CareFirst BlueChoice, Inc.

[840 First Street, NE]
[Washington, DC 20065]
[(202) 479-8000]

An independent licensee of the BlueCross and Blue Shield Association

ATTACHMENT [C]
IN-NETWORK SCHEDULE OF BENEFITS

The benefits and limitations described in this schedule are subject to all terms and conditions stated in the Evidence of Coverage.

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

When determining the benefits a Member may receive, CareFirst BlueChoice considers all provisions and limitations in the Evidence of Coverage as well as its medical policies. When these conditions of coverage are not met or followed, payments for benefits may be denied. Certain Utilization Management requirements will also apply. When these requirements are not met, payments may be reduced or denied.

Benefits for Covered Services, Covered Dental Services, and Covered Vision Services may be provided either under the In-Network Evidence of Coverage or Out-of-Network Evidence of Coverage. Benefits will not be provided for the same service or supply under both this In-Network Evidence of Coverage and the Out-of--Network Evidence of Coverage. However, for certain services there are visit or other limitations. Where there is a benefit limitation, the benefit limitation is combined for both the In-Network and Out-of-Network Evidence of Coverage.

IN-NETWORK DEDUCTIBLE
The Individual Benefit Period Deductible is $1,500. The Family Benefit Period Deductible is $3,000. **Individual Coverage:** The Member must satisfy the Individual Deductible. **Family Coverage**: The Deductible can be met entirely by one Member or by combining eligible expenses of two or more covered family Members. **There is no Individual Deductible with Family Coverage.** The Family Deductible must be reached before CareFirst BlueChoice pays benefits for any Member who has Family Coverage. The In-Network Deductible and the Out-of-Network Deductible do not contribute to one another.

The following amounts may not be used to satisfy the Benefit Period Deductible:

- Difference between the price of a Non-Preferred Brand Name Drug and Generic Drug when a Member selects a Non-Preferred Brand Name Drug when a Generic Drug is available.
- Charges in excess of the Allowed Benefit.
- Charges for services not covered under the Evidence of Coverage or that exceed the maximum number of covered visits/days listed below.
- Charges for Pediatric Vision Services or Pediatric Dental Services.
- Charges incurred under the Out-of-Network Evidence of Coverage.

[Deductible Credit

If a Member was covered on the day immediately preceding the effective date of this Evidence of Coverage under any other [compatible] group Evidence of Coverage [issued to the Group][,] then charges for Covered Services (as defined) Incurred by that Member and applicable toward Deductible expenses under the prior Evidence of Coverage, shall be used to satisfy all or any portion of the Deductible amounts under this Evidence of Coverage. This Deductible Credit provision applies only to the Deductible amount wholly or partially satisfied in the same [Benefit Period] [and] [tax year] as the effective date of this Evidence of Coverage. [Deductible credit only applies to initial enrollees.] [Deductible credit is not provided for Prescription Drugs.]]

WELLNESS CREDIT

Members who complete the participation requirements listed in the Description of Covered Services will receive a wellness credit equal to the following:

For an adult, a credit towards the Benefit Period Deductible, with a maximum amount of $300 per Benefit Period.

For a child age two (2) years and older, a credit towards the Benefit Period Deductible, with a maximum amount of $25 per Benefit Period.

Eligible Members will be issued the wellness credit on an individual basis. However, for a family, the maximum credit amount cannot exceed $700 per Benefit Period.

IN-NETWORK OUT-OF-POCKET MAXIMUM

The Individual Benefit Period Out-of-Pocket Maximum is $5,500.

The Family Benefit Period Out-of-Pocket Maximum is $11,000.

Individual Coverage: The Member must meet the Individual Out-of-Pocket Maximum.

Family Coverage: The Out-of-Pocket Maximum can be met entirely by one Member or by combining eligible expenses of two or more covered family Members. **There is no Individual Out-of-Pocket Maximum with Family Coverage.** The Family Out-of-Pocket Maximum must be reached before CareFirst BlueChoice pays benefits for any Member who has Family Coverage.

These amounts apply to the Benefit Period Out-of-Pocket Maximum:

- Copayments and Coinsurance for all Covered Services.
- Pediatric Dental Benefits Deductible and Coinsurance for Covered Dental Services.
- Benefit Period Deductible.
- Amounts paid toward Pediatric Vision Services

When the Member has reached the Out-of-Pocket Maximum, no further Copayments, Coinsurance or Deductible will be required in that Benefit Period for Covered Services.

The Out-of-Pocket Maximum for the In-Network Evidence of Coverage and the Out-of-Pocket Maximum for the Out-of-Network Evidence of Coverage do not contribute to one another.

