BlueChoice HMO
Open Access HSA

Summary of Benefits

Services	In-Network You Pay
ANNUAL DEDUCTIBLE[1]	
Individual	$2,700
Individual & Child(ren)	$5,450
Individual & Adult	$5,450
Family	$5,450
ANNUAL OUT-OF-POCKET LIMIT[1]	
Individual	$5,250
Individual & Child(ren)	$10,500
Individual & Adult	$10,500
Family	$10,500
LIFETIME MAXIMUM BENEFIT	None
PREVENTIVE SERVICES	
Well-Child Care	
0-24 months	No charge*
24 months-13 years (immunization visit)	No charge*
24 months-13 years (non-immunization visit)	No charge*
14-17 years	No charge*
Adult Physical Examination	No charge*
Routine GYN Visits	No charge*
Mammograms	No charge*
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge*
OFFICE VISITS, LABS AND TESTING	
Office Visits for Illness	Deductible, then $30 PCP/$40 Specialist per visit
Diagnostic Services	Deductible, then $40 or 50% of cost, whichever is less
X-ray and Lab Tests	Deductible, then $40 or 50% of cost, whichever is less
Allergy Testing[3]	Deductible, then $30 PCP/$40 Specialist per visit
Allergy Shots[3]	Deductible, then $30 PCP/$40 Specialist per visit
Outpatient Physical, Speech and Occupational Therapy[4] (limited to 30 visits/condition/benefit period)	Deductible, then $40 per visit
Outpatient Chiropractic[4,5] (limited to 20 visits/condition/benefit period)	Deductible, then $40 per visit
EMERGENCY CARE AND URGENT CARE	
Physician's Office	Deductible, then $30 PCP/$40 Specialist per visit
Urgent Care Center	Deductible, then $40 per visit
Hospital Emergency Room	Deductible, then $100 per visit (waived if admitted)
Ambulance (if medically necessary)	No charge after deductible*
HOSPITALIZATION[6]	
Inpatient Facility Services	Deductible, then $1,000 per admission
Outpatient Facility Services	Deductible, then $40 per visit
Inpatient Physician Visits	Deductible, then $30 per visit
Outpatient Physician Services	Deductible, then $40 per visit

Services	In-Network You Pay
HOSPITAL ALTERNATIVES[6]	
Home Health Care	No charge after deductible*
Hospice	No charge after deductible*
Skilled Nursing Facility (limited to 100 days/benefit period)[4]	Deductible, then $40 per day
MATERNITY	
Prenatal and Postnatal Office Visits	Deductible, then $30 per visit
Delivery and Facility Services	Deductible, then $1,000 per admission
Nursery Care of Newborn[2]	No charge after deductible*
Initial Office Consultation(s) for Infertility Services/Procedures	Deductible, then $40 Specialist per visit
Artificial Insemination[7]	Deductible, then 50% of the allowed benefit (after diagnosis is confirmed)
In Vitro Fertilization Procedures[7]	Not covered
MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)[6]	
Inpatient Facility Services	Deductible, then $1,000 per admission (limited to 60 days/benefit period)
Inpatient Physician Services	Deductible, then $30 PCP/$40 Specialist per visit
Outpatient Services (MH & SA)	Deductible, then 30% of the allowed benefit
Partial Hospitalization[4] (each day counts as 1/2 day towards inpatient limit)	Deductible, then $1,000 per admission
Medication Management Visit	Deductible, then $30 PCP/$40 Specialist per visit
MISCELLANEOUS	
Durable Medical Equipment[6]	No charge after deductible*
Acupuncture	Deductible, then $40 Specialist per visit
Transplants[6,8]	Deductible, then covered as stated in Evidence of Coverage
Hearing Aids for ages 0-18 (limited to one hearing aid every 3 years)[4]	No charge after deductible*
VISION	
Routine Exam (Optometrist or Ophthalmologist) (limited to 1 visit/benefit period)	Not covered
Eyeglasses and Contact Lenses	Not covered
PRESCRIPTION DRUGS	You pay 100% of the discounted cost of your prescription drugs up to your annual deductible; then, you pay 75% coinsurance until you meet your annual out-of-pocket maximum.

[1] The deductible can be met entirely by one Member or by combining eligible expenses of two or more members. The out-of-pocket can be met in the same way.
[2] Newborns must be enrolled within 31 days of birth.
[3] If office copayment has been paid additional office copayment not required for this service.
[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.
[5] Consultation for chiropractic services is the same as office visit for illness.
[6] Preauthorization required.
[7] 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.
[8] Please refer to your Evidence of Coverage to determine your coverage level.
* No copayments or coinsurance.

HSA plans must be sold with an integrated Rx benefit.
All copayments apply towards the deductible and out-of-pocket limit.

