HealthyBlue Plus $1,500

Summary of Benefits

Services	In-Network You Pay[1]	Out-of-Network You Pay[1]
	Visit www.carefirst.com/doctors to locate providers	
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)[2]		
Individual	$1,500	$3,000
Family	$3,000	$6,000
ANNUAL OUT-OF-POCKET MAXIMUM (BENEFIT PERIOD)[3,4]		
Individual	$5,500	$7,500
Family	$11,000	$15,000
LIFETIME MAXIMUM BENEFIT		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	No charge*
Adult Physical Examination including routine GYN visit	No charge*	No charge* after deductible
Breast Cancer Screening	No charge*	No charge*
Pap Test	No charge*	No charge* after deductible
Prostate Cancer Screening	No charge*	No charge* after deductible
Colorectal Cancer Screening	No charge*	No charge* after deductible
OFFICE VISITS, LABS AND TESTING		
Facility Charge: In addition to the physician copays/ coinsurances listed below, if a service is rendered on a hospital campus, ADD facility charge	$50 per visit	Deductible, then $100 per visit
Office Visits for Illness[5]	No charge* PCP/$30 Specialist per visit	Deductible, then $50 per visit
Convenience Care (Retail Health Clinics)	No charge*	Deductible, then $50 per visit
Diagnostic Services[5,6]	No charge*	Deductible, then $50 per visit
Lab and Tests[5,6]	No charge*	Deductible, then $50 per visit
X-ray[5,6]	No charge*	Deductible, then $50 per visit
Allergy Testing & Shots[5]	$30 per visit	Deductible, then $50 per visit
Physical, Speech and Occupational Therapy (limited to 30 visits per injury or illness/benefit period)[5,7]	$30 per visit	Deductible, then $50 per visit
Chiropractic (limited to 20 visits/condition/benefit period)[5]	$30 per visit	Deductible, then $50 per visit
Acupuncture[5]	$30 per visit	Deductible, then $50 per visit
EMERGENCY CARE AND URGENT CARE		
Urgent Care Center[8]	$50 per visit	$50 per visit
Hospital Emergency Room—Facility Services[8]	$200 per visit (waived if admitted)	$200 per visit (waived if admitted)
Emergency Room—Physician Services[8]	No charge*	No charge*
Ambulance (if medically necessary)[8]	$50 per service	$50 per service

Services	In-Network You Pay[1]	Out-of-Network You Pay[1]
HOSPITALIZATION—MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES		
Outpatient Facility Surgery (Freestanding Facility)	$100 per visit	Deductible, then $500 per visit
Outpatient Facility Surgery (Hospital Facility)	Deductible, then $500 per visit	Deductible, then $750 per visit
Outpatient Physician Services	No charge* after deductible	Deductible, then $50 per visit
Inpatient Facility Services	Deductible, then $500 per admission	Deductible, then $750 per visit
Inpatient Physician Services	No charge* after deductible	Deductible, then $50 per visit
HOSPITAL ALTERNATIVES		
Home Health Care	Deductible, then $30 per visit	Deductible, then $50 per visit
Hospice	Deductible, then $30 per visit	Deductible, then $50 per visit
Skilled Nursing Facility (limited to 100 days/benefit period)	Deductible, then $30 per admission	Deductible, then $50 per admission
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then $50 per visit
Delivery and Facility Services	Deductible, then $500 per admission	Deductible, then $750 per admission
Nursery Care of Newborn	No charge* after deductible	Deductible, then $50 per visit
Artificial Insemination[9]	Deductible, then $30 per visit	Deductible, then $50 per visit
In Vitro Fertilization Procedures[9]	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Facility Services	Deductible, then $500 per admission	Deductible, then $750 per admission
Inpatient Physician Services	No charge* after deductible	Deductible, then $50 per visit
Outpatient Facility Services	No charge*	Deductible, then $50 per visit
Outpatient Physician Services	No charge*	Deductible, then $50 per visit
Office Visits	No charge*	Deductible, then $50 per visit
Partial Hospitalization Facility Services	No charge*	Deductible, then $50 per visit
Partial Hospitalization Physician Services	No charge*	Deductible, then $50 per visit
Medication Management	No charge*	Deductible, then $50 per visit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Hearing Aids (limited to minor children and limited to one hearing aid per hearing-impaired ear every 36 months)	No charge* after deductible	Deductible, then 20% of Allowed Benefit
PRESCRIPTION DRUGS[10,11]		
Prescription Drug Deductible	$0	
Preventive Drugs	No charge*	
Oral Chemo Drugs and Diabetic Supplies	No charge*	
Generic Drugs	No charge*	
Preferred Brand Drugs[12]	34-day supply-$45; 90-day supply-$90	
Non-preferred Brand Drugs[13]	34-day supply-$65; 90-day supply-$130	
Specialty Drugs	50% coinsurance	
PEDIATRIC VISION (UNDER 19)		
Routine Exam (limited to 1 visit/benefit period)	No charge*	Total charge minus $40 reimbursement
Frames and Contact Lenses– Pediatric Collection Only	No charge*	Reimbursements apply
Spectacle Lenses	No charge*	Reimbursements apply

