

BluePreferred • HSA

Integrated Deductible

Summary of Benefits

Services	In-Network You Pay ¹	Out-of-Network You Pay ²
ANNUAL DEDUCTIBLE^{3,4}		
Individual	\$1,500	
Individual & Child(ren)	\$3,000	(combined in- and out-of-network)
Individual & Adult	\$3,000	
Family	\$3,000	
ANNUAL OUT-OF-POCKET LIMIT^{3,4}		
Individual	\$4,000	
Individual & Child(ren)	\$8,000	(combined in and out-of-network)
Individual & Adult	\$8,000	
Family	\$8,000	
LIFETIME MAXIMUM		None
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months	No charge**	\$20 per visit or 30% of Allowed Benefit*
24 months-13 years (immunization visit)	No charge**	\$20 per visit or 30% of Allowed Benefit*
24 months-13 years (non-immunization visit)	No charge**	\$20 per visit or 30% of Allowed Benefit*
14-17 years	No charge**	\$20 per visit or 30% of Allowed Benefit*
Adult Physical Examination	No charge**	\$20 per visit or 30% of Allowed Benefit*
Routine GYN Visits	No charge**	\$20 per visit or 30% of Allowed Benefit*
Mammograms	No charge**	\$20 per visit or 30% of Allowed Benefit*
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge**	\$20 per visit or 30% of Allowed Benefit*
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Diagnostic Services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
X-ray and Lab Tests	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Allergy Testing	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Allergy Shots	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Outpatient Physical, Speech and Occupational Therapy ⁵ (limited to 30 visits/condition/benefit period)	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Outpatient Chiropractic ^{5,6} (limited to 20 visits/condition/benefit period)	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
EMERGENCY CARE AND URGENT CARE		
Physician's Office	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Urgent Care Center	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Hospital Emergency Room	Deductible, then \$100 per visit, plus 10% of Allowed Benefit (waived if admitted)	Paid as in-network
Ambulance (if medically necessary)	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
HOSPITALIZATION^{5,7}		
Inpatient Facility Services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Outpatient Facility Services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Inpatient Physician Services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Outpatient Physician Services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit

Services	In-Network You Pay ¹	Out-of-Network You Pay ²
HOSPITAL ALTERNATIVES⁷		
Home Health Care	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Hospice	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Skilled Nursing Facility (limited to 100 days/benefit period) ⁵	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
MATERNITY		
Prenatal and Postnatal Office Visits	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Delivery and Facility Services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Initial Office Consultation(s) for Infertility Services/Procedures	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Nursery Care of Newborn	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Artificial Insemination ⁸	Deductible, then 50% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
In Vitro Fertilization Procedures ⁸	Not covered	Not covered
MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)⁷		
Inpatient Facility Services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Inpatient Physician Services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Outpatient Services (MH and SA)	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Partial Hospitalization ⁵	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Medication Management Visit	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
MISCELLANEOUS		
Durable Medical Equipment ⁷	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Acupuncture	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
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 Allowed Benefit	Deductible, then 30% of Allowed Benefit
VISION		
Routine Exam (Optometrist or Ophthalmologist) (limited to 1 visit/benefit period)	\$10 per visit at participating Vision Provider	Plan pays \$33, you pay balance
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers	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. 12/11), MD/CF/MSGR/SOB/PPO/HSA (10/12), MD/CF/MSGR/SOB/PPO/HSA/CORE (R. 7/07), MD/CF/MSGR/GS (9/09), MD/GHMSI/MD DOL APPEAL (R. 9/11), PPO-HSA DOCS AMEND (MSGR) (R. 4/09), MD/CF/BLUECARD (5/12), MD/CFMI/MSGR/GRP APP (9/09), MDCFMI/MSGR/GC (9/09), MD/CFMI/MSGR/COC (4/09), MD/CFMI/MSGR/DOCS/RPN (R. 12/11), MD/CFMI/MSGR/SOB/PPO/HSA (10/12), MD/CFMI/MSGR/SOB/PPO/HSA/CORE (4/09), MD/CFMI/MSGR/GS (R. 9/09), MD/CFMI/MSGR/HSA/DOCS/AMEND (9/09), CFMI/BLUECARD (5/12), CFMI/DOL APPEAL (R. 9/11) and any amendments to these form numbers.



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