

# BlueChoice Opt-Out

## Summary of Benefits

MARYLAND SMALL GROUP REFORM

SERVICES	IN-NETWORK YOU PAY	OUT-OF-NETWORK YOU PAY <sup>(4)</sup>
<b>Annual Deductible and Annual Out-of-Pocket Maximums</b>		
<b>Out-of-Pocket Limit<sup>(2)</sup></b>		
• Single	\$3,300	(combined in- and out-of-network)
• Subscriber & Child	\$6,400	
• Subscriber & Spouse	\$7,700	
• Family	\$10,100	
<b>Lifetime Maximum Per Person</b>	Unlimited	
<b>Preventive Services and Office Visits</b>		
Office Visits for Illness	\$10 PCP/\$20 Specialist	20%
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%
Allergy Shots	\$10 PCP/\$20 Specialist	20%
Allergy Testing	No charge	20%
Routine GYN Visits	\$10 Copay	20%
Outpatient Mammography Screening		
• age 40-49 once every other calendar year	No charge	20%
• age 50+ once/calendar year	No charge	20%
Prostate Cancer Screening	No charge	20%
Outpatient Physical, Speech and Occupational Therapy; Payable to a maximum of 30 visits/condition/year <sup>(4)</sup>	\$20 Copay	20%
Habilitative Benefits: Outpatient occupational, physical and speech therapy visits for congenital disorders and birth defects, 0 through 18 years	\$20 Copay	20%
Outpatient Chiropractic Services limited to 20 visits/condition/year <sup>(4)</sup>	\$20 Copay	20%
Nutritional Services for treatment of cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, kidney disease (6 visits/condition/year) <sup>(4)</sup>	No charge	20%
<b>Maternity</b>		
Prenatal and Postnatal	\$10 Copay	20%
Delivery and Hospitalization	No charge	20%
Nursery Care of Newborn <sup>(3)</sup>	No charge	20%
Lab Tests	No charge	20%
Artificial Insemination	Plan pays 50% of allowed charges (after diagnosis is confirmed)	50%
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 <sup>(4)</sup>
<b>Hospitalization (365 days per year)<sup>(4)</sup></b>		
Inpatient Semi-private Room and Board, operating/recovery room	No charge	20%
Physician Consultation	No charge	20%
Prescription Drugs (inpatient)	No charge	20%
<b>Hospital Alternatives</b>		
Home Health Care	No charge	20%
Hospice	No charge	20%
Skilled Nursing Facility (100 days/year) <sup>(4)</sup>	No charge	20%
<b>Medical and Surgical Services</b>		
Outpatient Specialty Physician	\$20 Copay	20%
Outpatient Surgery	\$20 Copay	20%
X-ray and Lab Tests	No charge	20%
Second Surgical Opinions	\$20 Copay	20%
Outpatient Preadmission Testing	No charge	20%
<b>Mental Health/Alcohol and Substance Abuse (Combined)</b>		
Hospitalization limited to 60 days per year; <sup>(4)</sup> may substitute 2 partial days for 1 full day	No charge	40%
Outpatient Visits	30%	50%
Inpatient Detoxification	No charge	40%
<b>Emergency Care and Urgent Care</b>		
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
<b>Miscellaneous Services</b>		
Ambulance (medically necessary)	No charge	20%
Medical Devices (including Durable Medical Equipment)	No charge	20%
Hearing Aids for ages 0-18; limited to \$1,400 max per hearing aid (every 3 years)	No charge	20%
<b>Vision Services</b>		
Annual Routine Vision Exams • Participating Vision Care Center	\$10 Copay	Plan pays \$20, 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](http://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)

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