

# BlueChoice HMO Open Access Summary of Benefits



Howard County Public Schools—Retirees

| Benefits                                                                                            | CareFirst Open Access HMO                                                             |
|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| Network Coverage                                                                                    | Regional Network (MD, Washington, D.C. and Northern Virginia)                         |
| <b>COST SHARING LIFETIME LIMITS</b>                                                                 |                                                                                       |
| Calendar Year Deductible<br>Individual<br>Family                                                    | None<br>None                                                                          |
| Calendar Year Out-of-Pocket Maximum<br>Individual<br>Family                                         | \$2,000<br>\$6,000                                                                    |
| Coinsurance                                                                                         | 100%                                                                                  |
| Lifetime Maximum                                                                                    | None                                                                                  |
| <b>PROFESSIONAL SERVICES</b>                                                                        |                                                                                       |
| Primary Care Office Visit                                                                           | \$10 copay                                                                            |
| Gynecology Office Visit                                                                             | \$0 for Well Woman visit or \$20 copay for all other visits                           |
| Specialist Office Visit                                                                             | \$20 copay                                                                            |
| Physical Therapy Office Visit                                                                       | 100% after copay (30 visits per condition per calendar year, combined with ST and OT) |
| Speech Therapy Office Visit                                                                         | 100% after copay (30 visits per condition per calendar year, combined with PT and OT) |
| Occupational Therapy Visit                                                                          | 100% after copay (30 visits per condition per calendar year, combined with PT and ST) |
| Chiropractic Office Visit                                                                           | 100% after copay (limited to 20 visits per benefit period)                            |
| Allergy Shots/Other Covered Injections                                                              | 100% after copay                                                                      |
| Allergy Serum                                                                                       | 100% after copay                                                                      |
| Allergy Testing                                                                                     | Covered as either a PCP or Specialist office visit                                    |
| Diagnostic tests                                                                                    | 100% after copay                                                                      |
| Diagnostic tests performed by lab or other testing facility and billed separately from office visit | 100%                                                                                  |
| <b>PREVENTIVE CARE</b>                                                                              |                                                                                       |
| Well Child Visit/Immunization                                                                       | \$0 copay                                                                             |
| Routine Adult Physical                                                                              | \$0 copay                                                                             |
| Routine Gynecological Exam                                                                          | \$0 copay, one exam per calendar year.                                                |
| Routine Pap Smear                                                                                   | 100% when included with routine gynecological exam. One exam per calendar year.       |
| Routine Mammogram                                                                                   | 100% unlimited visits                                                                 |
| PSA Testing                                                                                         | Covered based on place of service. One per calendar year for males 40 and over        |
| <b>INPATIENT CARE (PREAUTHORIZATION REQUIRED)</b>                                                   |                                                                                       |
| Room and Board                                                                                      | 100% Pre-Authorization Required                                                       |
| Physician/Surgical Services                                                                         | 100%                                                                                  |
| Anesthesia Services                                                                                 | 100%                                                                                  |
| Intensive Care Unit/Critical Care Unit                                                              | 100%                                                                                  |
| Maternity/Nursery/Birthing Center                                                                   | 100%                                                                                  |
| Skilled Nursing/Rehab Facility Care                                                                 | 100% unlimited days                                                                   |
| Dialysis/Radiation/Chemotherapy                                                                     | 100%                                                                                  |
| Hospice (Preauthorization Required)                                                                 | 100%                                                                                  |
| Physical/Speech/Occupational Therapy                                                                | 100%                                                                                  |

| Benefits                                                                                       | CareFirst Open Access HMO                                                                                                               |
|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| Network Coverage                                                                               | Regional Network (MD, Washington, D.C. and Northern Virginia)                                                                           |
| <b>OUTPATIENT HOSPITAL SERVICES</b>                                                            |                                                                                                                                         |
| Surgical/Anesthesia Services                                                                   | 100%                                                                                                                                    |
| Dialysis/Radiation/Chemotherapy                                                                | 100%                                                                                                                                    |
| Outpatient Diagnostic Services                                                                 | 100%                                                                                                                                    |
| <b>MATERNITY/INFERTILITY SERVICES</b>                                                          |                                                                                                                                         |
| Pre-and Postnatal care and delivery                                                            | 100%                                                                                                                                    |
| Routine nursery care                                                                           | 100%                                                                                                                                    |
| Sterilization/Reverse Sterilization requires preauthorization                                  | 100% Reverse Sterilization is not covered                                                                                               |
| Artificial Insemination (AI)                                                                   | 50% of Allowed Benefit (limited to 6 courses of treatment per lifetime)                                                                 |
| In Vitro Fertilization (IVF)*—maximum of 3 IVF attempts/lifetime (Preauthorization Required)   | 50% of Allowed Benefit                                                                                                                  |
| <b>MEDICAL EMERGENCIES (USE OF ER)</b>                                                         |                                                                                                                                         |
| Emergency Room                                                                                 | 100% after \$50 copay (waived if admitted)                                                                                              |
| Urgent Care Center                                                                             | 100% after \$20 copay                                                                                                                   |
| <b>MEDICAL EQUIPMENT/SUPPLIES</b>                                                              |                                                                                                                                         |
| Durable Medical Equipment                                                                      | 100%                                                                                                                                    |
| Prosthetic Devices (Pre-authorization required)                                                | 100%                                                                                                                                    |
| Orthopedic Devices                                                                             | 100%                                                                                                                                    |
| Foot Orthotics (Subject to medical necessity)                                                  | 100%                                                                                                                                    |
| <b>MENTAL HEALTH AND SUBSTANCE USE DISORDER (PREAUTHORIZATION REQUIRED FOR INPATIENT ONLY)</b> |                                                                                                                                         |
| Mental Health:<br>Inpatient<br>Outpatient                                                      | 100%<br>\$20 copay                                                                                                                      |
| Substance Abuse:<br>Inpatient<br>Outpatient                                                    | 100%<br>\$20 copay                                                                                                                      |
| <b>OTHER SERVICES</b>                                                                          |                                                                                                                                         |
| Ambulance                                                                                      | Ground: 100% non-emergency—not covered<br>Air: Covered 100% non-emergency—not covered                                                   |
| Kidney, Cornea Bone Marrow Transplants                                                         | 100%                                                                                                                                    |
| Heart, Heart-Lung, Lung, Pancreas, Liver Transplants                                           | 100%                                                                                                                                    |
| Cardiac Rehabilitation                                                                         | 100% after \$20 copay                                                                                                                   |
| Hearing Aids for Children and Adults (limited to one hearing aid/per ear every 36 months)      | 100% of Allowed Benefit per aid/per hearing impaired ear to a maximum of \$1,400; member may be balanced billed up to the total charge. |
| Habilitative Services (for children up to age 19)                                              | 100% after copay for Physical, Speech and Occupational Therapy. Pre-authorization required.                                             |
| Acupuncture                                                                                    | 100% of Allowed Benefit, no copay                                                                                                       |
| Vision (Routine eye exam)                                                                      | Routine eye exam covered at 100% after a \$10 copay. One exam per calendar year                                                         |

**Retiree Plan Participants under age 65 and over age 65:** Expenses for non-covered services and charges in excess of reasonable and customary do not apply toward the out-of-pocket limit.

The purpose of this Open Enrollment chart is to give you basic information about your benefits options and how to enroll for coverage or make changes to existing coverage. This guide is only a summary of your choices and does not fully describe each benefit option. Please refer to your Certificates of Coverage provided by your health plan carriers for important additional information about the plans. Every effort has been made to make the information accurate; however, in the case of any discrepancy, the provisions of the legal documents will govern.



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