Note: Upon enrollment in CareFirst BlueChoice, you will need to select a Primary Care Provider (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: MD/CFBC/MSGR/GRP APP (R. 9/09); MD/CFBC/MSGR/EOC (R. 7/08); MD/CFBC/MSGR/GC (R. 9/09); MD/BC/AMEND DOCS OPEN ACCESS MSGR (R. 6/09); MD/CFBC/MSGR/GS (9/09); MD/CFBC/MSGR/DOCS (7/07); MD/CFBC/MSGR/HSA/SOB/CORE(R. 1/09); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/MSGR/BLUECARD (7/07) and any amendments.

www.carefirst.com

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Pharmacy Program

Integrated Deductible – CORE

See Annual Deductible on Medical Summary of Benefits
0% Coinsurance ■ 75% Member Coinsurance

Summary of Benefits

Plan Feature	Amount	Description
Deductible	See medical summary of benefit for annual deductible amount	Once you meet your combined medical and drug 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. Preferred Preventive Drugs are not subject to any medical or drug deductible.
Out-of-Pocket Maximum	See medical summary of benefit for annual out-of-pocket amount	Once you reach your out-of-pocket maximum, CareFirst or CareFirst BlueChoice will pay 100% of the applicable allowed benefit for most covered services for the remainder of the year. All deductibles, copays, coinsurance, and other eligible out-of-pocket costs count toward your out-of-pocket maximum. Keep in mind that balance billed amounts do not count toward your annual out-of-pocket maximum.
Preferred Preventive Drugs (up to a 34-day supply)	$0	A Preferred Preventive Drug (not subject to any copay and deductible) is a medication or item on CareFirst's Preferred Preventive Drug List that is prescribed under certain medical criteria by a provider under a written prescription for – Aspirin, Folic Acid, Fluoride, Iron Supplements, Smoking Cessation Products, and FDA approved contraceptives for women. A full copy of this list can be obtained by going to **www.carefirst.com/rx**, clicking on the FAQ icon, and looking for the Preferred Preventive Drugs. This list is subject to change.
Generic Drugs – except Preferred Preventive Drugs (Tier 1) (up to a 34-day supply)	75% Coinsurance	All generic drugs are covered at this copay level.
Preferred Brand Name Drugs (Tier 2) (up to a 34-day supply)	75% Coinsurance	All preferred brand name drugs are covered at this copay level.
Non-Preferred Brand Name Drugs (Tier 3) (up to a 34-day supply)	75% Coinsurance	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.
Maintenance Copays (up to a 90-day supply)	75% Coinsurance	Maintenance drugs of up to a 90-day supply are available through the Rx Delivered or retail pharmacy.
Mandatory Generic Substitution	Yes	If you choose a non-preferred brand name drug (Tier 3) when a generic equivalent (Tier 1) is available, 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. If a generic option is not available, you will only pay the appropriate copay.
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 (800) 294-5979 to begin the prior authorization process. For the most up-to-date prior authorization list, visit the prescription drug website 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/CF/MSGR/SOB/PPO/HSA/CORE (R. 7/07) MD/CFBC/MSGR/HDP/SOB/CORE (10/08) MD/CFMI/MSGR/SOB/PPO/HSA CORE (4/09)

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc.
CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are both independent licensees of the Blue Cross and Blue Shield Association.
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CUT6948-1P (10/12) ■ MSGR ■ Available with CORE Medical only

