

BluePreferred

MARYLAND SMALL GROUP REFORM

Summary of Benefits

SERVICES	PREFERRED PROVIDERS IN-NETWORK YOU PAY ⁽¹⁾	NON-PREFERRED PROVIDERS OUT-OF-NETWORK YOU PAY ⁽²⁾
Annual Deductible and Annual Out-of-Pocket Maximums		
Deductible • Individual • Two-Party or Family	\$400 \$800	\$400 \$800
Out-of-Pocket Limit • Individual • Two-Party or Family	\$2,750 \$5,500	\$2,750 \$5,500
Lifetime Maximum per person	\$2,000,000	\$2,000,000
Preventive Services and Office Visits		
Well-Child Care (including immunizations and boosters) • 0 through 24 months • older than 24 months through 13 years • 14 through 17 years	\$10 Copay \$10 Copay \$10 Copay	\$10 Copay \$10 Copay 20%
Adult Preventive Check-ups and Physicals	\$10 Copay	Deductible, then 20%
Routine GYN Visits	\$10 Copay	Deductible, then 20%
Allergy Tests	Deductible	Deductible, then 20%
Allergy Shots	\$5 Copay	Deductible, then 20%
Nutritional Services for treatment of cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, kidney disease (6 visits/condition/year) ⁽⁶⁾	\$10 Copay	Deductible, then 20%
Other Preventive Services and Office Visits		
Outpatient Mammography Screening	\$0	CareFirst participating provider: \$0 ⁽²⁾ Non-participating provider: Balance above Plan Allowance ⁽²⁾
Prostate Cancer Screening	\$0	CareFirst participating provider: \$0 ⁽²⁾ Non-participating provider: Balance above Plan Allowance ⁽²⁾
Office Visits for Illness	\$10 Copay	Deductible, then 20%
Outpatient Physical, Speech and Occupational Therapy (up to 30 visits per therapy/condition/year) ⁽⁴⁾⁽⁶⁾	Deductible	Deductible, then 20%
Habilitative Benefits: Outpatient occupational, physical and speech therapy visits for congenital disorders and birth defects, 0 through 18 years ⁽⁴⁾	Deductible	Deductible, then 20%
Outpatient Chiropractic Services (limited to 20 visits/condition/year) ⁽⁴⁾⁽⁶⁾	Deductible	Deductible, then 20%
Medical and Surgical Services		
Outpatient Physician (if office visit)	\$10 Copay	Deductible, then 20%
Second Surgical Opinions	\$10 Copay	Deductible, then 20%
Outpatient Hospital Services or Surgery	Deductible	Deductible, then 20%
Diagnostic Tests, X-ray and Lab Tests	Deductible	Deductible, then 20%
Outpatient Preadmission Testing	Deductible	Deductible, then 20%

(Continued next side)

NOTE: This summary is for comparison purposes only and does not create rights not given through the 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-employment income. If you have questions, please contact your Broker or a CareFirst BlueCross BlueShield Sales Representative

SERVICES	PREFERRED PROVIDERS IN-NETWORK YOU PAY ⁽¹⁾	NON-PREFERRED PROVIDERS OUT-OF-NETWORK YOU PAY ⁽²⁾
Mental Health/Alcohol and Substance Abuse (Combined)		
Hospitalization (limited to 60 days per year; ⁽⁶⁾ may substitute 2 partial days for 1 full day)	Deductible	Deductible, then 20%
Outpatient Visits (per year) ⁽⁶⁾	Deductible, then 20%	Deductible, then 35%
Inpatient Detoxification	Deductible	Deductible, then 20%
Medication Management Visit	\$10 Copay	Deductible, then 20%
Hospital Alternatives		
Home Health Care	Deductible	Deductible, then 20%
Hospice	Deductible	Deductible, then 20%
Skilled Nursing Facility (100 days/year) ⁽⁶⁾	Deductible	Deductible, then 20%
Hospitalization (365 days per year)⁽⁶⁾		
Inpatient Semi-Private Room and Board, Operating/Recovery Room	Deductible	Deductible, then 20%
Physician Services	Deductible	Deductible, then 20%
Other Medical Services (anesthesia, consultations, etc.)	Deductible	Deductible, then 20%
Maternity		
Prenatal and Postnatal Care (when billed with delivery)	Deductible	Deductible, then 20%
Delivery and Hospitalization	Deductible	Deductible, then 20%
Diagnostic Services and Lab Tests	Deductible	Deductible, then 20%
Artificial Insemination	Deductible, then 50%	Deductible, then 50%
In Vitro Fertilization, GIFT, Ovum Transplant, Zygote Intrafallopian Transfer	Not Covered	Not Covered
Nursery Care of Newborn	Deductible	Deductible, then 20%
Miscellaneous Services		
Durable Medical Equipment	Deductible	Deductible, then 20%
Hearing Aids for ages 0-18; limited to \$1,400 per hearing aid (every 3 years) ⁽⁶⁾	Deductible	Deductible, then 20%
Vision Services		
Annual Routine Vision Exams • Participating Vision Service Providers	\$10 Copay	Total charge minus \$20
Eyeglasses and Contact Lenses	Discounts available from Participating Providers	Not covered
Emergency Care		
Emergency Room (copay waived if admitted) ⁽⁵⁾ • Facility, physician services, ancillaries	Deductible, \$35 Copay	Deductible, \$35 Copay
Physician's Office	\$10 Copay	\$10 Copay
Ambulance	Deductible	Deductible

(1) In-network: When you have care rendered by or are referred to a provider in the Preferred Provider network. In-network coinsurances are based on a percentage of the 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.

(2) 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. The Plan Allowance is generally the contracted rates or fee schedules that Participating Providers have agreed to accept as payment for covered services. These payments are established by CareFirst, however, in certain circumstances, an allowance may be established by law. When services are rendered by Non-Participating Providers, charges in excess of the Plan Allowance are the member's responsibility.

(3) The Family Deductible can be met entirely by one Member or by combining eligible expenses of two or more members. The Family Out-of-Pocket Limit can be met in the same way.

(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 BluePreferred 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.

General Exclusions This plan will not pay for: Services or supplies which, in the opinion of CareFirst, are not medically necessary or appropriate; Services or supplies which, in the opinion of CareFirst, are experimental, investigational, or not in accordance with accepted medical or psychiatric practices.

Not all services and procedures are covered by your benefits contract. This list is a summary and is not intended to itemize every procedure not covered by CareFirst BlueCross BlueShield. 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: DOCS-PPO REV (R. 7/03) • COC-NCA (MSGR) REV 10/01 • SOB-PPO-CORE REV (MSGR) 7/01 PPO-ENH 100/80 (MSGR) REV 9/02 • MD/PPO/MSGR CHGS 3/02 and any amendments to these form numbers.

Medical
Option **7**

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