The following amounts may <u>not</u> be used to satisfy the Benefit Period Out-of-Pocket Maximum:

- Difference between the price of a Non-Preferred Brand Name Drug and Generic Drug when a Member selects a Non-Preferred Brand Name Drug when a Generic Drug is available.
- Charges in excess of the Allowed Benefit.
- Charges for services which are not covered under the Evidence of Coverage or that exceed the maximum number of covered visits/days listed below.
- Charges incurred under the Out-of-Network Evidence of Coverage.

SERVICE	LIMITATIONS	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS
OUTPATIENT FACILITY, OFFICE AND PROFESSIONAL SERVICES			
Freestanding Physician's Office		No	No Copayment or Coinsurance (PCP) $30 (Specialist) per provider per date of service
Hospital-Based Outpatient Department/Clinic/ Office (Non-surgical)	The Copayment does not apply to covered preventive services.	No	$50 per visit **and** No Copayment or Coinsurance (PCP) $30 (Specialist) per provider per date of service
Laboratory Tests	The Copayment does not apply to covered preventive services.	No	No Copayment or Coinsurance
Radiologic Imaging	The Copayment does not apply to covered preventive services.	No	No Copayment or Coinsurance
Other Diagnostic Testing (except as otherwise provided)	The Copayment does not apply to covered preventive services.	No	No Copayment or Coinsurance

SERVICE	LIMITATIONS	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS
Preventive Care - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. At a minimum, benefits will be provided for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society or required by the Patient Protection and Affordable Care Act (PPACA).			
Prostate Cancer Screening		No	No Copayment or Coinsurance
Colorectal Cancer Screening		No	No Copayment or Coinsurance
Pap Smear		No	No Copayment or Coinsurance
Breast Cancer Screening		No	No Copayment or Coinsurance
Human Papillomavirus Screening Test		No	No Copayment or Coinsurance
Immunizations		No	No Copayment or Coinsurance
Well Child Care (includes related lab tests and immunizations)		No	No Copayment or Coinsurance
Adult Preventive Care (includes related services)		No	No Copayment or Coinsurance

SERVICE	LIMITATIONS	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS
Preventive Gynecological Care (includes related services)		No	No Copayment or Coinsurance
Preventive Services for Obesity		No	No Copayment or Coinsurance
Treatment Services			
Professional Nutritional Counseling and Medical Nutrition Therapy	Benefits available when provided in conjunction with preventive services, diabetic education, and hospice care.	No	$30 per provider per date of service **and** $50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Office Visits for Treatment of Childhood Obesity	Limited to Members under age 19.	No	No Copayment or Coinsurance
Family Planning			
Non-Preventive Gynecological Care		No	No Copayment or Coinsurance (PCP) $30 (Specialist) per provider per date of service **and** $50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Contraceptive Counseling		No	No Copayment or Coinsurance
Contraceptive Drugs and Devices		No	No Copayment or Coinsurance
Insertion or removal, and any Medically Necessary examination associated with the use of any contraceptive devices or drugs	Drug or device must be approved by the FDA as a contraceptive.	No	No Copayment or Coinsurance
Elective Sterilization Services – Female Members	Benefits available to female Members with reproductive capacity, only.	No	No Copayment or Coinsurance
Maternity and Related Services			
Preventive Services		No	No Copayment or Coinsurance

SERVICE	LIMITATIONS	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS
Non-Preventive Services		Yes	No Copayment or Coinsurance (PCP) $30 (Specialist) per provider per date of service **and** $50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Professional Services for Delivery		Yes	No Copayment or Coinsurance
Professional Services for Nursery Care		Yes	No Copayment or Coinsurance
Allergy Services			
Allergy Testing and/or Allergy Treatment		No	$30 per provider per date of service **and** $50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Allergy Shots		No	$30 per provider per date of service **and** $50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Rehabilitative Services			
Rehabilitative/ Habilitative Physical Therapy		No	$30 per provider per date of service **and** $50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Rehabilitative/ Habilitative Occupational Therapy		No	$30 per provider per date of service **and** $50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Rehabilitative/ Habilitative Speech Therapy		No	$30 per provider per date of service **and** $50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic

SERVICE	LIMITATIONS	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS
Spinal Manipulation Services		No	$30 per provider per date of service **and** $50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Habilitative Services for Children	Limited to Members under the age of twenty-one (21)	No	$30 per provider per date of service **and** $50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Habilitative Services for Adults	Benefits available for Members age twenty-one (21) and older Limited to thirty (30) visits (per injury or illness) per Benefit Period for Physical Therapy, thirty (30) visits (per injury or illness) per Benefit Period for Occupational Therapy and thirty (30) visits (per injury or illness) per Benefit Period for Speech Therapy combined under the In-Network Evidence of Coverage and Out-of-Network Evidence of Coverage. Prior authorization is required	No	$30 per provider per date of service **and** $50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Cardiac Rehabilitation	Limited to ninety (90) days per Benefit Period combined under the In-Network Evidence of Coverage and Out-of-Network Evidence of Coverage	No	$30 per provider per date of service **and** $50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Pulmonary Rehabilitation	Limited to one (1) pulmonary rehabilitation program per lifetime combined under the In-Network Evidence of Coverage and Out-of-Network Evidence of Coverage	No	$30 per provider per date of service **and** $50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Other Treatment Services			
Outpatient Therapeutic Treatment Services (excluding Cardiac Rehabilitation and pulmonary rehabilitation)		No	$30 per provider per date of service **and** $50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic

SERVICE	LIMITATIONS	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS
Blood and Blood Products		No	$30 per provider per date of service **and** $50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Clinical Trial		Benefits are available to the same extent as benefits provided for other services.	
Organ and Tissue Transplants	Except for cornea transplants and kidney transplants, prior authorization is required.	Benefits are available to the same extent as benefits provided for other services.	
Outpatient Surgical Facility and Professional Services			
Surgical Care at an Outpatient Hospital Facility		Yes	$300 per visit
Surgical Care at an Ambulatory Care Facility		No	$100 per visit
Outpatient Surgical Professional Services Provided at an Outpatient Hospital or Ambulatory Care Facility	Routine/Screening Colonoscopy is not subject to the Copayment and Deductible.	Yes	No Copayment or Coinsurance
INPATIENT HOSPITAL SERVICES			
Inpatient Facility (medical or surgical condition, including maternity and rehabilitation)	Prior authorization is required except for emergency admissions and all maternity admissions. Hospitalization solely for rehabilitation limited to ninety (90) days per Benefit Period combined under the In-Network Evidence of Coverage and Out-of-Network Evidence of Coverage.	Yes	$300 per admission
Inpatient Professional Services except for delivery services and nursery services under Maternity Care		Yes	No Copayment or Coinsurance

SERVICE	LIMITATIONS	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS
SKILLED NURSING FACILITY SERVICES			
Skilled Nursing Facility Services	Limited to sixty (60) days per Benefit Period combined under the In-Network Evidence of Coverage and Out-of-Network Evidence of Coverage. Prior authorization is required.	Yes	$30 per admission
HOME HEALTH SERVICES			
Home Health Services	Limited to ninety (90) visits per "episode of care" combined under the In-Network Evidence of Coverage and Out-of-Network Evidence of Coverage. A new episode of care begins if the Member does not receive Home Health Care for the same or a different condition for sixty (60) consecutive days. Prior authorization is required.	Yes	$30 per provider per date of service
Postpartum Home Visits	Benefits are available to all Members.	Yes	No Copayment or Coinsurance
HOSPICE SERVICES			
Inpatient Care	Prior authorization is required. Services limited to a maximum one hundred eighty (180) day hospice eligibility period. Limited to sixty (60) days per hospice eligibility period combined under the In-Network Evidence of Coverage and Out-of-Network Evidence of Coverage.	Yes	$30 per date of service
Outpatient Care	Prior authorization is required. Services limited to a maximum one hundred eighty (180) day hospice eligibility period.	Yes	$30 per provider per date of service
Respite Care	Services limited to a maximum one hundred eighty (180) day hospice eligibility period.	Yes	$30 per provider per date of service
Bereavement Services	Covered only if provided within ninety (90) days following death of the deceased.	Yes	$30 per provider per date of service
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES			
Outpatient Services			
Office Visits		No	No Copayment or Coinsurance
Outpatient Hospital Facility Services		No	No Copayment or Coinsurance