HealthyBlue 2.0

Non-Integrated *Summary of Benefits*

Services	In-Network	Out-of-Network
HEALTHY REWARD	Earn $300 per adult and up to $700 per family towards reducing your deductible for completing 3 simple steps. Visit www.carefirst.com/healthyblue for more information.	
PROVIDER NETWORK	BlueChoice Network	Out-of-Network
ANNUAL DEDUCTIBLE (BENEFIT PERIOD)[1]		
Individual	$2,000	$4,000
Individual & Child(ren)	$4,000	$8,000
Individual & Adult	$4,000	$8,000
Family	$4,000	$8,000
ANNUAL OUT-OF-POCKET LIMIT (BENEFIT PERIOD)[1]		
Individual	$4,500	$7,500
Individual & Child(ren)	$9,000	$15,000
Individual & Adult	$9,000	$15,000
Family	$9,000	$15,000
LIFETIME MAXIMUM	None	None
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months	No charge*	$10 copay
24 months-13 years (immunization visit)	No charge*	$10 copay
24 months-13 years (non-immunization visit)	No charge*	$10 copay
14-17 years	No charge*	$10 copay
Adult Physical Examination	No charge*	Deductible, then 40% coinsurance
Routine GYN Visits	No charge*	Deductible, then 40% coinsurance
Mammograms	No charge*	Deductible, then 40% coinsurance
Cancer Screening[2] (Pap Test, Prostate and Colorectal)	No charge*	Deductible, then 40% coinsurance
OFFICE VISITS, LABS & TESTING		
Office Visits for Illness	No charge* PCP/$40 Specialist copay	Deductible, then 40% coinsurance
Diagnostic Services	No charge*	Deductible, then 40% coinsurance
X-ray and Lab Tests	No charge*	Deductible, then 40% coinsurance
Allergy Testing[2]	No charge* PCP/$40 Specialist copay	Deductible, then 40% coinsurance
Allergy Shots[2]	No charge* PCP/$40 Specialist copay	Deductible, then 40% coinsurance
Outpatient Physical, Speech and Occupational Therapy[3] (limited to 30 visits/condition/benefit period)	$40 copay	Deductible, then 40% coinsurance
Outpatient Chiropractic[3,4] (limited to 20 visits/benefit period)	$40 copay	Deductible, then 40% coinsurance
EMERGENCY CARE AND URGENT CARE		
Physician's Office	No charge* PCP/$40 Specialist copay	Deductible, then 40% coinsurance
Urgent Care Center	$40 copay	$40 copay
Hospital Emergency Room	Deductible, then $100 copay (waived if admitted)	Deductible, then $100 copay (waived if admitted)
Ambulance (if medically necessary)	No charge*	No charge*
HOSPITALIZATION		
Inpatient Facility Services[5]	Deductible, then $500 copay per admission	Deductible, then 40% coinsurance
Outpatient Facility Services	Deductible, then $40 copay	Deductible, then 40% coinsurance
Inpatient Physician Visits	Deductible, then $30 copay	Deductible, then 40% coinsurance
Outpatient Physician Services	Deductible, then $40 copay	Deductible, then 40% coinsurance

Services	In-Network	Out-of-Network
HOSPITAL ALTERNATIVES[5]		
Home Health Care	Deductible, then no charge*	Deductible, then 40% coinsurance
Hospice	Deductible, then no charge*	Deductible, then 40% coinsurance
Skilled Nursing Facility (limited to 100 days per benefit period)[3]	Deductible, then $40 copay	Deductible, then 40% coinsurance
MATERNITY		
Prenatal and Postnatal Office Visits	Deductible, then $30 copay	Deductible, then 40% coinsurance
Delivery and Facility Services	Deductible, then $500 copay per admission	Deductible, then 40% coinsurance
Nursery Care of Newborn[6]	Deductible, then $30 copay	Deductible, then 40% coinsurance
Initial Office Consultation(s) for Infertility Services/Procedures	Deductible, then $40 Specialist copay	Deductible, then 40% coinsurance
Artificial and Intrauterine Insemination[7]	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance
In Vitro Fertilization Procedures	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE[5]		
Inpatient Facility Services	Deductible, then $500 copay per admission	Deductible, then 40% coinsurance
Inpatient Physician Visits	Deductible, then $30 copay	Deductible, then 40% coinsurance
Outpatient Services (MH & SA)	$40 copay	Deductible, then 40% coinsurance
Partial Hospitalization	Deductible, then $40 copay	Deductible, then 40% coinsurance
Medication Management Visit	No charge* PCP/$40 Specialist copay	Deductible, then 40% coinsurance
MISCELLANEOUS		
Durable Medical Equipment[5]	Deductible, then no charge*	Deductible, then 40% coinsurance
Acupuncture	$40 Specialist copay	Deductible, then 40% coinsurance
Transplants[5,8]	Deductible, then $40 copay	Deductible, then 40% coinsurance
Hearing Aids for ages 0-18 (limited to one hearing aid every 3 years)[3]	Deductible, then $40 copay	Deductible, then 40% coinsurance
VISION		
Routine Exam (limited to 1 visit/benefit period)	$10 per visit at participating Vision Provider	Play pays $33, member pays balance
Eyeglasses and Contact Lenses	Discounts from participating Vision Provider	Not covered

* No copayments or coinsurance.
[1] The deductible can be met entirely by one Member or by combining eligible expenses of two or more members. The out-of-pocket can be met in the same way.
[2] If office copayment has been paid additional office copayment not required for this service.
[3] 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.
[4] Consultation for chiropractic services is the same as office visit for illness.
[5] Preauthorization required.
[6] Newborns must be enrolled within 31 days of birth.
[7] 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.
[8] Please refer to your Evidence of Coverage to determine your coverage level.

Notes: ■ Upon enrollment you will need to select a Primary Care Provider (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 your 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: MD/CFBC/MSGR/GRP APP (R. 9/09); MD/CFBC/MSGR/GC (R. 9/09); MD/CFBC/MSGR/EOC (R, 7/08); MD/CFBC/MSGR/DOCS (7/07); MD/
CFBC/MSGR/OON/HB2 (12/11); MD/CFBC/MSGR/GS (9/09; MD/CFBC/MSGR/HSA/SOB/CORE (R. 1/09); MD/CFBC/MSGR/HDP/SOB/HB2 (8/12); MD/
CFBC/DOL APPEAL (R. 9/11); MD/CFBC/HB/BLUECARD MEM (1/10) and any amendments.

