BluePreferred

Summary of Benefits

Services	Preferred Providers In-Network You Pay[1]	Non-Preferred Providers Out-of-Network You Pay[2]
ANNUAL DEDUCTIBLE (BENEFIT PERIOD)[3,4]		
Individual	None	$300
Individual & Child(ren)[5]	None	$600
Individual & Adult	None	$600
Family	None	$600
ANNUAL OUT-OF-POCKET MAXIMUM (BENEFIT PERIOD)[6]		
Individual	$1,000	$2,000
Individual & Child(ren)[5]	$2,000	$4,000
Individual & Adult	$2,000	$4,000
Family	$2,000	$4,000
LIFETIME MAXIMUM	None	
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months	No charge*	CareFirst pays 100% of Allowed Benefit
24 months-13 years (immunization visit)	No charge*	CareFirst pays 100% of Allowed Benefit
24 months-13 years (non-immunization visit)	No charge*	CareFirst pays 100% of Allowed Benefit
14-17 years	No charge*	CareFirst pays 100% of Allowed Benefit
Adult Physical Examination	No charge*	Deductible, then 20% of Allowed Benefit
Routine GYN Visits	No charge*	Deductible, then 20% of Allowed Benefit
Mammograms	No charge*	CareFirst pays 100% of Allowed Benefit
Cancer Screening		
Pap Test and Prostate	No charge*	CareFirst pays 100% of Allowed Benefit
Colorectal	No charge*	Deductible, then 20% of Allowed Benefit
OFFICE VISITS, LABS & TESTING		
Office Visits for Illness	$10 per visit	Deductible, then 20% of Allowed Benefit
Diagnostic Services	No charge*	Deductible, then 20% of Allowed Benefit
X-ray and Lab Tests	No charge*	Deductible, then 20% of Allowed Benefit
Allergy Testing	No charge*	Deductible, then 20% of Allowed Benefit
Allergy Shots	$5 per visit	Deductible, then 20% of Allowed Benefit
Outpatient Physical, Speech and Occupational Therapy	$15 per visit	Deductible, then 20% of Allowed Benefit
Outpatient Spinal Manipulation	$15 per visit	Deductible, then 20% of Allowed Benefit
EMERGENCY CARE AND URGENT CARE		
Physician's Office	$10 per visit	Deductible, then 20% of Allowed Benefit
Urgent Care Center	$10 per visit	Deductible, then 20% of Allowed Benefit
Hospital Emergency Room (limited to emergency services)	$50 per visit (copay waived if admitted)	Paid as in-network
Ambulance (if medically necessary)	No charge*	Deductible, then 20% of Allowed Benefit
HOSPITALIZATION		
Inpatient Facility Services	No charge*	Deductible, then 20% of Allowed Benefit
Outpatient Facility Services	No charge*	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	No charge*	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge*	Deductible, then 20% of Allowed Benefit

Services	Preferred Providers In-Network You Pay[1]	Non-Preferred Providers Out-of-Network You Pay[2]
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 90 visits per episode of care)	No charge*	Deductible, then 20% of Allowed Benefit
Hospice (limited to a maximum 180 day Hospice eligibility period)	No charge*	Deductible, then 20% of Allowed Benefit
Skilled Nursing Facility (limited to 60 days per Benefit Period)	No charge*	Deductible, then 20% of Allowed Benefit
MATERNITY[7]		
Prenatal and Postnatal Office Visits	No charge*	Deductible, then 20% of Allowed Benefit
Delivery and Facility Services	No charge*	Deductible, then 20% of Allowed Benefit
Nursery Care of Newborn	No charge*	Deductible, then 20% of Allowed Benefit
Initial Office Consultation(s) for Infertility Services/Procedures	$10 per visit	Deductible, then 20% of Allowed Benefit
Artificial Insemination[7]	Not covered	Not covered
In Vitro Fertilization Procedures[7]	Not covered	Not covered
MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)		
Inpatient Services (MH and SA each limited to 60 days per Benefit Period)	No charge*	Deductible, then 20% of Allowed Benefit
Outpatient Services Visits 1 – 40 Visits 41 and over	 25% of Allowed Benefit 40% of Allowed Benefit	 Deductible, then 25% of Allowed Benefit Deductible, then 40% of Allowed Benefit
Partial Hospitalization	No charge*	Deductible, then 20% of Allowed Benefit
Medication Management Visit	$10 per visit	Deductible, then 20% of Allowed Benefit
MISCELLANEOUS		
Durable Medical Equipment	No charge*	Deductible, then 20% of Allowed Benefit
Acupuncture	Only when CareFirst approved for anesthesia	Only when CareFirst approved for anesthesia
Transplants	Covered as stated in Evidence of Coverage	Covered as stated in Evidence of Coverage
Hearing Aids	Not covered	Not covered
VISION		
Routine Exam (limited to 1 visit/benefit period)	$10 per visit at participating vision provider	Total charge minus $33
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers	Not covered

* No copayments or coinsurance.

[1] In-network: When covered services are rendered by a provider in the Preferred Provider network, care is reimbursed at the in-network level. In-network coinsurances are based on a percentage of the 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, the Allowed Benefit for a Preferred Provider may be established by law.

[2] Out-of-network: When covered services are 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. The Allowed Benefit is generally the contracted rates or fee schedules that Preferred Providers have agreed to accept as payment of covered services. These payments are established by CareFirst, however, in certain circumstances, the Allowed Benefit for an out-of-network provider may be established by law. When services are rendered by Non-Preferred Providers, charges in excess of the Allowed Benefit are the member's responsibility.

[3] If you have 'Individual & Adult' or 'Individual & Child(ren)' coverage, each Member must satisfy his/her own deductible by meeting the individual deductible. If you have family coverage, all Members' individual deductibles will be combined to meet the family deductible; however, no individual Member may contribute more than the individual deductible amount.

[4] Copayment or portion of deductible may be required at the point of sale while in the deductible period. CareFirst will only apply the Allowed Benefit to the deductible. Charges in excess of the Allowed Benefit are the Members responsibility and will not go toward the deductible.

[5] Please refer to your Evidence of Coverage and Schedule of Benefits to determine your coverage level.

[6] If you have 'Individual & Adult' or 'Individual & Child(ren)' coverage, each Member must satisfy his/her own out-of-pocket limit by meeting the individual out-of-pocket Limit. If you have family coverage, all Members' individual out-of-pocket limits will be combined to meet the family out-of-pocket limit; however, no individual Member may contribute more than the individual out-of-pocket amount.

[7] 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 & IVF) services performed as treatment option for infertility are only available under the terms of the members contract. Preauthorization required.

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 benefit described are issued under form numbers: DC/CF/GC (R.7/10), DC/CF/BP/EOC (R. 11/09), DC/CF/BP/DOCS (7/08), DC/CF/BP/SOB (7/08), DC/CF/ATTC (R. 1/10), DC/GHMSI/DOL APPEAL (3/06), DC/CF/RX3 (R. 12/08), DC/CF/VISION (R. 1/06), And any amendments.

CareFirst BlueCross BlueShield

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