

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		
• Self-Only	No Deductible	\$400
• Two-Party or Family	No Deductible	\$800
Out-of-Pocket Limit		
• Self-Only	\$2,750	\$2,750
• Two-Party or Family	\$5,500	\$5,500
Lifetime Maximum per person	\$2,000,000 (combined in- and out-of-network)	
Preventive Services and Office Visits		
Office Visits for Illness	\$10 Copay	Deductible, then 20%
Adult Preventive Check-ups and Physicals	\$10 Copay	Deductible, then 20%
Well-Child (including immunizations and boosters)		
• 0 through 24 months	\$10 Copay	\$10 Copay
• older than 24 months through 13 years	\$10 Copay	\$10 Copay
• 14 through 17 years	\$10 Copay	20%
Allergy Shots	\$5 Copay	Deductible, then 20%
Allergy Testing	\$5 Copay	Deductible, then 20%
Routine GYN Visits	\$10 Copay	Deductible, then 20%
Outpatient Mammography Screening	No charge	CareFirst participating provider: \$0 ⁽²⁾ Non-participating provider: Balance above Plan Allowance ⁽²⁾
• age 40-49 once every other calendar year		
• age 50+ once/calendar year		
Prostate Cancer Screening	No charge	CareFirst participating provider: \$0 ⁽²⁾ Non-participating provider: Balance above Plan Allowance ⁽²⁾
Outpatient Physical, Speech and Occupational Therapy (up to 30 visits per therapy/condition/year) ⁽⁴⁾⁽⁶⁾	\$15 Copay	Deductible, then 20%
Habilitative Benefits (outpatient occupational, physical and speech therapy visits for congenital disorders and birth defects, 0 through 18 years) ⁽⁴⁾	\$15 Copay	Deductible, then 20%
Outpatient Chiropractic Services (limited to 20 visits/condition/year) ⁽⁴⁾⁽⁶⁾	\$15 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%
Maternity		
Prenatal and Postnatal Care (when billed with delivery)	No charge	Deductible, then 20%
Delivery and Hospitalization	No charge	Deductible, then 20%
Nursery Care of Newborn	No charge	Deductible, then 20%
Lab Tests	No charge	Deductible, then 20%
Artificial Insemination	50%	Deductible, then 50%
In Vitro Fertilization, GIFT, Ovum Transplant, Zygote Intrafallopian Transfer	Not covered	Not covered

(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⁾
Hospitalization (365 days per year)⁽⁶⁾		
Inpatient Semi-private Room and Board, Operating/Recovery Room	No charge	Deductible, then 20%
Physician Services	No charge	Deductible, then 20%
Other Medical Services (anesthesia, consultations, etc.)	No charge	Deductible, then 20%
Hospital Alternatives		
Home Health Care	No charge	Deductible, then 20%
Hospice	No charge	Deductible, then 20%
Skilled Nursing Facility (100 days/year) ⁽⁶⁾	No charge	Deductible, then 20%
Medical and Surgical Services		
Outpatient Physician (if office visit)	\$10 Copay	Deductible, then 20%
Outpatient Surgery	No charge	Deductible, then 20%
X-ray and Lab Tests	No charge	Deductible, then 20%
Second Surgical Opinions	\$10 Copay	Deductible, then 20%
Outpatient Preadmission Testing	No charge	Deductible, then 20%
Mental Health and Substance Abuse (combined)		
Hospitalization (limited to 60 days per year; ⁽⁶⁾ may substitute 2 partial days for 1 full day)	No charge	Deductible, then 20%
Outpatient Visits (per year) ⁽⁶⁾	20%	Deductible, then 35%
Inpatient Detoxification	No charge	Deductible, then 20%
Medication Management Visit	\$10 Copay	Deductible, then 20%
Emergency Care		
Physician's Office	\$10 Copay	\$10 Copay
Emergency Room (copay waived if admitted) ⁽⁵⁾ • Facility, physician services, ancillaries	\$35 Copay	Deductible, \$35 Copay
Miscellaneous Services		
Ambulance	No charge	Deductible
Durable Medical Equipment	No charge	Deductible, then 20%
Hearing Aids for ages 0-18; limited to \$1,400 max per hearing aid (every 3 years) ⁽⁶⁾	No charge	Deductible, then 20%
Vision Services		
Annual Routine Vision Exams • Participating Vision Care Center	\$10 Copay	Total charge minus \$20
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers	Not covered

(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 of 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 • 703 MD/PPO/AMEND/COC (MSGR) (07/03) and any amendments to these form numbers.

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Medical
Option **8**