BluePreferred

Summary of Benefits

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
	Visit www.carefirst.com/findadoc to locate providers	
FIRSTHELP—24/7 NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **www.carefirst.com/needcare** to learn more about your options for care.	When your doctor is not available, call FirstHelp at 800-535-9700 to speak with a registered nurse about your health questions and treatment options.	
BLUE REWARDS		
Visit **www.carefirst.com/bluerewards** for more information	Blue Rewards is an incentive program where you can earn up to $300 per adult and $750 per family for taking an active role in getting healthy and staying healthy.	
ANNUAL DEDUCTIBLE (Benefit period)[4]		
Individual	$300	$600
Family	$600	$1,200
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[5]		
Medical[6]	$1,000 Individual/$3,000 Family	$3,000 Individual/$9,000 Family
Prescription Drug[6]	$4,500 Individual/$9,000 Family	All drug costs are subject to in-network out-of-pocket maximum
LIFETIME MAXIMUM BENEFIT		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	20% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	No charge*	Deductible, then 20% of Allowed Benefit
Breast Cancer Screening	No charge*	No charge*
Pap Test	No charge*	No charge*
Prostate Cancer Screening	No charge*	No charge*
Colorectal Cancer Screening	No charge*	No charge*
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	$20 per visit	Deductible, then 20% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans)	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Lab	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
X-ray	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Allergy Testing	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Allergy Shots	$5 per visit	Deductible, then 20% of Allowed Benefit
Physical, Speech and Occupational Therapy	$20 per visit	Deductible, then 20% of Allowed Benefit
Chiropractic	$20 per visit	Deductible, then 20% of Allowed Benefit
Acupuncture	Not covered (except when approved or authorized by Plan when used for anesthesia)	Not covered (except when approved or authorized by Plan when used for anesthesia)
EMERGENCY SERVICES		
Urgent Care Center	$100 per visit	Deductible, then 20% of Allowed Benefit
Emergency Room—Facility Services	$100 per visit (Waived if admitted) no deductible	$100 per visit (Waived if admitted) no deductible
Emergency Room—Physician Services	No charge*	No charge*
Ambulance (if medically necessary)	No charge* after deductible	Deductible, then 20% of Allowed Benefit

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
HOSPITALIZATION (Members are responsible for applicable physician and facility fees)		
Outpatient Facility Services	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Inpatient Facility Services	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 40 visits per benefit period)	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Hospice (Inpatient—limited to 30 days; Outpatient—unlimited during Hospice eligibility period)	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Skilled Nursing Facility (limited to 60 days/benefit period)	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then 20% of Allowed Benefit
Delivery and Facility Services	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Nursery Care of Newborn	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Artificial and Intrauterine Insemination[7]	No charge* after deductible	Deductible, then 20% of Allowed Benefit
In Vitro Fertilization Procedures[7] (limited to 3 attempts per live birth up to $100,000 lifetime maximum)	No charge* after deductible	Deductible, then 20% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE ABUSE (Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	Deductible, then 10% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Outpatient Facility Services	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Office Visits	$20 per visit	Deductible, then 20% of Allowed Benefit
Medication Management	$20 per visit	Deductible, then 20% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Hearing Aids for ages 0-18 (limited to 1 hearing aid per hearing impaired ear every 3 years)	No charge*	No charge*
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

Note: Allowed Benefit is the fee that participating providers in the network have agreed to accept for a particular service. The participating provider cannot charge the member more than this amount for any covered service. Example: Dr. Carson charges $100 to see a sick patient. To be part of CareFirst's network, he has agreed to accept $50 for the visit. The member will pay their copay/coinsurance and deductible (if applicable) and CareFirst will pay the remaining amount up to $50.

* No copayment or coinsurance.

[1] When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.

[2] 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.

[3] 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.

[4] For family coverage only: When one family member meets the individual deductible, they can start receiving benefits. Each family member cannot contribute more than the individual deductible amount. The family deductible must be met before the remaining family members can start receiving benefits

[5] For Family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit.

[6] Plan has an integrated medical and prescription drug out-of-pocket maximum.

[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. Preauthorization required.

Not all services and procedures are covered by your benefits contract. This summary is for comparison purposes only and does not create rights not given through the benefit plan.

The benefits described are issued under form numbers: CFMI/51+/GC (R. 1/13); CFMI/51+/EOC (4/09); CFMI/DOL APPEAL (R. 9/11); CFMI/51+/DOCS (4/09); CFMI/51+/PPO SOB (4/09); CFMI/VISION RIDER (10/11); CFMI/51+/RX (R. 7/12); CFMI/51+/ELIG (R. 1/10) and any amendments. MD/CF/GC (R. 1/13); MD/BP/EOC (10/07); MD/GHMSI/DOL APPEAL (R. 9/11); MD/BP/DOCS (10/07); MD/CF/BP/SOB (R. 4/08); MD/CF/ATTC (R. 7/09); MD/CF/RX (R. 7/12) and any amendments.

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