

BlueChoice HMO

MARYLAND GROUPS NOT SUBJECT TO SMALL GROUP REFORM

Summary of Benefits

SERVICES	In-Network You Pay
ANNUAL DEDUCTIBLE (Calendar year)	
Individual	None
Individual & Child(ren) ⁴	None
Individual & Adult	None
Family	None
ANNUAL OUT-OF-POCKET LIMIT (Calendar year)³	
Individual	\$2,000
Individual & Child(ren) ⁴	\$3,000
Individual & Adult	\$3,800
Family	\$6,000
LIFETIME MAXIMUM	None
PREVENTIVE SERVICES	
Well-Child Care	
0-24 months	\$30 per visit
24 months-13 years (immunization visit)	\$30 per visit
24 months-13 years (non-immunization visit)	\$30 per visit
14-17 years	\$30 per visit
Adult Physical Examination	\$30 PCP/\$40 Specialist per visit
Routine GYN Visits	\$30 PCP/\$40 Specialist per visit
Mammograms	No charge ²
Cancer Screening (Pap Test, Prostate and Colorectal) ⁵	\$30 PCP/\$40 Specialist per visit
OFFICE VISITS, LABS & TESTING	
Office Visits for Illness	\$30 PCP/\$40 Specialist per visit
Diagnostic Services ⁵	\$30 PCP/\$40 Specialist per visit
X-ray and Lab Tests	No charge ²
Allergy Testing ⁵	\$30 PCP/\$40 Specialist per visit
Allergy Shots ⁵	\$30 PCP/\$40 Specialist per visit
Outpatient Physical, Speech and Occupational Therapy (limited to 30 visits/condition/benefit period)	\$40 per visit
Outpatient Spinal Manipulation (limited to 20 visits/benefit period)	\$40 per visit
EMERGENCY CARE AND URGENT CARE	
Physician's Office	\$30 PCP/\$40 Specialist per visit
Urgent Care Center	\$40 per visit
Hospital Emergency Room	\$50 per visit (waived if admitted)
Ambulance (if medically necessary)	No charge ²
HOSPITALIZATION	
Inpatient Facility Services	\$300 per admission
Outpatient Facility Services	No charge ²
Inpatient Physician Services	No charge ²
Outpatient Physician Services	\$30 PCP/\$40 Specialist per visit

SERVICES	In-Network You Pay
HOSPITAL ALTERNATIVES	
Home Health Care	No charge ²
Hospice	No charge ²
Skilled Nursing Facility	No charge ²
MATERNITY	
Prenatal and Postnatal Office Visits	\$30 PCP/\$40 Specialist per visit (not to exceed 10 times the copay per pregnancy)
Delivery and Facility Services	\$300 per admission
Nursery Care of Newborn	No charge ²
Initial Office Consultation(s) for Infertility Services/Procedures	\$30 PCP/\$40 Specialist per visit
Artificial Insemination ¹	50% of Allowed Benefit
In Vitro Fertilization Procedures ¹ (limited to 3 attempts/live birth up to \$100,000 lifetime maximum)	50% of Allowed Benefit
MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)	
Inpatient Facility Services	\$300 per admission
Inpatient Physician Services (limited to one visit/day during covered admission)	No charge ²
Outpatient Services (MH & SA)	1-5 visits - 20% of Allowed Benefit 6-30 visits - 35% of Allowed Benefit 31+ visits - 50% of Allowed Benefit
Partial Hospitalization (limited to 60 days/benefit period)	\$40 per day
Medication Management Visit	\$30 PCP/\$40 Specialist per visit
MISCELLANEOUS	
Durable Medical Equipment (limited to a plan payment of \$7,500/benefit period)	25% of Allowed Benefit
Acupuncture	Not covered (except when approved or authorized by Plan when used for anesthesia)
Transplants	Covered as stated in Evidence of Coverage
Hearing Aids for ages 0-18 (limited to \$1,400 max per hearing aid every 3 years)	No charge ²
VISION	
Routine Exam (limited to 1 visit/benefit period)	\$10 per visit
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers

¹ Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment option for infertility. However, assisted reproduction (AI & IVF) services performed as treatment option for infertility are only available under the terms of the members contract. Preauthorization required.

² No copayment or coinsurance.

³ If you have two-party coverage, each Member must satisfy his/her own out-of-pocket limit by meeting the individual out-of-pocket Limit. If you have family coverage, all Members' individual out-of-pocket limits will be combined to meet the family out-of-pocket limit; however, no individual Member may contribute more than the individual out-of-pocket amount.

⁴ Please refer to your Evidence of Coverage to determine your coverage level.

⁵ If office visit copayment has been paid, additional office copayment not required for this service.

Note: Upon enrollment in CareFirst BlueChoice, you will need to select a Primary Care Physician (PCP).

To select a PCP, go to www.carefirst.com for the most current listing of PCPs from our online provider directory. You may also call the Member Services toll free phone number on the front of your CareFirst BlueChoice ID card for assistance in selecting a PCP or obtaining a printed copy of the CareFirst BlueChoice provider 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.

Policy Form Numbers: MD/CFBC/GC (R. 7/03); HMO/CC GPS/MD 4/01; MD/CFBC/EOC (R. 7/03); MD/CFBC/DOCS (R. 7/03); MD/BC-OOP/SOB (R. 7/03); MD/CFBC/ELIG (R. 5/05) and any amendments.

www.carefirst.com