CareFirst BlueChoice, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. CareFirst BlueCross BlueShield is the business name of CareFirst of Maryland, Inc. and an independent licensee of the Blue Cross and Blue Shield Association, providing access to the Preferred Provider Organization Network only and does not assume any financial risk or obligation with respect to claims. ® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.

BlueVision

A plan for healthy eyes, healthy lives

Professional vision services including routine eye examinations, eyeglasses and contact lenses offered by CareFirst BlueChoice, through the Davis Vision, Inc. national network of providers.

Healthy Vision – an Important Asset

Healthy eyes are an important part of your overall health. Routine eye examinations not only keep your eyewear current; they can also detect high-risk health issues such as diabetes and glaucoma before symptoms occur. Whether you have 20/20 vision or 20/200 vision, you should have a routine eye examination on a regular basis to keep your eyes healthy.

That's why we are pleased to offer BlueVision as part of your CareFirst BlueChoice medical coverage, giving you complete eye health as part of your medical plan. BlueVision makes eye health easy, offering a large network of optometrists, ophthalmologists and opticians from which to choose.

To administer your group's vision benefits, CareFirst BlueChoice has selected Davis Vision, Inc. – one of the nation's leading managed vision and eye care providers.

How the Plan Works

How do I find a provider?

BlueVision offers a national network consisting of optometrists, ophthalmologists and opticians. To find a provider, go to **www.carefirst.com** and utilize the "Find a Doctor" feature or call Davis Vision at **(800) 783-5602** for a list of network providers closest to you. Be sure to ask your provider if he or she participates with the Davis Vision network before you receive care.

Need more information? Please visit **www.carefirst.com** or call **(800) 783-5602.**

BlueVision

A plan for healthy eyes, healthy lives

How do I receive care from a network provider?
BlueVision is as easy to use as it is effective. Simply call your provider and schedule an appointment. Identify yourself as a CareFirst BlueChoice member and provide the doctor with your identification number, as well as your date of birth. Then go to the provider to receive your service. There are no claim forms to file.

Summary of Benefits: (12-month benefit period)

In-Network	You Pay
Eye Examinations	
Routine Eye Examination with dilation (per benefit period)	$10

In-Network	You Pay
Frames[2]	
Priced up to $70 retail	$40
Priced above $70 retail	$4o, plus 90% of the amount over $70
Spectacle Lenses[2]	
Single Vision	$35
Bifocal	$55
Trifocal	$65
Lenticular	$110
Lens Options *(add to spectacle lens prices above)*[2,3]	
Standard Progressive Addition Lenses	$75
Premium Progressive Addition Lenses	$125
Polarized Lenses	$75
High Index Lenses	$55
Glass Lenses	$18

1 At certain retail locations, members receive comparable value through their everyday low price on examination, frame and contact lens purchase.
2 CareFirst BlueChoice does not underwrite lenses, frames and contact lenses in this program. This portion of the Plan is not an insurance product.
3 Please note that special lens designs, materials, powers and frames may require additional cost.
4 Please note that some providers have flat fees that are equivalent to these discounts.

In-Network	You Pay
Lens Options *(continued)*[2,3]	
Polycarbonate Lenses	$30
Blended Invisible Bifocals	$20
Intermediate Vision Lenses	$30
Photogrey Extra® Lenses	$35
Scratch-Resistant Coating	$20
Standard ARC (anti-reflective coating)	$45
Ultraviolet (UV) Coating	$15
Solid Tint	$10
Gradient Tint	$12
Plastic Photosensitive Lenses	$65
Contact Lenses[2]	
Contact Lens Evaluation and Fitting	85% of Retail Price
Conventional	80% of Retail Price
Disposable/Planned Replacement	90% of Retail Price
Lens 1-2-3® Mail Order Contact Lens Replacement Program	Up to 40% off Retail Prices
Laser Vision Correction[2]	Up to 25% off allowed amount or 95% of advertised special[4]

Out-of-Network	You Pay
Routine Eye Examination with dilation (per benefit period)	Plan pays $33, you pay balance
Frames[2]	Plan pays $15, you pay balance
Single Lenses[2]	Plan pays $20, you pay balance
Bifocal Lenses[2]	Plan pays $35, you pay balance
Trifocal Lenses[2]	Plan pays $45, you pay balance
Medically Necessary Contacts[2]	Plan pays $80, you pay balance
Routine Contacts[2]	Plan pays $10, you pay balance
Bifocal Contacts[2]	Plan pays $10, you pay balance

Other DISCOUNTS available through the network manager Davis Vision, Inc.

What if I go out-of-network?

