

SCHEDULE OF BENEFITS

CareFirst pays only for Covered Services. The Member pays for services, supplies or care, which are not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

When determining the benefits a Member may receive, CareFirst considers all provisions of the Contract, its medical policies, and its operating procedures. Certain utilization management requirements may apply.

DEDUCTIBLE
<p>The Deductible applies to In-Network and Out-of-Network services, on a combined basis. Members can meet the Deductible through any combination of In-Network and/or Out-of-Network Deductible expenses.</p> <p>The Individual Deductible is \$750 per calendar year.</p> <p>The Family Deductible is \$1,500 per calendar year.</p> <p>If the Member has Individual Coverage, he or she must meet the Individual Deductible</p> <p>When Members are covered under Two-Party Coverage, each Member must satisfy his or her own Deductible by meeting the Individual Deductible.</p> <p>Members covered under Family Coverage can satisfy their own Deductible by meeting the Individual Deductible. In addition, if 2 covered family members separately meet their own Individual Deductibles, this will also satisfy the Deductible for all other covered family members.</p> <p>The following amounts apply to the Deductible:</p> <ul style="list-style-type: none">• 100% of the Allowed Benefit for covered In-Network services that are subject to the Deductible, as stated in the Benefits chart below.• 100% of the Allowed Benefit for covered Out-of-Network services that are subject to the Deductible, as stated in the Benefits chart below. <p>The following amounts may <u>not</u> be used to satisfy the Deductible:</p> <ul style="list-style-type: none">• Inpatient Hospital Copayments;• Vision Care Services Copayments;• Amounts incurred for failure to comply with the Utilization Management Program requirements;• The portion of any provider charge that is in excess of the Allowed Benefit. <p>The Benefit chart, below, identifies whether a Covered Service is subject to a Deductible.</p>
DEDUCTIBLE CARRYOVER PROVISION
<p>If the Member has Deductible expenses in the last three (3) months of one (1) calendar year he may be able to apply these expenses toward meeting his Deductible for the following year. The Member can apply these expenses to his next year's Deductible if the expenses apply to services that are subject to the Deductible and the Member did not exceed his Deductible in the prior year.</p>

OUT-OF-POCKET LIMIT

The Out-of-Pocket Limit applies to In-Network and Out-of-Network services, on a combined basis. Members can meet the Deductible through any combination of In-Network and/or Out-of-Network out-of-pocket expenses.

The Individual Out-of-Pocket Limit is \$3,000 per calendar year.

The Family Out-of-Pocket Limit is \$6,000 per calendar year.

If the Member has Individual Coverage, the Member must meet the Individual Out-of-Pocket Limit

When Members are covered under Two-Party Coverage, each Member must satisfy his or her own Out-of-Pocket Limit by meeting the Individual Out-of-Pocket Limit.

Members covered under Family Coverage can satisfy their own Out-of-Pocket Limit by meeting the Individual Out-of-Pocket Limit. In addition, if 2 covered family members separately meet their own Individual Out-of-Pocket Limits, this will also satisfy the Out-of-Pocket Limit for all other covered family members.

These amounts apply to the Out-of-Pocket Limit:

- The Deductible;
- Coinsurance for Covered In-Network Services;
- Coinsurance for Covered Out-of-Network Services.

The following amounts may not be used to meet the Out-of-Pocket Limit:

- Inpatient Hospital Copayment;
- Coinsurance for Outpatient Mental Health Services;
- Vision Care Services Copayments;
- Coinsurance or Copayments, if any, for services covered under an Attachment, unless specifically provided in the Attachment;
- Amounts incurred for failure to comply with the Utilization Management Program requirements;
- The portion of any provider charges which is in excess of the Allowed Benefit.

When a Member reaches the Out-of-Pocket Limit, no further Coinsurance or Copayments will be required in that calendar year for services subject to the Out-of-Pocket Limit.

UTILIZATION MANAGEMENT NON-COMPLIANCE

Failure or refusal to comply with Utilization Management Requirements will result in:
Benefits for health care facility services associated with your care or treatment will be reduced by 50%.

LIFETIME MAXIMUM

There is an unlimited Lifetime Maximum per Member.

