

BluePreferred • HSA

Integrated Deductible

Summary of Benefits

Services	In-Network You Pay ¹	Out-of-Network You Pay ²
ANNUAL DEDUCTIBLE^{3,4}		
Individual	\$1,200	
Individual & Child(ren)	\$2,400	(combined in- and out-of-network)
Individual & Adult	\$2,400	
Family	\$2,400	
ANNUAL OUT-OF-POCKET LIMIT^{3,4}		
Individual	\$3,400	
Individual & Child(ren)	\$6,800	(combined in and out-of-network)
Individual & Adult	\$6,800	
Family	\$6,800	
LIFETIME MAXIMUM		None
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months	No charge**	\$20 per visit or 30% of AB*
24 months-13 years (immunization visit)	No charge**	\$20 per visit or 30% of AB*
24 months-13 years (non-immunization visit)	No charge**	\$20 per visit or 30% of AB*
14-17 years	No charge**	\$20 per visit or 30% of AB*
Adult Physical Examination	No charge**	\$20 per visit or 30% of AB*
Routine GYN Visits	No charge**	\$20 per visit or 30% of AB*
Mammograms	No charge**	\$20 per visit or 30% of AB*
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge**	\$20 per visit or 30% of AB*
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	Deductible, then 10% of AB	Deductible, then 30% of AB
Diagnostic Services	Deductible, then 10% of AB	Deductible, then 30% of AB
X-ray and Lab Tests	Deductible, then 10% of AB	Deductible, then 30% of AB
Allergy Testing	Deductible, then 10% of AB	Deductible, then 30% of AB
Allergy Shots	Deductible, then 10% of AB	Deductible, then 30% of AB
Outpatient Physical, Speech and Occupational Therapy ⁵ (limited to 30 visits/condition/benefit period)	Deductible, then 10% of AB	Deductible, then 30% of AB
Outpatient Chiropractic ^{5,6} (limited to 20 visits/condition/benefit period)	Deductible, then 10% of AB	Deductible, then 30% of AB
EMERGENCY CARE AND URGENT CARE		
Physician's Office	Deductible, then 10% of AB	Deductible, then 30% of AB
Urgent Care Center	Deductible, then 10% of AB	Deductible, then 30% of AB
Hospital Emergency Room	Deductible, then \$100 per visit, plus 10% of AB (waived if admitted)	Paid as in-network
Ambulance (if medically necessary)	Deductible, then 10% of AB	Deductible, then 30% of AB
HOSPITALIZATION^{5,7}		
Inpatient Facility Services	Deductible, then 10% of AB	Deductible, then 30% of AB
Outpatient Facility Services	Deductible, then 10% of AB	Deductible, then 30% of AB
Inpatient Physician Services	Deductible, then 10% of AB	Deductible, then 30% of AB
Outpatient Physician Services	Deductible, then 10% of AB	Deductible, then 30% of AB

