

OPEN ACCESS
No PCP Referrals

BlueChoice Opt-Out

Summary of Benefits

MARYLAND SMALL GROUP REFORM

SERVICES	IN-NETWORK YOU PAY	OUT-OF-NETWORK YOU PAY ⁽⁴⁾
Annual Deductible and Annual Out-of-Pocket Maximums		
Out-of-Pocket Limit⁽²⁾		
• Single	\$3,300	(combined in- and out-of-network)
• Subscriber & Child	\$6,400	
• Subscriber & Spouse	\$7,700	
• Family	\$10,100	
Lifetime Maximum Per Person	Unlimited	Unlimited
Preventive Services and Office Visits		
Adult preventive check-ups and physicals	\$10 PCP/\$20 Specialist	20%
Well-child (including immunizations)		
• 0 through 13	\$10 Copay	20%
• 14 years and older	\$10 Copay	20%
Outpatient mammography screening		
• age 40-49 once every other calendar year	Paid in full	20%
• age 50+ once/calendar year	Paid in full	20%
Allergy shots	\$10 PCP/\$20 Specialist	20%
Allergy testing	Paid in full	20%
Office visits for illness	\$10 PCP/\$20 Specialist	20%
Outpatient physical, speech and occupational therapy; Payable to a maximum of 30 visits/condition/year ⁽⁴⁾	\$20 Copay	20%
Outpatient chiropractic services limited to 20 visits/condition/year ⁽⁴⁾	\$20 Copay	20%
Routine GYN visits	\$10 Copay	20%
Prostate cancer screening	Paid in full	20%
Habilitative benefits: Outpatient occupational, physical and speech therapy visits for congenital disorders and birth defects, 0 through 18 years	\$20 Copay	20%
Nutritional services for treatment of cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, kidney disease (6 visits/condition/year) ⁽⁴⁾	Paid in full	20%
Maternity		
Prenatal and postnatal	\$10 Copay	20%
Delivery and hospitalization	Paid in full	20%
Diagnostic services and lab tests	Paid in full	20%
Artificial insemination	Plan pays 50% of allowed charges (after diagnosis is confirmed)	50%
Nursery care of newborn ⁽³⁾	Paid in full	20%
In vitro fertilization, GIFT, Ovum transplant, zygote intrafallopian transfer	Not covered	Not covered

(Continued next side)

NOTE: This is a summary of the benefits available through CareFirst BlueChoice whenever medically necessary and performed or authorized by the Member's designated CareFirst BlueChoice Primary Care Physician.

SERVICES	IN-NETWORK YOU PAY	OUT-OF-NETWORK YOU PAY ⁽⁴⁾
Hospitalization (365 days per year)⁽⁴⁾		
Inpatient semi-private room and board, operating/recovery room	Paid in full	20%
Physician consultation	Paid in full	20%
Prescription drugs (inpatient)	Paid in full	20%
Hospital Alternatives		
Home health care	Paid in full	20%
Hospice	Paid in full	20%
Skilled nursing facility (100 days/year) ⁽⁴⁾	Paid in full	20%
Medical and Surgical Services		
Outpatient specialty physician	\$20 Copay	20%
Second surgical opinions	\$20 Copay	20%
Outpatient surgery	\$20 Copay	20%
Diagnostic tests, X-ray and lab tests	Paid in full	20%
Outpatient preadmission testing	Paid in full	20%
Mental Health/Alcohol and Substance Abuse (Combined)		
Hospitalization limited to 60 days per year; ⁽⁴⁾ may substitute 2 partial days for 1 full day	Paid in full	40%
Outpatient visits	30%	50%
Inpatient detoxification	Paid in full	40%
Emergency Care and Urgent Care		
Primary Care Physician's office	\$10 Copay	Paid as in-network
Plan Urgent Care Center	\$20 Copay	Paid as in-network
Hospital Emergency room or Non-Plan Facility	\$35 Copay (waived if admitted)	Paid as in-network
Ambulance (medically necessary)	Paid in full	20%
Miscellaneous Services		
Medical Devices (including Durable Medical Equipment)	Paid in full	20%
Vision Services		
Annual Routine Vision Exams (additional charge for contact lens exams) • Participating Vision Care Center • Participating Ophthalmologist	\$10 Copay \$25 Copay	Plan pays \$20, Member pays balance Plan pays \$30, Member pays balance
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers	Plan pays allowance based on purchase

(1) Out-of-network coinsurances are based on a percentage of the out-of-network Plan Allowance. Member may be responsible for any amount above Plan Allowance.

(2) The Family Out-of-Pocket Limit can be met entirely by one Member or by combining eligible expenses of two or more Members.

(3) Newborns must be enrolled within 31 days of birth.

(4) 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.

These programs are available to self-employed individuals who earn a substantial portion of their income from self-employment. In addition, certain licensed professionals can purchase this coverage. Self-employed individuals who wish to purchase this coverage will be required to provide proof of self-employed income. If you have any questions, please contact your broker or sales representative.

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 number on the front of your CareFirst BlueChoice (BlueChoice) ID card for assistance in selecting a PCP or obtaining a printed copy of the 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 10/01 • DOCS-HMO REV (MSGR) (R. 7/03) • SOB-HMO-CORE REV (MSGR) 10/01 • MD/BC/MSGR CHGS 3/02 • CC/HMO/IP COPAY (MSGR) 7/01 • MD/BC/VISION (MSGR) 12/01 • BC OPT-OUT OPEN ACCESS MSGR (4/03) • SOB-HMO-ENH OPEN ACCESS MSGR (4/03) • MD/BC/AMEND EOC (MSGR) (7/03)

CareFirst BlueChoice, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.
® Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.