BlueVision offers an allowance for a routine eye exam, eyeglasses, and contact lenses at a non-Davis Vision provider. You will be responsible for paying the entire amount of the service fees up-front. Out-of-network benefits are limited to an allowed benefit. After the services, you can submit your claim to Davis Vision for reimbursement. You can find the claim form by going to **www.carefirst.com**, locate *"Solution Center,"* then click on *"Claim Forms."*

May I use my benefit at different times?

Of course there will be times when you choose not to select your eyeglasses at the same time you receive your examination. You may "split" your benefits by getting your examination and your eyewear at different times. You don't even need to go to the same provider, but your care will be most effective when you stay with the same provider. When bringing an outside prescription to any provider, please confirm in advance that the provider will fill an outside prescription.

Can I get contacts and eyeglasses in the same benefit period?

With BlueVision, you receive one pair of eyeglasses or a supply of contact lenses per benefit period at a discounted price. Charges for contact lens evaluation and fitting are discounted through the plan. You are entitled to one pair of eyewear or a supply of contact lenses per benefit year.

Laser Vision Correction Services

CareFirst BlueChoice is pleased to provide you and your eligible dependents with the opportunity to receive Laser Vision Correction Services at significant discounts through a network of experienced, credentialed surgeons. For more information, visit **www.carefirst.com** and click on "Members & Visitors," then click on "Benefit Summaries."

Mail Order Replacement Contact Lenses

Free membership and access to a mail order replacement contact lens service, Lens 1-2-3®, provides a fast and convenient way to purchase replacement contact lenses at significant savings. For more information, please call **(800) LENS-123 (800-536-7123)** or visit **www.Lens123.com**.

Exclusions

The following services are excluded from coverage:

1. Diagnostic services, except as listed in WHAT IS COVERED under the evidence of coverage.
2. Medical care or surgery. Covered services related to medical conditions of the eye may be covered under the evidence of coverage.
3. Prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the evidence of coverage or a rider or endorsement purchased by your Group and attached to the evidence of coverage.
4. Services or supplies not specifically approved by the Vision Care Designee where required in WHAT IS COVERED under the evidence of coverage.
5. Orthoptics, vision training and low vision aids.
6. Glasses, sunglasses or contact lenses.
7. Vision Care services for cosmetic use.

Exclusions apply to the Routine Eye Examination portion of your vision coverage. Discounts on materials such as glasses and contacts still apply.

Benefits issued under policy form numbers: MD/BCOO/VISION (R. 1/06) • DC/BCOO/VISION (R. 1/06) • VA/BCOO/VISION (R. 1/06).

Need more information? Please visit **www.carefirst.com** or call **(800) 783-5602.**

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Pharmacy Program

STANDARD B

$250 Deductible ■ $15/25/50 Retail Copays

Summary of Benefits

Plan Feature	Amount	Description
Deductible	$250	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) (up to a 34-day supply)	$15	All generic drugs are covered at this copay level.
Preferred Brand Name Drugs (Tier 2) (up to a 34-day supply)	$25	All preferred brand name drugs are covered at this copay level.
Non-Preferred Brand Name Drugs (Tier 3) (up to a 34-day supply)	$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.
Maintenance Copays (up to a 90-day supply)	generic: $30 preferred: $50 non-preferred: $100	Maintenance drugs of up to a 90-day supply are available for twice the copay through the Rx Delivered or retail pharmacy.
Mandatory Generic Substitution	Yes	If you choose a non-preferred brand name drug (Tier 3) when a generic equivalent (Tier 1) is available, 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. If a generic option is not available, you will only pay the appropriate copay.
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 (800) 294-5979 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**.

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Policy Form Numbers: 13.607 (R. 10/06) • MD/CF/MSGR/RX/PPO (7/06) • MD/CFBC/MSGR/RX (7/06) • MD/CF/MSGR/RX/PPO (7/06) MD/CFMI/MSGR/RX/PPO (4/09).

Access **www.carefirst.com/rx** for more information and for the most up-to-date preferred drug list.

