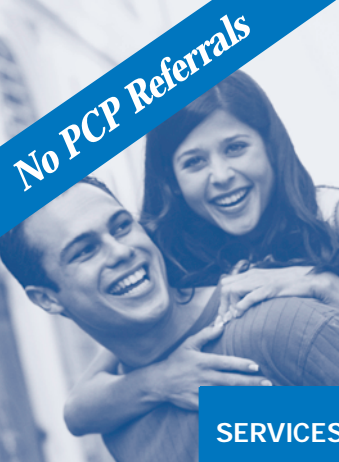


No PCP Referrals



# BlueChoice HMO

## HRA/HSA BlueFund and Compatible Plans

MARYLAND GROUP NOT SUBJECT TO SMALL GROUP REFORM

### Summary of Benefits

SERVICES	In-Network You Pay
<b>ANNUAL DEDUCTIBLE<sup>3</sup></b>	
Individual	\$1,200
Individual & Child(ren) <sup>4</sup>	\$2,400
Individual & Adult	\$2,400
Family	\$2,400
<b>ANNUAL OUT-OF-POCKET LIMIT<sup>3</sup></b>	
Individual	\$2,400
Individual & Child(ren) <sup>4</sup>	\$4,800
Individual & Adult	\$4,800
Family	\$4,800
<b>LIFETIME MAXIMUM</b>	None
<b>PREVENTIVE SERVICES</b>	
Well-Child Care	
0-24 months	No charge <sup>2</sup>
24 months-13 years (immunization visit)	No charge <sup>2</sup>
24 months-13 years (non-immunization visit)	No charge <sup>2</sup>
14-17 years	No charge <sup>2</sup>
Adult Physical Examination	No charge <sup>2</sup>
Routine GYN Visits	No charge <sup>2</sup>
Mammograms	No charge <sup>2</sup>
Cancer Screening <sup>5</sup> (Pap Test, Prostate and Colorectal)	No charge <sup>2</sup>
<b>OFFICE VISITS, LABS &amp; TESTING</b>	
Office Visits for Illness	Deductible, then \$15 PCP/\$25 Specialist per visit
Diagnostic Services <sup>5</sup>	Deductible, then \$15 PCP/\$25 Specialist per visit
X-ray and Lab Tests	No charge <sup>2</sup> after deductible is met
Allergy Testing <sup>5</sup>	Deductible, then \$15 PCP/\$25 Specialist per visit
Allergy Shots <sup>5</sup>	Deductible, then \$15 PCP/\$25 Specialist per visit
Outpatient Physical, Speech and Occupational Therapy	Deductible, then \$25 per visit (limited to 30 visits/condition/benefit period)
Outpatient Spinal Manipulation	Deductible, then \$25 per visit (limited to 20 visits/benefit period)
<b>EMERGENCY CARE AND URGENT CARE</b>	
Physician's Office	Deductible, then \$15 PCP/\$25 Specialist per visit
Urgent Care Center	Deductible, then \$25 per visit
Hospital Emergency Room	Deductible, then \$100 per visit (waived if admitted)
Ambulance (if medically necessary)	No charge <sup>2</sup> after deductible is met
<b>HOSPITALIZATION</b>	
Inpatient Facility Services	Deductible, then \$250 per admission
Outpatient Facility Services	No charge <sup>2</sup> after deductible is met
Inpatient Physician Services	No charge <sup>2</sup> after deductible is met
Outpatient Physician Services	Deductible, then \$15 PCP/\$25 Specialist per visit

SERVICES	In-Network You Pay
<b>HOSPITAL ALTERNATIVES</b>	
Home Health Care	No charge <sup>2</sup> after deductible is met
Hospice	No charge <sup>2</sup> after deductible is met
Skilled Nursing Facility	No charge <sup>2</sup> after deductible is met
<b>MATERNITY</b>	
Prenatal and Postnatal Office Visits	Deductible, then \$15 PCP/\$25 Specialist per visit
Delivery and Facility Services	Deductible, then \$250 per admission
Nursery Care of Newborn	No charge <sup>2</sup> after deductible is met
Initial Office Consultation(s) for Infertility Services/Procedures	Deductible, then \$25 Specialist copay
Artificial Insemination <sup>1</sup>	Deductible, then 50% of Allowed Benefit
In Vitro Fertilization Procedures <sup>1</sup>	Deductible, then 50% of Allowed Benefit
<b>MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)</b>	
Inpatient Facility Services (MH & SA)	Deductible, then \$250 per admission
Inpatient Physician Services (limited to 1 visit/day during covered admission)	No charge <sup>2</sup> after deductible is met
Outpatient Services (MH & SA)	Visits 1-5: Deductible, then 20% of Allowed Benefit Visits 6-30: Deductible, then 35% of Allowed Benefit Visits 31+: Deductible, then 50% of Allowed Benefit
Partial Hospitalization (limited to 60 days/benefit period)	\$25 per visit after deductible is met
Medication Management Visit	Deductible, then \$15 PCP/\$25 Specialist per visit
<b>MISCELLANEOUS</b>	
Durable Medical Equipment	Deductible, then 25% of Allowed Benefit (limited to plan payment of \$7,500/benefit period)
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 for one hearing aid for each hearing impaired ear every 3 years)	No charge <sup>2</sup> after deductible is met
<b>VISION</b>	
Routine Exam (limited to 1 visit/benefit period)	HRA Plan - \$10 per visit at participating vision provider HSA Plan - Not covered
Eyeglasses and Contact Lenses	HRA Plan - Discounts from participating vision centers HSA Plan - Not covered

<sup>1</sup> 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) services performed as treatment option for infertility are only available under the terms of the member's contract. Preauthorization required.

<sup>2</sup> No copayments or coinsurance.

<sup>3</sup> The deductible can be met entirely by one Member or by combining eligible expenses of two or more Members. The Out-of-Pocket Limit can be met in the same way.

<sup>4</sup> Please refer to your Evidence of Coverage to determine your coverage level.

<sup>5</sup> If office copayment has been paid, additional copayment not required for this service.

HSA plans must be sold with a combined RX benefit and HRA plans have the option of combined Rx benefits or a separate plan.

**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](http://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); MD/CFBC/EOC (R.7/03); MD/CFBC/DOCS (R. 7/03); MD/CFBC/ELIG (R. 5/05); MD/CFBC/ADD SERV AMEND (9/06); MD/CFBC HDHP/LL AMEND (9/06); MD/CFBC/HDHP RX (9/06); MD/BC-OOP/SOB HDHP (9/06)