SERVICE	LIMITATIONS	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS
Outpatient Professional Services Provided at an Outpatient Hospital Facility		No	No Copayment or Coinsurance
Medication Management		No	No Copayment or Coinsurance
Methadone Maintenance		No	No Copayment or Coinsurance
Partial Hospitalization		No	No Copayment or Coinsurance
Professional Services at a Partial Hospitalization Facility		No	No Copayment or Coinsurance
Inpatient Services			
Inpatient Facility Services	Prior authorization is required.	Yes	$300 per admission
Inpatient Professional Services		Yes	No Copayment or Coinsurance
EMERGENCY SERVICES AND URGENT CARE			
Limited Service Immediate Care		No	$30 per provider per date of service
Urgent Care Facility		No	$50 per provider per date of service
Hospital Emergency Room	Limited to Emergency Services or unexpected, urgently required services.	No	$200 per visit, waived if admitted
Hospital Emergency Room Professional Services	Limited to Emergency Services or unexpected, urgently required services.	No	No Copayment or Coinsurance
Follow-up Care after Emergency Surgery	Limited to Emergency Services or unexpected, urgently required services.	No	No Copayment or Coinsurance (PCP) $30 (Specialist) per provider per date of service **and** $50 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Ambulance Service	Prior authorization is required for air ambulance services, except for Medically Necessary air ambulance services in an emergency.	No	$50 per provider per date of service
MEDICAL DEVICES AND SUPPLIES			
Durable Medical Equipment		Yes	No Copayment or Coinsurance
Breastfeeding Equipment and Supplies		No	No Copayment or Coinsurance

SERVICE	LIMITATIONS	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS
Diabetes Equipment and Supplies		Yes	No Copayment or Coinsurance
Hair Prosthesis	Limited to one (1) hair prosthesis per Benefit Period combined under the In-Network Evidence of Coverage and Out-of-Network Evidence of Coverage.	Yes	No Copayment or Coinsurance
WELLNESS BENEFIT			
Health Risk Assessment		No	No Copayment or Coinsurance
Health Risk Assessment Feedback		No	No Copayment or Coinsurance
COMPLEX CHRONIC OR HIGH RISK ACUTE DISEASE MANAGEMENT			
Associated Costs for the Patient-Centered Medical Home Program (PCMH)		No	No Copayment or Coinsurance
Chronic Care Coordination Program		No	No Copayment or Coinsurance
Complex Case Management		No	No Copayment or Coinsurance
Comprehensive Medication Review (CMR)	Limited to services rendered by Designated Providers.	No	No Copayment or Coinsurance
Enhanced Monitoring Program		No	No Copayment or Coinsurance
Expert Consultation Program (ECP)		No	No Copayment or Coinsurance
Home Based Services Program (HBS)		No	No Copayment or Coinsurance

SERVICE	LIMITATIONS	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS
PRESCRIPTION DRUGS			
Prescription Drugs	If a Generic Drug is not available, a Non-Preferred Brand Name Drug shall be dispensed. Limited to a 34-day supply of Prescription Drugs. Diabetic supplies and oral chemotherapy drugs are not subject to the Copayment or Coinsurance. The Member shall pay the lesser of the cost of the prescription or the applicable Copayment.	No	**Preferred Preventive Drugs:** No Copayment or Coinsurance **Generic Drugs:** No Copayment or Coinsurance **Preferred Brand Name Drugs:** $45 per prescription **Non-Preferred Brand Name Drugs:** $65 per prescription **Specialty Drugs:** 50% of the Allowed Benefit per prescription
Maintenance Drugs	If a Generic Drug is not available, a Non-Preferred Brand Name Drug shall be dispensed. Limited to a 90-day supply of Maintenance Drugs. Diabetic supplies and oral chemotherapy drugs are not subject to the Copayment or Coinsurance. The Member shall pay the lesser of the cost of the prescription or the applicable Copayment.	No	**Preferred Preventive Drugs:** No Copayment or Coinsurance **Generic Drugs:** No Copayment or Coinsurance **Preferred Brand Name Drugs:** $90 per prescription **Non-Preferred Brand Name Drugs:** $130 per prescription **Specialty Drugs:** 50% of the Allowed Benefit per prescription

Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services through the rest of that Calendar Year.				
			MEMBER PAYS	
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**CONTRACTING VISION PROVIDER**	**NON-CONTRACTING VISION PROVIDER**
Eye Examination	Limited to one per Benefit Period combined under the In-Network Evidence of Coverage and the Out-of-Network Evidence of Coverage.	No	No Copayment or Coinsurance	Expenses in excess of the Pediatric Vision Allowed Benefit of $40 are a non-Covered Vision Service.
Lenses - Important note regarding Member Payments: "Basic" means spectacle lenses with no "add-ons" such as, glare resistant treatment, ultraviolet coating, progressive lenses, transitional lenses and others which may result in additional costs to the Member.				
Basic Single vision	Limited to one pair per Benefit Period combined under the In-Network Evidence of Coverage and the Out-of-Network Evidence of Coverage.	No	No Copayment or Coinsurance	Expenses in excess of the Pediatric Vision Allowed Benefit of $40 are a non-Covered Vision Service.
Basic Bifocals	Limited to one pair per Benefit Period combined under the In-Network Evidence of Coverage and the Out-of-Network Evidence of Coverage.	No	No Copayment or Coinsurance	Expenses in excess of the Pediatric Vision Allowed Benefit of $60 are a non-Covered Vision Service.
Basic Trifocals	Limited to one pair per Benefit Period combined under the In-Network Evidence of Coverage and the Out-of-Network Evidence of Coverage.	No	No Copayment or Coinsurance	Expenses in excess of the Pediatric Vision Allowed Benefit of $80 are a non-Covered Vision Service.
Basic Lenticular	Limited to one pair per Benefit Period combined under the In-Network Evidence of Coverage and the Out-of-Network Evidence of Coverage.	No	No Copayment or Coinsurance	Expenses in excess of the Pediatric Vision Allowed Benefit of $100 are a non-Covered Vision Service.
Frames				
Frames	Limited to one frame per Benefit Period. Services rendered by Contracting Vision Providers limited to frames contained in the Vision Care Designee's collection.	No	No Copayment or Coinsurance	Expenses above the Pediatric Vision Allowed Benefit of $70 are a non-Covered Vision Service.
Low Vision				

Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services through the rest of that Calendar Year.				
			MEMBER PAYS	
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**CONTRACTING VISION PROVIDER**	**NON-CONTRACTING VISION PROVIDER**
Low Vision Eye Examination	Prior authorization is required. It is the Member's responsibility to obtain prior authorization for services obtained from a Non-Contracting Vision Provider. Limited to one comprehensive low vision evaluation every 5 years and 4 follow-up visits in any 5-year period combined under the In-Network Evidence of Coverage and the Out-of-Network Evidence of Coverage.	No	No Copayment or Coinsurance.	Expenses above the Pediatric Vision Allowed Benefit of $300 are a non-Covered Vision Service.
Follow-up care	Prior authorization required. It is the Member's responsibility to obtain prior authorization for services obtained from a Non-Contracting Vision Provider. Limited to four visits in any five-year period combined under the In-Network Evidence of Coverage and the Out-of-Network Evidence of Coverage.	No	No Copayment or Coinsurance.	Expenses above the Pediatric Vision Allowed Benefit of $100 are a non-Covered Vision Service.
High-power Spectacles, Magnifiers and Telescopes	Prior authorization is required. It is the Member's responsibility to obtain prior authorization for services obtained from a Non-Contracting Vision Provider	No	No Copayment or Coinsurance.	Expenses above the Pediatric Vision Allowed Benefit of $600 are a non-Covered Vision Service.
Contact Lenses				

Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services through the rest of that Calendar Year.				
			MEMBER PAYS	
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**CONTRACTING VISION PROVIDER**	**NON-CONTRACTING VISION PROVIDER**
Elective	Includes evaluation, fitting and follow-up fees. Limited to one per Benefit Period combined under the In-Network Evidence of Coverage and the Out-of-Network Evidence of Coverage. Services rendered by Contracting Vision Providers limited to contact lenses contained in the Vision Care Designee's collection.	No	No Copayment or Coinsurance	Expenses above the Pediatric Vision Allowed Benefit of $105 are a non-Covered Service.
Medically Necessary	Prior authorization is required. It is the Member's responsibility to obtain prior authorization for services obtained from a Non-Contracting Vision Provider. Limited to one per Benefit Period combined under the In-Network Evidence of Coverage and the Out-of-Network Evidence of Coverage.	No	No Copayment or Coinsurance	Expenses above the Pediatric Vision Allowed Benefit of $225 are a non-Covered Service.

Pediatric Dental – Limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Dental Services through the rest of that Calendar Year.
Pediatric Dental Deductible
The In-Network Deductible of $25 per Member per Benefit Period applies to all Class II, III, and IV Covered Dental Services.
Pediatric Dental Out-of-Pocket Maximum
Amounts paid by the Member for Covered Pediatric Dental Services will be applied to the Out-of-Pocket Maximum stated above. Once the Out-of-Pocket Maximum has been reached, the Member will no longer be required to pay any Deductible or Coinsurance.

SERVICE	LIMITATIONS	SUBJECT TO PEDIATRIC DENTAL DEDUCTIBLE?	MEMBER PAYS
Class I Preventive & Diagnostic Services		No	No Coinsurance
Class II Basic Services		Yes	20% of the Pediatric Dental Allowed Benefit
Class III Major Services – Surgical		Yes	20% of the Pediatric Dental Allowed Benefit
Class IV Major Services – Restorative		Yes	50% of the Pediatric Dental Allowed Benefit
Class V Orthodontic Services	Limited to Medically Necessary Orthodontia	No	50% of the Pediatric Dental Allowed Benefit

CareFirst BlueChoice, Inc.
[Signature]

_____
[Name]
[Title]