

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) ⁶		None
Individual & Adult		None
Family		None
ANNUAL OUT-OF-POCKET LIMIT³		
Individual	\$3,300	
Individual & Child(ren) ⁶	\$6,400	(combined in- and out-of-network)
Individual & Adult	\$7,700	
Family	\$10,100	
LIFETIME MAXIMUM		Unlimited
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months	\$10 per visit	40% of Plan Allowance*
24 months-13 years (immunization visit)	\$10 per visit	40% of Plan Allowance*
24 months-13 years (non-immunization visit)	\$20 per visit	40% of Plan Allowance*
14-17 years	\$20 per visit	40% of Plan Allowance*
Adult Physical Examination	\$20 PCP/\$30 Specialist per visit	40% of Plan Allowance*
Routine GYN Visits	\$20 per visit	40% of Plan Allowance*
Mammograms	No charge ²	40% of Plan Allowance*
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge ²	40% of Plan Allowance*
OFFICE VISITS, LABS & TESTING		
Office Visits for Illness	\$20 PCP/\$30 Specialist per visit	40% of Plan Allowance*
Diagnostic Services	No charge ²	40% of Plan Allowance*
X-ray and Lab Tests	No charge ²	40% of Plan Allowance*
Allergy Testing ⁷	\$20 PCP/\$30 Specialist per visit	40% of Plan Allowance*
Allergy Shots ⁷	\$20 PCP/\$30 Specialist per visit	40% of Plan Allowance*
Outpatient Physical, Speech and Occupational Therapy ⁵ (limited to 30 visits/condition/benefit period)	\$30 per visit	40% of Plan Allowance*
Outpatient Chiropractic ⁵ (limited to 20 visits/condition/benefit period)	\$30 per visit	40% of Plan Allowance*
EMERGENCY CARE AND URGENT CARE		
Physician's Office	\$20 PCP/\$30 Specialist per visit	Paid as in-network
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 ²	40% of Plan Allowance*
HOSPITALIZATION		
Inpatient Facility Services	No charge ²	40% of Plan Allowance*
Outpatient Facility Services	\$30 per visit	40% of Plan Allowance*
Inpatient Physician Services	No charge ²	40% of Plan Allowance*
Outpatient Physician Services	\$30 per visit	40% 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 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		
Home Health Care	No charge ²	40% of Plan Allowance ⁴
Hospice	No charge ²	40% of Plan Allowance ⁴
Skilled Nursing Facility (limited to 100 days/year) ⁵	No charge ²	40% of Plan Allowance ⁴
MATERNITY		
Prenatal and Postnatal Office Visits	\$20 PCP/\$30 Specialist per visit	40% of Plan Allowance ⁴
Delivery and Facility Services	No charge ²	40% of Plan Allowance ⁴
Nursery Care of Newborn ⁴	No charge ²	40% of Plan Allowance ⁴
Artificial Insemination ¹	50% of the allowed charges (after diagnosis is confirmed)	50% of Plan Allowance ⁴
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)	No charge ²	40% of Plan Allowance ⁴
Inpatient Physician Services	No charge ²	40% of Plan Allowance ⁴
Outpatient Services (MH & SA)	30% of the allowed benefit	50% of Plan Allowance ⁴
Partial Hospitalization ⁵ (each day counts as 1/2 day toward Inpatient limit)	No charge ²	40% of Plan Allowance ⁴
Medication Management Visit	\$20 PCP/\$30 Specialist per visit	40% of Plan Allowance ⁴
MISCELLANEOUS		
Durable Medical Equipment	No charge ²	40% of Plan Allowance ⁴
Acupuncture	Covered only when medically necessary and plan approved for anesthesia and when services are rendered in conjunction with Physical Therapy	Covered only when 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) ⁵	No charge ²	40% of Plan Allowance
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 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 No copayments or coinsurance.
- 3 The Out-of-Pocket Limit can be met entirely by one Member or by combining eligible expenses of two or more members.
- 4 Newborns must be enrolled within 31 days of birth.
- 5 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.
- 6 Please refer to your Evidence of Coverage to determine your coverage level.
- 7 If office copayment has been paid, additional office copayment not required for this service.
- Out-of-network coinsurances are based on a percentage of the out-of-network Plan Allowance. Member is responsible for 100% of charges above Plan Allowance.

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: EOC-CC (MSGR) REV 10/05 • DOCS-HMO REV (MSGR) (R. 7/03) • SOB-HMO-CORE REV (MSGR) 7/04 • MD/BC/OOP/VISION (R. 6/04) • MD/BC OO/OA MSGR (4/04) • MD/BC/AMEND DOCS OPEN ACCESS MSGR (4/03) • SOB-HMO-ENHANCE MSGR (R. 1/05) and any amendments.

Prescription Drug Program

\$100 Deductible
\$15/25/50 Retail Copays
UPGRADE V

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 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 BlueChoice preferred drug list. A copy can also be found at www.carefirst.com/rx.

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 also see if medications you are currently taking are on the preferred drug list by visiting the prescription drug site at www.carefirst.com/rx. You can get your prescription filled by using the retail or mail order programs.

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.

Retail Program

The retail program provides up to a 34-day supply of medication. Simply present your prescription drug identification card at one of more than 59,000 participating pharmacies nationwide and pay the appropriate copayment for your medication. Once your \$100 deductible has been met, you will pay the following for drugs:

Generic Drug (Tier 1)	\$15
Preferred Brand Name Drug (Tier 2)	\$25
*Non-Preferred Brand Name Drug (Tier 3)	\$50

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.

34-day supply	1 Copay
35 to 90-day supply (maintenance only)	2 Copays

Maintenance Drugs

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

Generic Drug (Tier 1)	\$30
Preferred Brand Name Drug (Tier 2)	\$50
*Non-Preferred Brand Name Drug (Tier 3)	\$100

* Non-preferred brand name drugs are not part of the preferred drug list but are covered at the highest copay.

ACCESS www.carefirst.com/rx FOR MORE INFORMATION ABOUT THE 3-TIER PRESCRIPTION DRUG PROGRAM AND FOR THE MOST UP-TO-DATE PREFERRED DRUG LIST.

Maryland Small Group Reform

Benefits Summary

Plan Feature	Amount	Description
Deductible	\$100	Once you meet your deductible, you will pay a different copay depending on whether you receive a generic drug, preferred brand name drug or non-preferred brand name drug.
Generic Drugs (Tier 1) <i>(up to a 34-day supply)</i>	\$15	All generic drugs are covered at this copay level.
Preferred Brand Name Drugs (Tier 2) <i>(up to a 34-day supply)</i>	\$25	All preferred brand name drugs are covered at this copay level.
Non-Preferred Brand Name Drugs (Tier 3) <i>(up to a 34-day supply)</i>	\$50	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 <i>(up to a 90-day supply)</i>	generic: \$30 preferred: \$50 non-preferred: \$100	Maintenance drugs of up to a 90-day supply are available for twice your 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 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 .

Need More Information?

On the Phone..

If you have questions about your prescription drug coverage or the preferred drug list, call Argus Health Systems at (800) 241-3371.

You should contact your physician or pharmacist if you have questions regarding the type of drug, side effects, drug interactions, storage, etc.

By Mail...

If you have questions about your Mail Order benefits, call Walgreens Mail Service at (800) 745-6285.

On the Web...

For the most recent information regarding the 3-tier prescription drug program, changes to the preferred drug list, etc. visit the prescription drug web site at www.carefirst.com/rx.

The preferred drug list can change 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. For the most recent information about the preferred drug 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: MD/CFBC/MSGR/RX (7/06)

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