Loyola University Maryland

Health Benefit Description Chart
Plan Year July 1, 2012 – June 30, 2013

CareFirst
From the CareFirst BlueCross BlueShield family of health care plans.

Benefit	Preferred Provider Option (PPO)		CAREFIRST BLUECHOICE (HMO)* Member Pays:
	In-Network Plan Pays:	Out-of-Network Plan Pays:	
INPATIENT HOSPITALIZATION (*Precertification required*)	80% of AB up to 365 days (no deductible)	60% of AB after deductible	Covered in full
INPATIENT MEDICAL/SURGICAL–PROFESSIONAL	80% of AB (no deductible)	60% of AB after deductible	Covered in full
EMERGENCY SERVICES *Accidental Injury/Medical Emergency*	100% of AB within 72 hours after $50 copay (no deductible)	100% of AB within 72 hours after $50 copay (no deductible)	$50 copayment for Emergency Room visits, waived if admitted
HOSPITAL – Outpatient Facility	100% of AB (no deductible)	60% of AB after deductible	Covered in full
OFFICE VISIT – Non-routine	100% of AB after $10 copayment	60% of AB after deductible	$10/$20 copayment
OUTPATIENT SURGERY – Professional	80% of AB (no deductible)	60% of AB after deductible	$10/$20 copayment (Facility covered in full)
MATERNITY CARE *(included Pre & Post Natal and Delivery)*	80% of AB after deductible	60% of AB after deductible	$10/$20 copayment (not to exceed 10 times the copay per pregnancy)
DIAGNOSTIC X-RAY, LAB & MACHINE TESTS	100% of AB (no deductible)	60% of AB after deductible	Covered in full
WELL CHILD CARE *(includes routine immunizations) Up through age 17*	100% of AB after $10 copayment (no deductible)	60% of AB (no deductible)	$10 copayment (For all ages)
ROUTINE PHYSICALS	100% of AB after $10 copayment (no deductible)	60% of AB after deductible	$10/$20 copayment/visit
ROUTINE GYN	100% of AB after $10 copayment (no deductible)	60% of AB after deductible	$10/$20 copayment/visit (no charge for PAP smear)
	1 visit per plan year including Pap tests		
MAMMOGRAPHY *Routine and Non-routine Mammography*	100% of AB (no deductible)	60% of AB (no deductible)	Covered in full
	Ages 35-39, one baseline mammogram • Age 40+, one per 12 months		
ROUTINE EYE EXAM	Not covered	Not covered	$10 copayment – discounts available on lenses/frames at Davis Vision Participating Providers
HOME HEALTH CARE – AGENCY *(Precertification required)*	80% of AB up to 90 days of unlimited visits per year (no deductible)	60% of AB after deductible up to 90 days of unlimited visits per year	Covered in full
DURABLE MEDICAL EQUIPMENT	80% of AB after deductible	60% of AB after deductible	Diabetic equipment and supplies covered in full; all other DME and medical supplies covered at 50% (No maximum)
ACUPUNCTURE *(When medically indicated for pain control, migraine or chronic headaches, arthritis or diabetic neuropathy.)*	100% of AB after $10 copayment (no deductible)	60% of AB after deductible	No Benefit
PRESCRIPTION DRUGS *(when filled by Plan pharmacies)* Certain prescription drugs require prior authorization	$8 generic $25 brand name	$8 generic $25 brand name	$5 generic/formulary $10 brand name formulary $25 brand name non-formulary
	Generic substitution applies		
MENTAL HEALTH AND SUBSTANCE ABUSE • **INPATIENT** *(Precertification required) Day or partial hospitalization*	80% of AB (no deductible)	60% of AB after deductible	Covered in full
• **OUTPATIENT**	100% of AB	60% of AB after deductible	Covered in full
OUTPATIENT PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY	80% of AB after deductible 100 combined visits per plan year	60% of AB after deductible 100 combined visits per plan year	$20 copayment per visit; 100 visits combined per condition per plan year including spinal manipulation.
HAIR PROSTHESIS *Following chemotherapy or radiation treatment for cancer. One per benefit period. Not to exceed $350 per hair prosthesis.*	100% of AB (no deductible)	100% of AB (no deductible)	Not subject to copayment or coinsurance
INVITRO FERTILIZATION *Refer to benefit contract for additional limitations*	80% of AB after deductible	80% of AB after deductible	50% of AB 3 attempts per member not to exceed a lifetime benefit of $100,000.
	Two year history of infertility. 3 attempts per live birth not to exceed a lifetime benefit of $100,000		
ARTIFICIAL INSEMINATION *Pre-authorization Required*	80% of AB after deductible	60% of AB after deductible	50% of AB
HABILITATIVE SERVICES *(For Children Only) Must be preauthorized after initial visit*	80% of AB after deductible; no maximums	60% of AB after deductible; no maximums	$20 copayment per visit (all visits must be Plan Approved)
NEWBORN VISITS IN THE HOSPITAL	80% of AB after deductible	60% of AB after deductible	Covered in full (as medically necessary)
HEARING AID *One Hearing Aid for each hearing-impaired ear once every 36 months.* *Benefits for a hearing aid are provided for a Member who is a minor child, when the hearing aid is prescribed, fitted and dispensed by a licensed audiologist.* *Benefits are also provided for ancillary services e.g., assessment, fitting, orientation, conformity evaluation, related to the benefit for a hearing aid for a minor child, and are not applied to the benefit limit above. Ancillary services are subject to any applicable deductible, coinsurance or copayment.*	100% not to exceed $1,400 for each ear (copays & deductible do not apply)	100% not to exceed $1,400 for each ear (copays & deductible do not apply)	100% of AB not to exceed $1,400 for each hearing impaired ear This benefit is not subject to any, copayment amount
	Combined in and out of network		
SURGICAL TREATMENT FOR MORBID OBESITY	80% of AB after deductible	60% of AB after deductible	Subject to the same copayments and coinsurance as other Medically Necessary surgical procedures.
PLAN YEAR DEDUCTIBLE *(In/out-of-network combined)*	$300 Individual $600 Family aggregate	$750 Individual $1,500 Family aggregate	N/A
OUT-OF-POCKET MAXIMUM *Plan coinsurance increases to 100% of AB for up to 100% of AB for covered services for the remainder of the plan year.*	$1,000 Individual $2,000 Family aggregate	$4,000 Individual $8,000 Family aggregate	$2,000 Individual $5,500 Family Aggregate
	per plan year (Includes deductible, coinsurance and copayments, in/out-of-network combined.)		
LIFETIME MAXIMUM	Unlimited	Unlimited	N/A
DEPENDENT AGE LIMIT	To the end of the month to age 26		

** Benefits will be provided only when services are performed or authorized by your CareFirst BlueChoice Plan primary care physician or other Plan Provider to whom you have been referred.*
AB = Allowed Benefit

This summary is intended as a brief description of benefits and is to be used only as a guide.
Actual benefits are subject to the contract provisions between CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc. and Loyola University Maryland.

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.
® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.