Loyola College in Maryland, Inc.

Health Benefit Description Chart

Plan Year 7/1/2009 – 6/30/2010

CareFirst BlueChoice

CareFirst BlueCross BlueShield

Benefit	PREFERRED PROVIDER OPTION (PPO) In-Network — Plan Pays:	PREFERRED PROVIDER OPTION (PPO) Out-of-Network — Plan Pays:	CAREFIRST BLUECHOICE (HMO)* — Member 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 after 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	80% 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 after 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
	$200 maximum per plan year in/out-of-network combined		
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 • **INPATIENT** *(Precertification required)* *Day or partial hospitalization*	80% of AB after deductible	60% of AB after deductible	$20 copay/visit; Partial hospitalization limited to 60 days per contract year.
• **OUTPATIENT** *(Precertification required after the 10th visit)*	Visits 1-30: 80% of AB after deductible Thereafter: 50% of AB after deductible	Visits 1-5: 80% of AB after deductible Visits 6-30: 65% of AB after deductible Thereafter: 50% of AB after deductible	Visits 1-5: 20% of AB Visits 6-30: 35% of AB Visits 31+: 50% of AB (Combined with Substance Abuse Care)
	Combined in and out of network		
SUBSTANCE ABUSE CARE • **INPATIENT** *(Precertification required)* *Day or partial hospitalization*	80% of AB after deductible	60% of AB after deductible	Covered in full
• **OUTPATIENT**	Visits 1-30: 80% of AB after deductible Thereafter: 50% of AB after deductible	Visits 1-5: 80% of AB after deductible Visits 6-30: 65% of AB after deductible Thereafter: 50% of AB after deductible	Visits 1-5: 20% of AB Visits 6-30: 35% of AB Visits 31+: 50% of AB (combined with Mental Health Benefits)
	Combined in and out of network		
OUTPATIENT PHYSICAL AND OCCUPATIONAL THERAPY	80% of AB after deductible 100 visits per plan year	60% of AB after deductible 100 visits per plan year	$20 copayment per visit; 100 visits combined per condition per plan year including spinal manipulation.
OUTPATIENT SPEECH THERAPY	80% of AB after deductible 30 visits per plan year	60% of AB after deductible 30 visits per plan year	
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 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 *(Excludes deductible, in/out-of-network combined.)*		
LIFETIME MAXIMUM	Unlimited	Unlimited	N/A
DEPENDENT AGE LIMIT	To the end of the month to age 25, unless full-time college student, then end of month to age 25		

** 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 College in Maryland, Inc.