CareFirst BlueCross BlueShield

BluePreferred

MARYLAND SMALL GROUP REFORM

Summary of Benefits

SERVICES	In-Network You Pay[2]	Out-Of Network You Pay[3]
ANNUAL DEDUCTIBLE[8]		
Individual	$250	(combined in- and out-of-network)
Individual & Child(ren)[7]	$500	
Individual & Adult	$500	
Family	$500	
ANNUAL OUT-OF-POCKET LIMIT[8]		
Individual	$2,500	(combined in- and out-of-network)
Individual & Child(ren)[7]	$5,000	
Individual & Adult	$5,000	
Family	$5,000	
LIFETIME MAXIMUM	$2,000,000 (combined in- and out-of-network)	
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months	$10 per visit	$10 per visit
24 months-13 years (immunization visit)	$10 per visit	$10 per visit
24 months-13 years (non-immunization visit)	$10 per visit	$10 per visit
14-17 years	$10 per visit	30% of Plan Allowance
Adult Physical Examination	$10 per visit	Deductible, then 30% of Plan Allowance
Routine GYN Visits	$10 per visit	Deductible, then 30% of Plan Allowance
Mammograms	No charge[9] after deductible	CareFirst participating provider: $0[3] Non-participating provider: Balance above Plan Allowance[3]
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge[9] after deductible	CareFirst participating provider: $0[3] Non-participating provider: Balance above Plan Allowance[3]
OFFICE VISITS, LABS & TESTING		
Office Visits for Illness	$10 per visit	Deductible, then 30% of Plan Allowance
Diagnostic Services	Deductible, then 10% of Plan Allowance	Deductible, then 30% of Plan Allowance
X-ray and Lab Tests	Deductible, then 10% of Plan Allowance	Deductible, then 30% of Plan Allowance
Allergy Testing	Deductible, then 10% of Plan Allowance	Deductible, then 30% of Plan Allowance
Allergy Shots	$5 per visit	Deductible, then 30% of Plan Allowance
Outpatient Physical, Speech and Occupational Therapy[4,6] (limited to 30 visits/condition/benefit period)	Deductible, then 10% of Plan Allowance	Deductible, then 30% of Plan Allowance
Outpatient Chiropractic[4,6] (limited to 20 visits/condition/benefit period)	Deductible, then 10% of Plan Allowance	Deductible, then 30% of Plan Allowance
EMERGENCY CARE AND URGENT CARE		
Physician's Office	$10 per visit	Deductible, then 30% of Plan Allowance
Urgent Care Center	$10 per visit	Deductible, then 30% of Plan Allowance
Hospital Emergency Room[5]	Deductible, then $35 per visit and 10% of Plan Allowance (waived if admitted)	Deductible, then $35 per visit and 10% of Plan Allowance (waived if admitted)
Ambulance (if medically necessary)	Deductible, then 10% of Plan Allowance	Deductible, then 30% of Plan Allowance
HOSPITALIZATION[6]		
Inpatient Facility Services	Deductible, then 10% of Plan Allowance	Deductible, then 30% of Plan Allowance
Outpatient Facility Services	Deductible, then 10% of Plan Allowance	Deductible, then 30% of Plan Allowance
Inpatient Physician Services	Deductible, then 10% of Plan Allowance	Deductible, then 30% of Plan Allowance
Outpatient Physician Services	Deductible, then 10% of Plan Allowance	Deductible, then 30% 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 BlueCross BlueShield (CareFirst), however, in certain circumstances, an allowance may be established by law.

Medical Option 2

SERVICES	In-Network You Pay[2]	Out-Of Network You Pay[3]
HOSPITAL ALTERNATIVES		
Home Health Care	Deductible, then 10% of Plan Allowance	Deductible, then 30% of Plan Allowance
Hospice	Deductible, then 10% of Plan Allowance	Deductible, then 30% of Plan Allowance
Skilled Nursing Facility (limited to 100 days/benefit period)[6]	Deductible, then 10% of Plan Allowance	Deductible, then 30% of Plan Allowance
MATERNITY		
Prenatal and Postnatal Office Visits	$10 per visit	Deductible, then 30% of Plan Allowance
Delivery and Facility Services	Deductible, then 10% of Plan Allowance	Deductible, then 30% of Plan Allowance
Nursery Care of Newborn	Deductible, then 10% of Plan Allowance	Deductible, then 30% of Plan Allowance
Artificial Insemination[1]	Deductible, then 50% of Plan Allowance	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)	Deductible, then 10% of Plan Allowance	Deductible, then 30% of Plan Allowance
Inpatient Physician Services	Deductible, then 10% of Plan Allowance	Deductible, then 30% of Plan Allowance
Outpatient Services (MH & SA)	Deductible, then 30% of Plan Allowance	Deductible, then 40% of Plan Allowance
Partial Hospitalization[6] (each day counts as 1/2 day toward inpatient limit)	Deductible, then 10% of Plan Allowance	Deductible, then 30% of Plan Allowance
Medication Management Visit	$10 per visit	Deductible, then 30% of Plan Allowance
MISCELLANEOUS		
Durable Medical Equipment	Deductible, then 10% of Plan Allowance	Deductible, then 30% 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 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)[6]	Deductible, then 10% of Plan Allowance	Deductible, then 30% of Plan Allowance
VISION		
Routine Exam (optometrist or ophthalmologist) (limited to 1 visit/benefit period)	$10 per visit at participting vision provider	Plan pay $33, member pays balance
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers	Not covered

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[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] In-network: When you have care rendered by or referred to a provider in the Preferred Provider network. In-network coinsurances are based on a percentage of the Plan Allowance.

[3] Out-of-network: When you have care rendered by a provider not in the Preferred Provider Network, care is reimbursed as out-of-network. Out-of-network coinsurances are based on a percentage of the Plan Allowance. When services are rendered by Non-Participating Providers, charges in excess of the Plan Allowance are the member's responsibility. However, when services are rendered by a Participating Provider, then member is only responsible for the amount up to the Plan Allowance.

[4] Please note that outpatient rehabilitation from chiropractors or physical, speech and occupational therapists will always be processed as in-network. Some of these providers do not have a contract with CareFirst and may bill members for charges above the Plan Allowance. However, if these services are rendered by a Non-Preferred Provider M.D., the services will be paid at the Out-of-Network benefit shown in this summary of benefits.

[5] Emergency room copay applies to the deductible.

[6] CareFirst BlueCross BlueShield may be providing your benefits on either a contract year or calendar year basis. Please refer to your benefits contract to determine which method applies to your benefit plan.

[7] Please refer to your Evidence of Coverage to determine your coverage level.

[8] The deductible and out-of-pocket limit can be met entirely by one member or by combining eligible expenses of two or more members.

[9] No copayments or coinsurance.

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.

The benefits described are issued under form numbers: MD/CF/MSGR/DOCS (7/06)COC-NCA (MSGR) REV 10/05 • MD/CF/MSGR/SOB/PPO/CORE (7/06) • PPO-ENH 100/80 (MSGR) REV 9/02 and any amendments to these form numbers.

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