BlueChoice HMO

Summary of Benefits

SERVICES	In-Network You Pay
ANNUAL DEDUCTIBLE[1]	
Individual	None
Individual & Child(ren)	None
Individual & Adult	None
Family	None
ANNUAL OUT-OF-POCKET LIMIT[1]	
Individual	$3,300
Individual & Child(ren)	$6,600
Individual & Adult	$6,600
Family	$6,600
LIFETIME MAXIMUM	None
PREVENTIVE SERVICES	
Well-Child Care	
0-24 months	No charge*
24 months-13 years (immunization visit)	No charge*
24 months-13 years (non-immunization visit)	No charge*
14-17 years	No charge*
Adult Physical Examination	No charge*
Routine GYN Visits	No charge*
Mammograms	No charge*
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge*
OFFICE VISITS, LABS & TESTING	
Office Visits for Illness	$30 PCP/$40 Specialist per visit
Diagnostic Services	$40 or 50% of cost, whichever is less
X-ray and Lab Tests	$40 or 50% of cost, whichever is less
Allergy Testing[2]	$30 PCP/$40 Specialist per visit
Allergy Shots[2]	$30 PCP/$40 Specialist per visit
Outpatient Physical, Speech and Occupational Therapy[3] (limited to 30 visits/condition/benefit period)	$40 per visit
Outpatient Chiropractic[3,4] (limited to 20 visits/condition/benefit period)	$40 per visit
EMERGENCY CARE AND URGENT CARE	
Physician's Office	$30 PCP/$40 Specialist per visit
Urgent Care Center	$40 per visit
Hospital Emergency Room	$100 per visit (waived if admitted)
Ambulance (if medically necessary)	No charge*
HOSPITALIZATION[5]	
Inpatient Facility Services	$1,000 per admission
Outpatient Facility Services	$40 per visit
Inpatient Physician Services	$30 PCP/$40 Specialist per visit
Outpatient Physician Services	$40 per visit

SERVICES	In-Network You Pay
HOSPITAL ALTERNATIVES[5]	
Home Health Care	No charge*
Hospice	No charge*
Skilled Nursing Facility (limited to 100 days/year)[3]	$40 per day
MATERNITY	
Prenatal and Postnatal Office Visits	$30 per visit
Delivery and Facility Services[5]	$1,000 per admission
Nursery Care of Newborn[6]	No charge*
Initial Office Consultation(s) for Infertility Services/Procedures	$40 Specialist per visit
Artificial Insemination[7]	50% of the Allowed Benefit (after diagnosis is confirmed)
In Vitro Fertilization Procedures[7]	Not covered
MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)[5]	
Inpatient Facility Services (limited to 60 days/benefit period)	$1,000 per admission
Inpatient Physician Services	$30 PCP/$40 Specialist per visit
Outpatient Services (MH & SA)	30% of the Allowed Benefit
Partial Hospitalization[3] (each day counts as 1/2 day toward inpatient limit)	$1,000 per admission
Medication Management Visit	$30 PCP/$40 Specialist per visit
MISCELLANEOUS	
Durable Medical Equipment[5]	No charge*
Acupuncture	$40 Specialist per visit
Transplants[5]	Covered as stated in Evidence of Coverage
Hearing Aids for ages 0-18 (limited to one hearing aid every 3 years)[3]	No charge*
VISION	
Routine Exam (optometrist or ophthalmologist) (limited to 1 visit/benefit period)	$10 per visit at Participating Vision Provider
Eyeglasses and Contact Lenses	Discounts at Participating Vision Centers

* No copayments or coinsurance.
[1] Please refer to your Evidence of Coverage to determine your coverage level.
[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.

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/EOC (R. 7/08); MD/CFBC/MSGR/GC (R. 9/09); MD/CFBC/SOB/CORE (R. 1/09); MD/CFBC/MSGR/GS (9/09); MD/CFBC/MSGR/DOCS (7/07); MD/CFBC/DOL APPEAL (R. 6/06); MD/CFBC/MSGR/BLUECARD (7/07) and any amendments.

CareFirst BlueChoice

www.carefirst.com

Pharmacy Program

$2,500 Individual Deductible ■ $5,000 Family Deductible
75% Member Coinsurance ■ CORE

Summary of Benefits

Plan Feature	Amount	Description
Deductible	$2,500 Individual $5,000 Family	Once you meet your deductible, you will pay a 75% coinsurance whether you receive a generic drug, preferred brand name drug or non-preferred brand name drug.
Generic Drugs (Tier 1) (up to a 34-day supply)	75% Coinsurance	All generic drugs are covered at this copay level.
Preferred Brand Name Drugs (Tier 2) (up to a 34-day supply)	75% Coinsurance	All preferred brand name drugs are covered at this copay level.
Non-Preferred Brand Name Drugs (Tier 3) (up to a 34-day supply)	75% Coinsurance	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.
Maintenance Copays (up to a 90-day supply)	75% Coinsurance	Maintenance drugs of up to a 90-day supply are available through the Rx Delivered or retail pharmacy.
Mandatory Generic Substitution	Yes	If you choose a non-preferred brand name drug (Tier 3) when a generic equivalent (Tier 1) is available, 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. If a generic option is not available, you will only pay the appropriate copay.
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**.

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Policy Form Numbers: MD/CF/MSGR/SOB/PPO/CORE (7/07) • CF/MD/PPN/CHGS/AMEND (7/06) • CF/MD/POS/CHGS/AMEND (7/06) • MD/CFBC/MSGR/SOB/CORE (7/06) • MD/CFMI/MSGR/RX/PPO (4/09).

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

CareFirst BlueChoice

CareFirst BlueCross BlueShield

CUT6945-1P (5/11) ■ MSGR