Services	In-Network You Pay ¹	Out-of-Network You Pay ²
HOSPITAL ALTERNATIVES⁷		
Home Health Care	Deductible, then 10% of AB	Deductible, then 30% of AB
Hospice	Deductible, then 10% of AB	Deductible, then 30% of AB
Skilled Nursing Facility (limited to 100 days/benefit period) ⁵	Deductible, then 10% of AB	Deductible, then 30% of AB
MATERNITY		
Prenatal and Postnatal Office Visits	Deductible, then 10% of AB	Deductible, then 30% of AB
Delivery and Facility Services ⁷	Deductible, then 10% of AB	Deductible, then 30% of AB
Initial Office Consultation(s) for Infertility Services/Procedures	Deductible, then 10% of AB	Deductible, then 30% of AB
Nursery Care of Newborn	Deductible, then 10% of AB	Deductible, then 30% of AB
Artificial Insemination ⁸	Deductible, then 50% of AB	Deductible, then 50% of AB
In Vitro Fertilization Procedures ⁸	Not covered	Not covered
MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)⁷		
Inpatient Facility Services (limited to 60 days/benefit period)	Deductible, then 10% of AB	Deductible, then 30% of AB
Inpatient Physician Services	Deductible, then 10% of AB	Deductible, then 30% of AB
Outpatient Services (MH and SA)	Deductible, then 20% of AB	Deductible, then 35% of AB
Partial Hospitalization ⁵ (each day counts as 1/2 day toward inpatient limit)	Deductible, then 10% of AB	Deductible, then 30% of AB
Medication Management Visit	Deductible, then 10% of AB	Deductible, then 30% of AB
MISCELLANEOUS		
Durable Medical Equipment ⁷	Deductible, then 10% of AB	Deductible, then 30% of AB
Acupuncture	Deductible, then 10% of AB	Deductible, then 30% of AB
Transplants ⁷	Covered as stated in Certificate of Coverage	Covered as stated in Certificate of Coverage
Hearing Aids for ages 0-18 (limited to one hearing aid every 3 years) ⁵	Deductible, then 10% of AB	Deductible, then 30% of AB
VISION	Not Covered	Not Covered
PRESCRIPTION DRUGS		
You pay 100% of the discounted cost of your prescription drugs up to your annual deductible; then, you pay the regular prescription drug copays until you meet your annual out-of-pocket maximum. (Refer to your prescription drug benefit summary for copay amounts).		

CareFirst BlueCross BlueShield may be providing your benefits on either a contract year or calendar year basis. Please refer to your benefits contract to determine which method applies to your benefit plan. If your benefits are offered on a calendar year basis, your deductible period runs from January 1st through December 31st. If your benefits are offered on a contract year basis, your deductible period runs for a consecutive 12-months from the beginning of the contract period.

The Allowed Benefit (AB) 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, an allowance may be established by law.

¹ In-network: When you have care rendered by or referred to a provider in the Preferred Provider network. In-network coinsurances are based on a percentage of the AB.

² Out-of-network: When you have care 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 AB. When services are rendered by Non-Participating Providers, charges in excess of the AB are the member's responsibility. However, when services are rendered by a Participating Provider, then member is only responsible for the amount up to the AB.

³ Please refer to your Certificate of Coverage to determine your coverage level.

⁴ The deductible and out-of-pocket limit can be met entirely by one member or by combining eligible expenses of two or more members.

⁵ CareFirst BlueCross BlueShield may be providing your benefits on either a contract year or calendar year basis. Please refer to your benefits contract to determine which method applies to your benefit plan.

⁶ Consultation for chiropractic service is charged the same as office visit for illness.

⁷ Preauthorization required.

⁸ Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment option for infertility. However, assisted reproduction (AI only) services performed as treatment option for infertility are only available under the terms of the members contract.

* Preauthorization required.

** Whichever is greater.

*** No copayments or coinsurance.

All copayments apply towards the deductible and out-of-pocket limit.

Not all services and procedures are covered by your benefits contract. This plan 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: MD/CF/MSGR/GRP APP (R. 9/09), MD/CF/MSGR/GC (R.9/09), MD/CF/MSGR/COC (R. 7/08), MD/CF/MSGR/DOCS/RPN (R. 6/10), MD/CF/MSGR/SOB/PPO/HSA/ENHANCE (R. 7/07), MD/CF/MSGR/GS (9/09), MD/GHMSI/MD-DOL APPEAL (R. 6/06), PPO-HSA DOCS AMEND (MSGR) (R. 4/09), MD/CF/BLUECARD (R. 10/07), MD/CFMI/MSGR/GRP APP (9/09), MDCFMI/MSGR/GC (9/09), MD/CFMI/MSGR/COC (4/09), MD/CFMI/MSGR/DOCS/RPN (R. 6/10), MD/CFMI/MSGR/SOB/PPO/HSA/ENHANCE (4/09), MD/CFMI/MSGR/GS (R. 9/09), CFMI/CLAIMS PROCEEDS (R. 1/08), MD/CFMI/MSGR/HSA/DOCS/AMEND (9/09),MD/CFMI/BLUECARD/AMEND (10/07) and any amendments to these form numbers.



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