Services	In-Network You Pay[1]	Out-of-Network You Pay[1]
PEDIATRIC DENTAL (UNDER 19)		
Dental Deductible	$25	$50
Class I Preventive & Diagnostic Services Exams (2 per year), cleanings (2 per year), fluoride treatments (2 per year), sealants, bitewing X-rays (2 per year), full mouth X-ray (one every 3 years)	No charge*	20% of Allowed Benefit
Class II Basic Services Fillings (amalgam or composite), simple extractions, non-surgical periodontics	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Class III Major Services–Surgical Surgical periodontics, endodontics, oral surgery	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Class IV Major Services–Restorative Crowns, dentures, inlays and onlays	Deductible, then 50% of Allowed Benefit	Deductible, then 65% of Allowed Benefit
Class V Medically-Necessary Orthodontic Services	50% of Allowed Benefit	65% of Allowed Benefit

Note: Allowed Benefit is the fee that providers in the network have agreed to accept for a particular service. The 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] For family coverage only: The family deductible must be met before any member starts receiving benefits as indicated above. The deductible may be met by one member or any combination of members.
[3] For family coverage only: The family out-of-pocket maximum must be met before any member's services will be covered at 100% up to the Allowed Benefit. The out-of-pocket maximum may be met by one member or any combination of members.
[4] All drug costs are subject to the in-network out-of-pocket maximum.
[5] If a service is rendered on a hospital campus you could receive two bills, one from the physician and one from the facility.
[6] Members who reside in the CareFirst service area must use LabCorp as their Lab Test facility and freestanding facilities for Diagnostic Services and X-rays. Other providers may be used for out-of-network coverage.
[7] There are no limits for children ages 19 and under when Physical, Speech and Occupational Therapy is for treatment of Autism Spectrum Disorder.
[8] If the out-of-network benefit is listed as contributing toward the in-network deductible, then it also contributes toward the in-network out-of-pocket maximum.
[9] 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.
[10] Except for emergency services or out-of-area urgent care, if a member goes to a non-participating pharmacy, the member is responsible for the copay/coinsurance for the drug plus the difference between the allowed charge and the actual charge for that drug (called balance billed amount). The balance billed amount does not contribute to the out-of-pocket maximum.
[11] Benefits for Specialty Drugs are only available when Specialty Drugs are purchased from and dispensed by a specialty Pharmacy in the Exclusive Specialty Pharmacy Network.
[12] If a Generic drug becomes available for a Preferred Brand drug, the Preferred Brand drug moves to the Non-preferred Brand drug tier.
[13] If a provider prescribes a Non-preferred Brand drug, and the Member selects the Non-preferred Brand drug when a Generic drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the Non-preferred Brand drug and the Generic drug up to the cost of the drug. This amount will not contribute to the Out-of-Pocket Maximum.

Notes:
- 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.
- When the Allowed Benefit is less than the copay listed, the member payment will be the Allowed Benefit.
- PCPs outside the CareFirst service area in BlueCard® PPO include the following specialties: General Practice, Family Practice, Internal Medicine, Pediatrics and Geriatrics.

Policy Form Numbers: MD/CFBC/GC (1/14) • MD/CFBC/ADV IN/EOC (1/14) • MD/CFBC/DOL APPEAL (R. 9/11) • MD/CFBC/IN/DOCS (1/14) • MD/CFBC/HB+-ADV IN/1500 SOB (1/14) • MD/CFBC/HB/WELLNESS (R. 7/13) • MD/CFBC/ELIG (1/14) • MD/CF/GC (1/14) • MD/CF/ADV OON/EOC (1/14) • MD/GHMSI/DOL APPEAL (R. 9/11) • MD/CF/OON/DOCS (1/14) • MD/CF/HB+-ADV OON/1500 SOB (1/14) • MD/CF/ELIG (1/14) • CFMI/GC (1/14) • CFMI/ADV OON/EOC (1/14) • CFMI/DOL APPEAL (R. 9/11) • CFMI/OON/DOCS (1/14) • CFMI/HB+-ADV OON/1500 SOB (1/14) • CFMI/ELIG (1/14) and any amendments.

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