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CUT6569-1P (10/11) ■ MSGR

Select Preferred Provider Plan *Summary of Benefits*

Services	In-Network You Pay[1]	Out-of-Network You Pay[2]
ANNUAL DEDUCTIBLE[3]		
Individual Individual & Child(ren) Individual & Adult Family	$2,500 $5,000 $5,000 $5,000	(combined in- and out-of-network)
ANNUAL OUT-OF-POCKET LIMIT[3]		
Individual Individual & Child(ren) Individual & Adult Family	$4,900 $9,800 $9,800 $9,800	(combined in- and out-of-network)
LIFETIME MAXIMUM	None	
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months 24 months-13 years (immunization visit) 24 months-13 years (non-immunization visit) 14-17 years	No charge* No charge* No charge* No charge*	Deductible, then $40 per visit or 40%** of AB Deductible, then $40 per visit or 40%** of AB Deductible, then $40 per visit or 40%** of AB Deductible, then $40 per visit or 40%** of AB
Adult Physical Examination	No charge*	Deductible, then $40 per visit or 40%** of AB
Routine GYN Visits	No charge*	Deductible, then $40 per visit or 40%** of AB
Mammograms	No charge*	Deductible, then $40 per visit or 40%** of AB
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge*	Deductible, then $40 per visit or 40%** of AB
OFFICE VISITS, LABS & TESTING		
Office Visits for Illness	Deductible, then $40 per visit or 20%** of AB	Deductible, then $40 per visit or 40%** of AB
Diagnostic Services	Deductible, then $40 per visit or 20%** of AB	Deductible, then $40 per visit or 40%** of AB
X-ray and Lab Tests	Deductible, then $40 per visit or 20%** of AB	Deductible, then $40 per visit or 40%** of AB
Allergy Testing[4]	Deductible, then $40 per visit or 20%** of AB	Deductible, then $40 per visit or 40%** of AB
Allergy Shots[4]	Deductible, then $40 per visit or 20%** of AB	Deductible, then $40 per visit or 40%** of AB
Outpatient Physical, Speech and Occupational Therapy[5] (limited to 30 visits/condition/benefit period)	Deductible, then 30% of AB	Deductible, then 50% of AB
Outpatient Chiropractic[5,6] (limited to 20 visits/condition/benefit period)	Deductible, then 30% of AB	Deductible, then 50% of AB
EMERGENCY CARE AND URGENT CARE		
Physician's Office	Deductible, then $40 per visit or 20%** of AB	Deductible, then $40 per visit or 40%** of AB
Urgent Care Center	Deductible, then $40 per visit or 20%** of AB	Deductible, then $40 per visit or 40%** of AB
Hospital Emergency Room[7]	Deductible, then $100 per visit and 20% of AB (waived if admitted)	Paid as in-network
Ambulance (if medically necessary)	Deductible, then $40 per visit or 20%** of AB	Deductible, then $20 per visit or 40%** of AB
HOSPITALIZATION[8]		
Inpatient Facility Services	Deductible, then 20% of AB	Deductible, then 40% of AB
Outpatient Facility Services	Deductible, then $40 per visit or 20%** of AB	Deductible, then $40 per visit or 40%** of AB
Inpatient Physician Services	Deductible, then 20% of AB	Deductible, then 40% of AB
Outpatient Physician Services	Deductible, then $40 per visit or 20%** of AB	Deductible, then $40 per visit or 40%** of AB

Services	In-Network You Pay[1]	Out-of-Network You Pay[2]
HOSPITAL ALTERNATIVES[8]		
Home Health Care	Deductible, then $40 per visit or 20%** of AB	Deductible, then $40 per visit or 40%** of AB
Hospice	Deductible, then $40 per visit or 20%** of AB	Deductible, then $40 per visit or 40%** of AB
Skilled Nursing Facility[5] (limited to 100 days/benefit period)	Deductible, then $40 per visit or 20%** of AB	Deductible, then $40 per visit or 40%** of AB
MATERNITY		
Prenatal and Postnatal Office Visits	Deductible, then $40 per visit or 20%** of AB	Deductible, then $40 per visit or 40%** of AB
Delivery and Facility Services[8]	Deductible, then 20% of AB	Deductible, then 40% of AB
Nursery Care of Newborn	Deductible, then 20% of AB	Deductible, then 40% of AB
Initial Office Consulation for Infertility Services/Procedures	Deductible, then $40 per visit or 20%** of AB	Deductible, then $40 per visit or 40%** of AB
Artificial Insemination[9]	Deductible, then 50% of AB	Deductible, then 50% of AB
In Vitro Fertilization Procedures[9]	Not covered	Not covered
MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)[8]		
Inpatient Facility Services[5] (limited to 60 days/benefit period)	Deductible, then 20% of AB	Deductible, then 40% of AB
Inpatient Physician Services	Deductible, then 20% of AB	Deductible, then 40% of AB
Outpatient Services (MH & SA)	Deductible, then 30% of AB	Deductible, then 50% of AB
Partial Hospitalization[5] (each day counts as 1/2 day toward inpatient limit)	Deductible, then 20% of AB	Deductible, then 40% of AB
Medication Management Visit	Deductible, then $40 per visit or 20%** of AB	Deductible, then $40 per visit or 40%** of AB
MISCELLANEOUS		
Durable Medical Equipment[8]	Deductible, then $40 per visit or 20%** of AB	Deductible, then $40 per visit or 40%** of AB
Acupuncture	Deductible, then $40 per visit or 20%** of AB	Deductible, then $40 per visit or 40%** of AB
Transplants[8]	Covered as stated in Certificate of Coverage	Covered as stated in Certificate of Coverage
Hearing Aids for ages 0-18[5] (limited to one hearing aid every 3 years)	Deductible, then $40 per visit or 20%** of AB	Deductible, then $40 per visit of 40%** of AB
VISION		
Routine Exam (optometrist or ophthalmologist) (limited to 1 visit/benefit period)	Not covered	Not covered
Eyeglasses and Contact Lenses	Not covered	Not covered

AB = Allowed Benefit: The Allowed Benefit 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.

