CareFirst
Family of health care plans

BlueChoice HMO Open Access (Regional Plan)

SUMMARY OF BENEFITS

We're glad you're considering CareFirst BlueCross BlueShield. We know there's a lot of information to review when selecting a health plan. We hope this summary makes things a little easier.

This is a plan for people who:

- **Want a medical plan without a deductible**
- **Plan to receive care inside of the Maryland, District of Columbia and Northern Virginia area**
- **Want emergency care coverage when traveling out of the area**

For more information about CareFirst plan options and resources, visit carefirst.com/dcgov.

24-Hour Nurse Advice Line

Get free advice from a registered nurse. Call 800-535-9700 to discuss your health questions and treatment options.

Blue Rewards and Wellness

You have access to a comprehensive wellness program that offers incentives for completing certain activities.

Virtual Care through CloseKnit

CloseKnit gives you 24/7 access to the support you deserve—from primary and urgent care to therapy and more* through your desktop or the convenient CloseKnit mobile app. The app can be downloaded from Apple App Store or Google Play.

BlueChoice HMO Open Access (Regional Plan)	
EMPLOYEE MONTHLY CONTRIBUTION	
Self Only	$204.01
Self + One	$401.89
Family	$589.58
Services	**In-network You Pay[1,2]**
ANNUAL DEDUCTIBLE (Benefit period)[4]	
Individual	None
Family	None
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[5]	
Medical[6]	$3,500 Individual/$9,400 Family
Prescription Drug[6]	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*

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Services	**In-network You Pay[1,2]**
OFFICE VISITS, LABS AND TESTING	
Office Visits for Illness	$10 PCP/$20 Specialist per visit
Imaging (MRA/MRS, MRI, PET & CAT scans)	No charge*
Lab	No charge*
X-ray	No charge*
Allergy Testing	$10 PCP/$20 Specialist per visit
Allergy Shots	$10 PCP/$20 Specialist per visit
Physical, Speech and Occupational Therapy	$10 per visit
Chiropractic	$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*
HOSPITAL ALTERNATIVES	
Home Health Care (limited to 90 visits per episode of care)	No charge*
Hospice (Inpatient—limited to maximum 180 day Hospice eligibility period; Outpatient—limited to 60 days per Hospice eligibility period)	No charge*
Skilled Nursing Facility (limited to 60 days/benefit period)	$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 (limited to 6 attempts per live birth)	$20 per visit
Assisted Reproductive Technology[7] (limited to 3 attempts per live birth; and a lifetime maximum benefit of $100,000)	50% of CareFirst member cost
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 CareFirst member cost
Hearing Aids for ages 0-18 (limited to 1 hearing aid per hearing impaired ear every 3 years)	Not covered
VISION	
Routine Exam (limited to 1 visit/benefit period)	$10 per visit
Eyeglasses and Contact Lenses	Discounts from participating vision centers

Note: CareFirst member cost 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 an integrated medical and prescription drug out-of-pocket maximum.
[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. Assisted Reproductive Technologies ("ART") are also sometimes referred to as Advanced Reproductive Technologies.Coverage under the policy includes benefits for In Vitro Fertilization and other forms of ART.

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.

Notice of Nondiscrimination and Availability of Language Assistance Services
CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all of their corporate affiliates comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-258-6518.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855-258-6518.