BENEFITS				
SERVICE	SPECIAL LIMITATIONS	PROGRAM COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLE ?	OUT-OF NETWORK
PHYSICIAN AND PROVIDER SERVICES				
Preventive Services				
Child Wellness	Up to age 18 (Including related lab tests and immunizations)	100% of the Allowed Benefit	NO	70% of the Allowed Benefit
Adult Preventive Physical Examinations	Age 18 and over (Including related lab tests and immunizations)	100% of the Allowed Benefit	Out-of-Network Deductible applies	70% of the Allowed Benefit
PSA Test		100% of the Allowed Benefit	NO	70% of the Allowed Benefit
Colorectal Cancer Screening Tests		100% of the Allowed Benefit	NO	70% of the Allowed Benefit
Screening Mammography	Age 40 and above One preventive mammogram (of each breast) per Benefit Period	100% of the Allowed Benefit	NO	100% of the Allowed Benefit
Routine Pap Smears	None	100% of the Allowed Benefit	NO	100% of the Allowed Benefit
Diagnostic and Treatment Services				
Office Visits		100% of the Allowed Benefit, minus a Member Copayment of \$25 per visit	NO	70% of the Allowed Benefit
Allergy Injections		80% of the Allowed Benefit	YES	70% of the Allowed Benefit
Diagnostic Lab, X-Ray and Machine Tests Radiation Therapy, Chemotherapy (injection or intravenous)		80% of the Allowed Benefit	YES	70% of the Allowed Benefit
Outpatient Rehabilitation (physical, speech, occupational therapy)	Limited to diagnoses that are expected to show significant improvement within 90 days	100% of the Allowed Benefit, minus a Member Copayment of \$25 per visit	NO	70% of the Allowed Benefit
Spinal Manipulation	Benefits for chiropractic/spinal manipulation services are limited to Members who are twelve (12) years of age or older	100% of the Allowed Benefit, minus a Member Copayment of \$25 per visit	NO	70% of the Allowed Benefit
Private Duty Nursing	Limited to 100 visits per Benefit Period	80% of the Allowed Benefit	YES	70% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PROGRAM COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLE ?	OUT-OF NETWORK
Maternity and Related Services				
Maternity Care (Office Visit)		100% of the Allowed Benefit, minus a Member Copayment of \$25 per visit	NO	70% of the Allowed Benefit
Maternity Care	Applies only to professional services, including prenatal care, delivery and post-natal care	80% of the Allowed Benefit	YES	70% of the Allowed Benefit
Surgical Care				
	Benefits apply on an inpatient or outpatient basis	80% of the Allowed Benefit	YES	70% of the Allowed Benefit
Inpatient Physician and Health Care Practitioner Services and Consultations				
	Unlimited visits; Covered only if hospitalization qualifies for coverage	80% of the Allowed Benefit	YES	70% of the Allowed Benefit
Inpatient Ancillary Services, Including Radiology and Pathology				
	Covered only if hospitalization qualifies for coverage	80% of the Allowed Benefit	YES	70% of the Allowed Benefit
Anesthesia Service				
	Benefits apply on an inpatient or outpatient basis when provided in connection with a covered procedure	80% of the Allowed Benefit	YES	70% of the Allowed Benefit
Ambulance Service				
To or From Hospital		80% of the Allowed Benefit	YES	70% of the Allowed Benefit
Foreign Transportation	Applies only if Member is traveling outside the U.S.	Not Applicable	YES	70% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PROGRAM COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLE ?	OUT-OF NETWORK
HOSPITAL SERVICES				
Inpatient Hospital Services				
Inpatient Medical	Limited to 365 days per confinement (A new confinement begins only if the Member does not receive inpatient Hospital Services for 60 consecutive days) Must be authorized in advance under utilization management program Preferred Providers will handle In-Network utilization management requirements on Member's behalf	80% of the Allowed Benefit, minus a Member Copayment of \$200 per admission	YES	70% of the Allowed Benefit, minus a Member Copayment of \$200 per admission
Outpatient Hospital Services				
Emergency Room Treatment	Care must be for a bona-fide Medical Emergency	80% of the Allowed Benefit	YES	Covered as an In-Network benefit for a bona-fide emergency
Cardiac Rehabilitation (Hospital/facility)		80% of the Allowed Benefit	YES	70% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PROGRAM COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLE ?	OUT-OF NETWORK
