/CFBC/SHOP/ELIG (1/14); DC/CFBC/DOL APPEAL (R. 7/11)

OFF SHOP-DC/CFBC/GC (1/14); DC/CFBC/HMO/EOC (1/14); DC/CFBC/HMO/DOCS (1/14); DC/CFBC/HB HMO/2000/SOB (1/14); DC/CFBC/ELIG (1/14); DC/CFBC/DOL APPEAL (R. 7/11); and any Amendments.

HealthyBlue CareFirst BlueChoice

www.carefirst.com

SUM2147-1P (4/14) ■ DC ■ 2-50 Silver