BlueChoice Opt-Out *Open Access*

Summary of Benefits

SERVICES	In-Network You Pay	Out-Of Network You Pay
ANNUAL DEDUCTIBLE		
Individual	None	
Individual & Child(ren)	None	
Individual & Adult	None	
Family	None	
ANNUAL OUT-OF-POCKET LIMIT[1]		
Individual	$3,300	
Individual & Child(ren)	$10,100 (combined in- and out-of-network)	
Individual & Adult	$6,400	
Family	$10,100	
LIFETIME MAXIMUM	None	
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months	No charge**	20% of Allowed Benefit*
24 months-13 years (immunization visit)	No charge**	20% of Allowed Benefit*
24 months-13 years (non-immunization visit)	No charge**	20% of Allowed Benefit*
14-17 years	No charge**	20% of Allowed Benefit*
Adult Physical Examination	No charge**	20% of Allowed Benefit*
Routine GYN Visits	No charge**	20% of Allowed Benefit*
Mammograms	No charge**	20% of Allowed Benefit*
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge**	20% of Allowed Benefit*
OFFICE VISITS, LABS & TESTING		
Office Visits for Illness	$20 PCP/$30 Specialist per visit	20% of Allowed Benefit*
Diagnostic Services	No charge**	20% of Allowed Benefit*
X-ray and Lab Tests	No charge**	20% of Allowed Benefit*
Allergy Testing[2]	$20 PCP/$30 Specialist per visit	20% of Allowed Benefit*
Allergy Shots[2]	$20 PCP/$30 Specialist per visit	20% of Allowed Benefit*
Outpatient Physical, Speech and Occupational Therapy[3] (limited to 30 visits/condition/benefit period)	$30 per visit	20% of Allowed Benefit*
Outpatient Chiropractic[3,4] (limited to 20 visits/condition/benefit period)	$30 per visit	20% of Allowed Benefit*
EMERGENCY CARE AND URGENT CARE		
Physician's Office	$20 PCP/$30 Specialist per visit	20% of Allowed Benefit*
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**	20% of Allowed Benefit*
HOSPITALIZATION[5]		
Inpatient Facility Services	No charge**	20% of Allowed Benefit*
Outpatient Facility Services	$30 per visit	20% of Allowed Benefit*
Inpatient Physician Services	No charge**	20% of Allowed Benefit*
Outpatient Physician Services	$30 per visit	20% of Allowed Benefit*

The Allowed Benefit (AB) 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[5]		
Home Health Care	No charge**	20% of Allowed Benefit*
Hospice	No charge**	20% of Allowed Benefit*
Skilled Nursing Facility (limited to 100 days/year)[3]	No charge**	20% of Allowed Benefit*
MATERNITY		
Prenatal and Postnatal Office Visits	$20 PCP/$30 Specialist per visit	20% of Allowed Benefit*
Delivery and Facility Services[5]	No charge**	20% of Allowed Benefit*
Nursery Care of Newborn[6]	No charge**	20% of Allowed Benefit*
Initial Consultation(s) for Infertility Services/Procedures	$30 Specialist per visit	20% of Allowed Benefit*
Artificial Insemination[7]	50% of the Allowed Benefit (after diagnosis is confirmed)	50% of Allowed Benefit*
In Vitro Fertilization Procedures[7]	Not covered	Not covered
MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)[5]		
Inpatient Facility Services (limited to 60 days/benefit period)	No charge**	20% of Allowed Benefit*
Inpatient Physician Services	No charge**	20% of Allowed Benefit*
Outpatient Services (MH & SA)	30% of the Allowed Benefit	50% of Allowed Benefit*
Partial Hospitalization[3] (each day counts as 1/2 day toward inpatient limit)	No charge**	20% of Allowed Benefit*
Medication Management Visit	$20 PCP/$30 Specialist per visit	20% of Allowed Benefit*
MISCELLANEOUS		
Durable Medical Equipment[5]	No charge**	20% of Allowed Benefit*
Acupuncture	Not covered unless medically necessary and plan approved for anesthesia and when services are rendered in conjunction with Physical Therapy	
Transplants[5]	Covered as stated in Evidence of Coverage	Covered as stated in Evidence of Coverage
Hearing Aids for ages 0-18 (limited to one hearing aid every 3 years)[3]	No charge**	20% of Allowed Benefit*
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] The Out-of-Pocket Limit can be met entirely by one Member or by combining eligible expenses of two or more members.
[2] If office copayment has been paid, additional office copayment not required for this service.
[3] 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.
[4] Consultation for chiropractic services is charged the same as office visit for illness.
[5] Preauthorization required.
[6] Newborns must be enrolled within 31 days of birth.
[7] 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.
* Out-of-network coinsurances are based on a percentage of the out-of-network Allowed Benefit. Member is responsible for 100% of charges above Allowed Benefit.
** No copayments or coinsurance.