HOME HEALTH CARE				
	<p>Limited to 90 visits (up to four hours per visit) per Benefit Period</p> <p>A new episode of care begins if the Member does not receive Home Health Care for the same or a different condition for 60 consecutive days</p> <p>Must be authorized in advance under utilization management program</p> <p>Preferred Providers will handle In-Network utilization management requirements on Member's behalf</p>	80% of the Allowed Benefit	YES	70% of the Allowed Benefit
SKILLED NURSING FACILITY SERVICES				
	<p>Limited to 100 days per Benefit Period</p> <p>A new episode of care begins if the Member does not receive Home Health Care for the same or a different condition for 60 consecutive days</p> <p>Must be authorized in advance under utilization management program</p> <p>Preferred Providers will handle In-Network utilization management requirements on Member's behalf</p>	80% of the Allowed Benefit	YES	70% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PROGRAM COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLE ?	OUT-OF NETWORK
HOSPICE CARE SERVICES				
	<p>Must be authorized in advance under utilization management program</p> <p>Services limited to maximum 180 day Hospice Eligibility Period</p> <p>Inpatient care limited to 60 days per Hospice Eligibility Period</p> <p>Family counseling limited to \$500 per Hospice Eligibility Period</p> <p>Bereavement services limited to \$100 per Hospice Eligibility Period (covered only if provided within 90 days following the Member's death)</p> <p>Additional "reserve" benefits (up to 45 days) apply if the Member exceeds:</p> <ul style="list-style-type: none"> • The Hospice Eligibility Period and/or • The inpatient benefit limit 	80% of the Allowed Benefit	YES	70% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PROGRAM COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLE ?	OUT-OF NETWORK
MENTAL HEALTH AND SUBSTANCE ABUSE CARE				
Medication Management Office visits	None	100% of the Allowed Benefit, minus a Member Copayment of \$25 per day	Out-of-Network Deductible applies	70% of the Allowed Benefit
Mental Health Outpatient Services				
		100% of the Allowed Benefit, minus a Member Copayment of \$25 per visit	NO	70% of the Allowed Benefit
Mental Health Inpatient Services				
	Must be authorized in advance under utilization management program	80% of the Allowed Benefit, minus a Member Copayment of \$200 per admission	YES	70% of the Allowed Benefit, minus a Member Copayment of \$200 per admission Limited to 30 days per Benefit Period
Inpatient Visits	Covered only if hospitalization qualifies for coverage	80% of the Allowed Benefit	YES	70% of the Allowed Benefit Limited to 30 visits per Benefit Period
Partial Hospitalization				
	Partial hospitalization days can be substituted for or combined with Hospital days for Mental Health care up to annual limits described above for "Inpatient Hospital Services" Each partial hospitalization day counts as 1/2 of a Hospital day	80% of the Allowed Benefit	YES	50% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PROGRAM COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLE ?	OUT-OF NETWORK
SUBSTANCE ABUSE				
NOTE: The following benefits are available for Alcohol Abuse and for Drug Abuse. Services required for Alcohol Abuse are not combined with those for Drug Abuse in calculating benefit or payment limits				
Substance Abuse Outpatient Services				
	Up to 30 visits per Benefit Period	80% of the Allowed Benefit	YES	70% of the Allowed Benefit
Substance Abuse Inpatient Services				
	Must be authorized in advance under Utilization Management Requirements Must be authorized in advance under utilization management program	80% of the Allowed Benefit, minus a Member Copayment of \$200 per admission	YES	70% of the Allowed Benefit, (up to a maximum payment of \$250 per day) minus a Member Copayment of \$200 per admission Limited to a maximum of 30 days or \$5,000 per Benefit Period
Inpatient Visits	Covered only if hospitalization qualifies for coverage	80% of the Allowed Benefit	YES	70% of the Allowed Benefit Limited to a maximum of 30 visits per Benefit Period
MEDICAL DEVICES AND SUPPLIES				
		80% of the Allowed Benefit	YES	70% of the Allowed Benefit