| Open Point-of-Service (POS) Plan | CareFirst BlueChoice Advantage (POS) | |
|---|---|---|
| | In-Network | Out-of-Network |
| **Annual Deductible** | None | $300 individual, $600 family |
| **Preventive Care** | | |
| **Routine Physical Exam** | $15 copay* | Not Covered |
| **Well Baby/Child Care** | $15 copay* | 80% after deductible |
| **Childhood Immunizations** | $15 copay | 80% after deductible |
| **Physician Services** | | |
| **Physician Office Visit** | $15 copay | 80% after deductible |
| **Specialist Office Visit** | $20 copay | 80% after deductible |
| **Lab Work and X-rays** | Covered in full | 80% after deductible |
| **Allergy Evaluations** | $15 copay | 80% after deductible |
| **Allergy Shots** | Covered in full | 80% after deductible |
| **Maternity Care** | | |
| **Prenatal and Postnatal Care** | $15 copay | 80% after deductible |
| **Physician Services** | Covered in full | 80% after deductible |
| **Hospital Services** | Covered in full | 80% after deductible |
| **Emergency Service (when medically necessary)** | | |
| **Urgent Care Centers** | $20 copay | Paid as in-network |
| **Emergency Room** | $100 per visit<br>(copay waived if admitted) | Paid as in-network |
| **Emergency Physician Services** | Covered in full | Paid as in-network |
| **Emergency Ambulance** | Covered in full | Paid as in-network |
| **Hospital Services—Inpatient** | | |
| **Semi-private Room** | Covered in full | 80% after deductible |
| **Professional Services** | Covered in full | 80% after deductible |
| **Surgical Procedures** | Covered in full | 80% after deductible |
| **Specialty Care/Consultation** | Covered in full | 80% after deductible |
| **Anesthesia** | Covered in full | 80% after deductible |
| **Radiology and Drugs** | Covered in full | 80% after deductible |
| **Intensive Care** | Covered in full | 80% after deductible |
| **Coronary Care** | Covered in full | 80% after deductible |
| **Hospital Services—Outpatient** | | |
| **Surgical Procedures** | $20 copay | 80% after deductible |
| **Professional Fees** | $20 copay | 80% after deductible |
| **Mental Health/Substance Abuse Services** | | |
| **Inpatient Days** | Covered in full | 80% after deductible (up to 180 days) |
| **Outpatient Visits** | $15 copay | 80% after deductible |
| **Other Services** | | |
| **Catastrophic Illness** | Covered in full | Covered in full after $1,000 out-of-pocket expenses (excluding deductible) |
| **Durable Medical Equipment** | Covered in full | 80% after deductible |
| **Home Health Care/Skilled Nursing Care** | Covered in full<br>(up to 60 visits in- and out-of-network) | 80% after deductible<br>(up to 60 visits in- and out-of-network) |
| **Hospice Care** | Covered in full | 80% after deductible |

**Applies to services not specifically listed in the previous preventive care charts.*