Copayments or portion of deductible may be required at point of sale while in deductible period. Members will never be required to pay more than CareFirst's Allowed Benefit for services rendered.

1 In-network: When you have care rendered by or referred to a provider in the Preferred Provider network. In-network coinsurances are based on a percentage of the Allowed Benefit.
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 Allowed Benefit. When services are rendered by Non-Participating Providers, charges in excess of the Allowed Benefit are the member's responsibility. However, when services are rendered by a Participating Provider, then member is only responsible for the amount up to the Allowed Benefit.
3 The deductible and out-of-pocket limit can be met entirely by one member or by combining eligible expenses of two or more members.
4 If office visit copayment/coinsurance has been paid, additional office visit copayment/coinsurance is not required for this service.
5 CareFirst BlueCross BlueShield may be providing your 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.
6 Consultation for chiropractic services are charged the same as office visit for illness.
7 Emergency room copay applies to the deductible.
8 Preauthorization required.
9 Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options 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.
* No copayments or coinsurance.
** You are responsible for the greater of the copay or coinsurance amount. One copay/coinsurance per service per provider.

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.

The benefits described are issued under form numbers: MD/CF/MSGR/GRP APP (R. 9/09); MD/CF/MSGR/GC (R. 9/09); MD/CF/MSGR/GS (9/09); MD/CF/MSGR/DOCS/RPN (R. 6/10); MD/CF/MSGR/COC (R. 7/08); MD/CF/BLUECARD (R. 10/07); MD/GHMSI/MD-DOL APPEAL (R. 6/06); MD/CF/MSGR/SOB/PPO/CORE (R.7/07) and any amendments.

www.carefirst.com

CareFirst BlueCross BlueShield is the shared business name of Group Hospitalization and Medical Services, Inc. and CareFirst of Maryland, Inc. and is an independent licensee of the Blue Cross and Blue Shield Association.
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CUT6533-1P (6/11) ■ MSGR ■ Option D CORE

Pharmacy Program

STANDARD B

$250 Deductible ▪ $15/25/50 Retail Copays

Summary of Benefits

Plan Feature	Amount	Description
Deductible	$250	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) (up to a 34-day supply)	$15	All generic drugs are covered at this copay level.
Preferred Brand Name Drugs (Tier 2) (up to a 34-day supply)	$25	All preferred brand name drugs are covered at this copay level.
Non-Preferred Brand Name Drugs (Tier 3) (up to a 34-day supply)	$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.
Maintenance Copays (up to a 90-day supply)	generic: $30 preferred: $50 non-preferred: $100	Maintenance drugs of up to a 90-day supply are available for twice the copay through the Rx Delivered or retail pharmacy.
Mandatory Generic Substitution	Yes	If you choose a non-preferred brand name drug (Tier 3) when a generic equivalent (Tier 1) is available, 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. If a generic option is not available, you will only pay the appropriate copay.
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 (800) 294-5979 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**.

This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Policy Form Numbers: 13.607 (R. 10/06) • MD/CF/MSGR/RX/PPO (7/06) • MD/CFBC/MSGR/RX (7/06) • MD/CF/MSGR/RX/PPO (7/06) MD/CFMI/MSGR/RX/PPO (4/09).

Access **www.carefirst.com/rx** for more information and for the most up-to-date preferred drug list.

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Traditional Dental

Now with access to a National Network

Regular preventive dental care is an important part of staying healthy. That's why CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice, Inc. (CareFirst BlueChoice)*** are pleased to offer Traditional Dental coverage, which allows you the complete freedom to see any dentist you choose.

Advantages of the Plan

- **Freedom of Choice, Freedom to Save –** With Traditional Dental coverage, you have the freedom to see any dentist. So, whether you're at work, at home, on vacation or just traveling, you can be sure that your dental coverage will travel with you.
- **Preventive Care and More –** Benefits for you and your family include regular preventive care, X-rays, dental surgery and more. A summary of your benefits is available on the opposite side of this page. (Additional coverage for orthodontia may be included - ask your benefits manager for details).
- **Large Regional Network –** Over 3,800 dentists in Maryland, Virginia and Washington D.C. participate with CareFirst and CareFirst BlueChoice. This means that you can see a dentist where you live, where you work, or anywhere in between.
- **Nationwide Access to Participating Dentists* –** With our new national dental network, you now have access to more than 100,000 participating dentist locations throughout the United States. Whether you are in Baltimore or Boston, Laurel or Los Angeles, you have coverage for the dental services you need, when you need them.
- **Opportunity to Reduce Costs** – If you see a participating dentist, you will incur lower out-of-pocket costs for all dental services and you will have no claim forms to file. Participating dentists have agreed to accept CareFirst's or CareFirst BlueChoice's allowed benefit as payment in full for covered services. Once you meet your deductible and coinsurance, you won't be faced with additional expenses. You will not be balance billed!
- **Out-of-Network Benefit** – You can receive care from a non-participating dentist and have the same level of coverage; however, you may be subject to higher out-of-pocket costs and balance billing.

