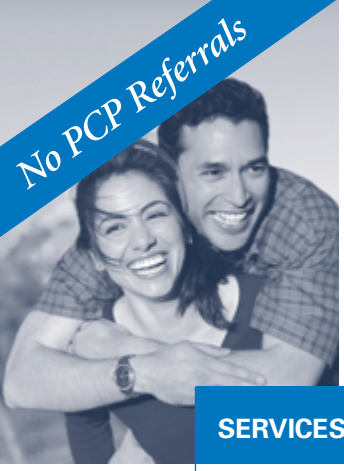

CareFirst BlueChoice

CareFirst BlueCross BlueShield

BlueChoice Opt-Out *Plus* • *Open Access*

MARYLAND SMALL GROUP REFORM

Summary of Benefits

SERVICES	In-Network You Pay	Out-Of-Network You Pay
ANNUAL DEDUCTIBLE[3]		
Individual	None	$300
Individual & Child(ren)[7]	None	$600
Individual & Adult	None	$600
Family	None	$600
ANNUAL OUT-OF-POCKET LIMIT[3]		
Individual	$3,300	$2,000
Individual & Child(ren)[7]	$6,400	$4,000
Individual & Adult	$7,700	$4,000
Family	$10,100	$4,000
LIFETIME MAXIMUM	Unlimited	$2,000,000
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months	$10 per visit	Deductible, then 20% of Plan Allowance*
24 months-13 years (immunization visit)	$10 per visit	Deductible, then 20% of Plan Allowance*
24 months-13 years (non-immunization visit)	$10 per visit	Deductible, then 20% of Plan Allowance*
14-17 years	$10 per visit	Deductible, then 20% of Plan Allowance*
Adult Physical Examination	$10 per visit	Deductible, then 20% of Plan Allowance*
Routine GYN Visits	$10 per visit	Deductible, then 20% of Plan Allowance*
Mammograms	No charge[2]	Deductible, then 20% of Plan Allowance*
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge[2]	Deductible, then 20% of Plan Allowance*
OFFICE VISITS, LABS & TESTING		
Office Visits for Illness	$10 PCP/$20 Specialist per visit	Deductible, then 20% of Plan Allowance*
Diagnostic Services	No charge[2]	Deductible, then 20% of Plan Allowance*
X-ray and Lab Tests	No charge[2]	Deductible, then 20% of Plan Allowance*
Allergy Testing[8]	$10 PCP/$20 Specialist per visit	Deductible, then 20% of Plan Allowance*
Allergy Shots[6]	$10 PCP/$20 Specialist per visit	Deductible, then 20% of Plan Allowance*
Outpatient Physical, Speech and Occupational Therapy[6] (limited to 30 visits/condition/benefit period)	$20 per visit	Deductible, then 30% of Plan Allowance*
Outpatient Chiropractic[6] (limited to 20 visits/condition/benefit period)	$20 per visit	Deductible, then 30% of Plan Allowance*
EMERGENCY CARE AND URGENT CARE		
Physician's Office	$10 PCP/$20 Specialist per visit	Paid as in-network
Urgent Care Center	$20 per visit	Paid as in-network
Hospital Emergency Room[5]	$35 per visit (waived if admitted)	Paid as in-network
Ambulance (if medically necessary)	No charge[2]	Deductible, then 20% of Plan Allowance*
HOSPITALIZATION		
Inpatient Facility Services	No charge[2]	Deductible, then 20% of Plan Allowance*
Outpatient Facility Services	$20 per visit	Deductible, then 20% of Plan Allowance*
Inpatient Physician Services	No charge[2]	Deductible, then 20% of Plan Allowance*
Outpatient Physician Services	$20 per visit	Deductible, then 20% of Plan Allowance*

SERVICES	In-Network You Pay	Out-Of-Network You Pay
HOSPITAL ALTERNATIVES		
Home Health Care	No charge[2]	Deductible, then 20% of Plan Allowance*
Hospice	No charge[2]	Deductible, then 20% of Plan Allowance*
Skilled Nursing Facility[6] (limited to 100 days/benefit period)	No charge[2]	Deductible, then 20% of Plan Allowance*
MATERNITY		
Prenatal and Postnatal Office Visits	$10 per visit	Deductible, then 20% of Plan Allowance*
Delivery and Facility Services	No charge[2]	Deductible, then 20% of Plan Allowance*
Nursery Care of Newborn[4]	No charge[2]	Deductible, then 20% of Plan Allowance*
Artificial Insemination[1]	50% of allowed charges (after diagnosis is confirmed)	Deductible, then 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]	Deductible, then 20% of Plan Allowance*
Inpatient Physician Services	No charge[2]	Deductible, then 20% of Plan Allowance*
Outpatient Services (MH & SA)	30% of allowed charges	Deductible, then 50% of Plan Allowance*
Partial Hospitalization[6] (each day counts as 1/2 day toward inpatient limit)	No charge[2]	Deductible, then 20% of Plan Allowance*
Medication Management Visit	$10 PCP/$20 Specialist per visit	Deductible, then 20% of Plan Allowance*
MISCELLANEOUS		
Durable Medical Equipment	No charge[2]	Deductible, then 20% of Plan Allowance*
Acupuncture	Not covered, unless medically necessary and Plan approved for anesthesia and when services are rendered in conjunction with Physical Therapy	Not covered, unless Plan approved for 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)[6]	No charge[2]	Deductible, then 20% of Plan Allowance*
VISION		
Routine Exam (Optometrist 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 purchase, 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 deductible can be met entirely by one Member or by combining eligible expenses of two or more members. The Out-of-Pocket can be met in the same way.
[4] Newborns must be enrolled within 31 days of birth.
[5] Emergency room copay applies to the deductible.
[6] 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.
[7] Please refer to your Evidence of Coverage to determine your coverage level.
[8] 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. If services are rendered from a nonparticipating provider, member is responsible for 100% of charges above the Plan Allowance. However, if services are rendered by a participating provider, member is only responsible for amount up to the Plan Allowance.

Note: Upon enrollment in CareFirst BlueChoice Opt-Out *Plus* Open Access, 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) • CC/HMO/IP COPAY (MSGR) 7/01 • MD/BC/VISION (MSGR) 12/01 • HMO-ENH 10/20 (MSGR) REV (11/04) • MD/CFBC/MSGR/DOCS (7/06) • MD/BC OOP/OA MSGR (4/06) • MD/CFBC/MSGR/SOB/CORE (7/06)