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/MSGR/GRP APP (R. 9/09) • MD/CFBC/MSGR/GC (R. 9/09) • MD/CFBC/MSGR/GS (9/09) • MD/CFBC/MSGR/EOC (R. 7/08) • MD/CFBC/MSGR/DOCS (7/07) • MD/CFBC/MSGR/SOB/CORE (7/06) • MD/BC OO/OA MSGR (R. 7/07) • MD/BC/AMEND DOCS OPEN ACCESS MSGR (R. 6/09) • MD/CFBC/MSGR/SOB/10 20 (2/07) • MD/CFBC/DOL APPEAL (R. 6/06) • MD/CFBC/MSGR/BLUECARD (7/07) and any amendments.

CareFirst BlueChoice

www.carefirst.com

CUT5962-1P (10/10) ■ MSGR ■ Option 3

Prescription Drug Program

UPGRADE II
$0 Deductible ■ $10/20/30 Retail Copays

The Three Tier Prescription Drug Program

This prescription drug program is offered as part of your health care benefits. This program covers both non-maintenance and maintenance prescription drugs dispensed by a retail pharmacy or designated mail service pharmacy.

This program is based on the CareFirst BlueCross BlueShield (CareFirst) or CareFirst BlueChoice, Inc. (CareFirst BlueChoice) preferred drug list, which is made up of certain brand name prescription drugs (Tier 2) and all generic prescription drugs (Tier 1). Your participating physician has a complete copy of the CareFirst or CareFirst BlueChoice preferred drug list. The preferred drug list changes frequently in response to Food and Drug Administration (FDA) requirements. The list is also adjusted when a generic drug is introduced for a brand name drug. When that happens, the generic drug will be added to the Tier 1 list and the brand name drug will move from Tier 2 to Tier 3.

How Do I Use My Benefit?

Talk to your doctor when you are prescribed medications to see if you are using drugs that are on the preferred drug list – these are also known as Tier 1 or Tier 2 drugs. You will save the most money if you can take those medications. You can get your prescription filled by using the retail or mail order programs. If you have questions about your coverage, call Argus Health Systems at (800) 241-3371.

Retail Program

The retail program provides up to a 34-day supply of medication. Simply present your prescription drug identification card at a participating pharmacy nationwide and pay the appropriate copayment for your medication.

Mail Order Program

The mail service program is a convenient way for you to order medications. Your prescription is reviewed and dispensed by registered pharmacists and mailed directly to your home. Call Walgreens Mail Service at (800) 745-6285 for more information.

Maintenance Drugs

Up to a 90-day supply of maintenance drugs are available through mail order or retail pharmacy at twice the appropriate copayment for your medication. Maintenance medication is a prescription drug anticipated to be required for 6 months or more to treat a chronic condition.

Access **www.carefirst.com/rx** for more information and for the most up-to-date preferred drug list.

Prescription Drug Program

Summary of Benefits

Plan Feature	Amount	Description
Deductible	None	Your benefit does not have a deductible.
Generic Drugs (Tier 1) (up to a 34-day supply)	$10	All generic drugs are covered at this copay level.
Preferred Brand Name Drugs (Tier 2) (up to a 34-day supply)	$20	All preferred brand name drugs are covered at this copay level.
Non-Preferred Brand Name Drugs (Tier 3) (up to a 34-day supply)	$30	All non-preferred brand name drugs are covered at this copay level. These drugs are not on the preferred drug list. Check the online preferred drug list to see if there is an alternative drug available. Discuss using alternatives with your physician or pharmacist.
Annual Maximum	N/A	Your benefit does not have an annual benefit maximum.
Maintenance Copays (up to a 90-day supply)	generic: $20 preferred: $40 non-preferred: $60	Maintenance drugs of up to a 90-day supply are available for twice the copay through the mail service or retail pharmacy.
Generic Substitution	Yes	If you choose a non-preferred brand name drug (Tier 3) over its generic equivalent (Tier 1) you will pay the highest copay PLUS the difference in cost between the non-preferred brand name drug and the generic drug up to the cost of the prescription.
Prior Authorization	Yes	Some prescription drugs require Prior Authorization. Prior Authorization is a tool used to ensure that you will achieve the maximum clinical benefit from the use of specific targeted drugs. Your physician or pharmacist must call (800) 294-5979 to begin the prior authorization process. For the most up-to-date prior authorization list, visit the prescription drug web site at **www.carefirst.com/rx**.

This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Policy Form Numbers: 13.607 (R. 10/06) • MD/CF/MSGR/RX/PPO (7/06) • MD/CFBC/MSGR/RX (7/06) • MD/CF/MSGR/RX/PPO (7/06) MD/CFMI/MSGR/RX/PPO (4/09).

Did You Know?

- If the cost of your medication is less than your copayment, you pay the cost of the medication.
- A generic drug is a prescription drug that by law must have the equivalent chemical composition as a specific brand name prescription drug.
- You can use your prescription drug card at more than 59,000 participating pharmacies nationwide.
- Frequently asked questions about your prescription benefits are available at **www.carefirst.com/rx**.

CareFirst BlueChoice

CareFirst BlueCross BlueShield

CUT5708-1P (11/10) ■ MSGR