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%, no deductible
Childhood Immunizations	Covered in full	80%, no deductible
Physician Services		
Physician Office Visit	$15 copay	80% after deductible
Specialist Office Visit	$25 copay	80% after deductible
Lab Work and X-rays	Covered in full	Diagnostic: 80% after deductible Routine: not covered
Allergy Evaluations	$15 copay each visit	80% after deductible
Allergy Shots	Covered in full	80% after deductible
Maternity Care		
Prenatal and Postnatal Care	$25 copay first visit, covered in full after*	80% after deductible
Physician Services	Covered in full	80% after deductible
Hospital Services	Covered in full	80% after deductible
Emergency Services (when medically necessary)		
Urgent Care Centers	$25 copay	Paid as in-network
Emergency Room	$150 copay (waived if admitted)	$100 copay (waived if admitted)
Emergency Physician Services	Covered in full	Covered in full
Emergency Ambulance	Covered in full	Covered in full
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	$25 copay	80% after deductible
Professional Fees	Covered in full	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 (excludes deductible)
Durable Medical Equipment**	Covered in full	80% after deductible
Home Health Care/	Covered in full	80% after deductible
Skilled Nursing Care	(up to 60 visits in- and out-of-network)	
Hospice Care	Covered in full	80% after deductible

**Applies to services not listed in the previous preventive care charts.*
***Does not include diabetic supplies such as lancets, glucose strips, etc. See CVS/Caremark Prescription for details.*

Please Note: *All percentages shown for out-of-network services are up to the allowed benefit, as determined by CareFirst BlueChoice. The description of benefits and services is only a summary. For complete information, please refer to the evidence of coverage on the ERSC website.*