Frequently Asked Questions

How much will I have to pay for dental services?

The chart on the opposite side of this sheet gives you an overview of many of the covered services along with the percentage of what you will pay for each class of services.

Is there a lot of paperwork?

There is no paperwork when you use a dentist who participates with CareFirst or CareFirst BlueChoice. If you see a non-participating dentist, you may be required to pay all costs at the time of care, and then submit a claim form in order to be reimbursed for covered services.

Who can I call with questions about my dental plan?

Call CareFirst BlueCross BlueShield toll free at:
(866) 891-2802.

** The DNOA Preferred network is utilized outside of the CareFirst service area. Dentists within this network are considered in-network providers.*

Traditional Dental

Now with access to a National Network

Summary of Benefits

Summary of Benefits		You Pay
Deductible Applies to Classes II, III & IV		$50 Individual / $150 Family
Annual Maximum (Classes I-IV)		$1,000
Preventive & Diagnostic Services (Class I)		
■ Oral Exams (two per benefit period) ■ Prophylaxis (two cleanings per benefit period) ■ Bitewing X-rays ■ Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray (once per 36 months)	■ Fluoride treatments (two per benefit period per member, age requirements may apply) ■ Sealants on permanent molars (once per tooth per 36 months per member, age requirements may apply) ■ Space maintainers (once per 60 months) ■ Palliative emergency treatment	No charge at Participating Dentist**
Basic Services (Class II)		
■ Direct placement fillings using approved materials (one filling per surface per 12 months)	■ Periodontical scaling and root planing (once per 24 months, one full mouth treatment) ■ Simple extractions	20% of Allowed Benefit after deductible**
Major Services – Surgical (Class III)		
■ Surgical periodontic services including osseous surgery, mucogingival surgery and occlusal adjustments (once per 60 months) ■ Endodontics (treatment as required involving the root and pulp of the tooth, such as root canal therapy)	■ Oral surgery (surgical extractions, treatment for cysts, tumor and abscesses, apicoectomy and hemi-section) ■ General anesthesia rendered for a covered dental service	50% of Allowed Benefit after deductible**
Major Services – Restorative (Class IV)		
■ Full and/or partial dentures (once per 60 months) ■ Fixed bridges, crowns, inlays and onlays (once per 60 months) ■ Denture adjustments and relining (limits apply for regular and immediate dentures)	■ Recementation of crowns, inlays and/or bridges (once per 12 months) ■ Repair of prosthetic appliances as required (once in any 12 month period per specific area of appliance) ■ Dental implants, subject to medical necessity review (once per 60 months)	50% of Allowed Benefit after deductible**
Orthodontic Services (Class V)*		
■ Benefits for orthodontic services may be available for covered members under age 19 who meet treatment criteria.		50% of Allowed Benefit to $800 or $1,200 lifetime maximum**

* *Coverage for orthodontia may be included–ask your benefits manager for details, including lifetime maximum.*

** *NOTE: CareFirst and CareFirst BlueChoice payments are based on the CareFirst and CareFirst BlueChoice Allowed Benefit. Participating Dentists accept 100% of the Allowed Benefit as payment in full for covered services. Non-participating dentists may bill the member for the difference between the Allowed Benefit and their charges.*

*** *The CareFirst BlueChoice Dental Plan is offered in conjunction with Group Hospitalization and Medical Services, Inc., doing business as CareFirst BlueCross BlueShield, which contracts with participating dentists and provides claims processing and administrative services under the Dental Plan.*

Summary of Exclusions: 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.

Benefits issued under policy form numbers: CareFirst of Maryland, Inc.: 13.603 (R. 4/08) and any amendments • 13.606 (R. 4/08) and any amendments.

Group Hospitalization and Medical Services, Inc.: MD/CF/DENTAL DOCS (4/08) • MD/CF/DO-SOB (7/03) • MD/CF/EOC/D-V (10/08) • MD/CF/ELIG (R. 1/08) • MD/CF/GC (R. 10/07) and any amendments.

Group Hospitalization and Medical Services, Inc.: MD/CF/DENTAL RIDER (R. 4/08)

CareFirst BlueChoice, Inc.: MD/BC/DENTAL RIDER (R. 4/08)

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