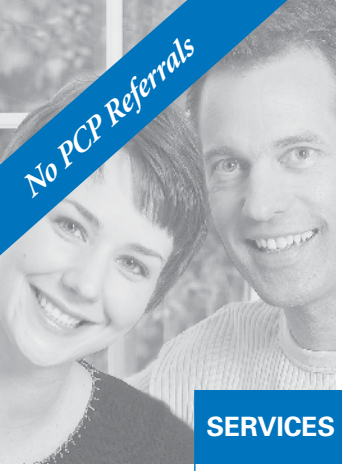

BlueChoice Opt-Out • *Open Access*

MARYLAND SMALL GROUP REFORM

CareFirst BlueChoice

Summary of Benefits

SERVICES	In-Network You Pay	Out-Of Network You Pay
ANNUAL DEDUCTIBLE		
Individual	None	
Individual & Child(ren)[6]	None	
Individual & Adult	None	
Family	None	
ANNUAL OUT-OF-POCKET LIMIT[3]		
Individual	$3,300	
Individual & Child(ren)[6]	$6,400 (combined in- and out-of-network)	
Individual & Adult	$7,700	
Family	$10,100	
LIFETIME MAXIMUM	Unlimited	
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months	$10 per visit	20% of Plan Allowance*
24 months-13 years (immunization visit)	$10 per visit	20% of Plan Allowance*
24 months-13 years (non-immunization visit)	$20 per visit	20% of Plan Allowance*
14-17 years	$20 per visit	20% of Plan Allowance*
Adult Physical Examination	$20 per visit	20% of Plan Allowance*
Routine GYN Visits	$20 per visit	20% of Plan Allowance*
Mammograms	No charge[2]	20% of Plan Allowance*
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge[2]	20% of Plan Allowance*
OFFICE VISITS, LABS & TESTING		
Office Visits for Illness	$20 PCP/$30 Specialist per visit	20% of Plan Allowance*
Diagnostic Services	No charge[2]	20% of Plan Allowance*
X-ray and Lab Tests	No charge[2]	20% of Plan Allowance*
Allergy Testing[7]	$20 PCP/$30 Specialist per visit	20% of Plan Allowance*
Allergy Shots[7]	$20 PCP/$30 Specialist per visit	20% of Plan Allowance*
Outpatient Physical, Speech and Occupational Therapy[5] (limited to 30 visits/condition/benefit period)	$30 per visit	20% of Plan Allowance*
Outpatient Chiropractic[5] (limited to 20 visits/condition/benefit period)	$30 per visit	20% of Plan Allowance*
EMERGENCY CARE AND URGENT CARE		
Physician's Office	$20 PCP/$30 Specialist per visit	Paid as in-network
Urgent Care Center	$30 per visit	Paid as in-network
Hospital Emergency Room	$35 per visit (waived if admitted)	Paid as in-network
Ambulance (if medically necessary)	No charge[2]	20% of Plan Allowance*
HOSPITALIZATION		
Inpatient Facility Services	No charge[2]	20% of Plan Allowance*
Outpatient Facility Services	$30 per visit	20% of Plan Allowance*
Inpatient Physician Services	No charge[2]	20% of Plan Allowance*
Outpatient Physician Services	$30 per visit	20% of Plan Allowance*

Plan Allowance: The Plan Allowance is generally the contracted rates or fee schedules that Preferred Providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueChoice, Inc., however, in certain circumstances, an allowance may be established by law.

SERVICES	In-Network You Pay	Out-Of Network You Pay
HOSPITAL ALTERNATIVES		
Home Health Care	No charge[2]	20% of Plan Allowance*
Hospice	No charge[2]	20% of Plan Allowance*
Skilled Nursing Facility (limited to 100 days/year)[5]	No charge[2]	20% of Plan Allowance*
MATERNITY		
Prenatal and Postnatal Office Visits	$20 per visit	20% of Plan Allowance*
Delivery and Facility Services	No charge[2]	20% of Plan Allowance*
Nursery Care of Newborn[4]	No charge[2]	20% of Plan Allowance*
Artificial Insemination[1]	50% of the allowed charges (after diagnosis is confirmed)	50% of Plan Allowance*
In Vitro Fertilization Procedures[1]	Not covered	Not covered
MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)		
Inpatient Facility Services (limited to 60 days/benefit period)	No charge[2]	40% of Plan Allowance*
Inpatient Physician Services	No charge[2]	40% of Plan Allowance*
Outpatient Services (MH & SA)	30% of the allowed benefit	50% of Plan Allowance*
Partial Hospitalization[5] (each day counts as 1/2 day toward inpatient limit)	No charge[2]	40% of Plan Allowance*
Medication Management Visit	$20 PCP/$30 Specialist per visit	20% of Plan Allowance*
MISCELLANEOUS		
Durable Medical Equipment	No charge[2]	20% of Plan Allowance*
Acupuncture	Covered only when medically necessary and plan approved for anesthesia and when services are rendered in conjunction with Physical Therapy	Covered only when medically necessary and plan approved for anesthesia and when services are rendered in conjunction with Physical Therapy
Transplants	Covered as stated in Evidence of Coverage	Covered as stated in Evidence of Coverage
Hearing Aids for ages 0-18 (limited to $1,400 max per hearing aid every 3 years)[5]	No charge[2]	20% of Plan Allowance
VISION		
Routine Exam (Ooptometrist or ophthalmologist) (limited to 1 visit/benefit period)	$10 per visit at participating vision provider	Plan pays $33, member pays balance
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers	Plan pays allowance based on purcharse, Member pays balance

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) services performed as treatment option for infertility are only available under the terms of the members contract. Preauthorization required.

2 No copayments or coinsurance.

3 The Out-of-Pocket Limit can be met entirely by one Member or by combining eligible expenses of two or more members.

4 Newborns must be enrolled within 31 days of birth.

5 CareFirst BlueChoice may be providing your BlueChoice benefits on either a contract or calendar year basis. Please refer to your benefits contract to determine which method applies to your group benefit plan.

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

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

* Out-of-network coinsurances are based on a percentage of the out-of-network Plan Allowance. Member is responsible for 100% of charges above Plan Allowance.

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: EOC-CC (MSGR) REV 10/05 • DOCS-HMO REV (MSGR) (R. 7/03) • SOB-HMO-CORE REV (MSGR) 7/04 • MD/BC/OOP/VISION (R. 6/04) • MD/BC OO/OA MSGR (4/04) • MD/BC/AMEND DOCS OPEN ACCESS MSGR (4/03) • SOB-HMO-ENHANCE MSGR (R. 1/05) and any amendments.

CUT5962-1S (7/06)