

BluePreferred

Summary of Benefits

Services	Preferred Providers In-Network You Pay ²	Non-Preferred Providers Out-of-Network You Pay ³
ANNUAL DEDUCTIBLE (Benefit period)^{4,9}		
Individual	\$250	\$500
Individual & Child(ren) ⁸	\$500	\$1,000
Individual & Adult	\$500	\$1,000
Family	\$500	\$1,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)⁵		
Individual	\$1,500	\$3,000
Individual & Child(ren) ⁸	\$3,000	\$6,000
Individual & Adult	\$3,000	\$6,000
Family	\$3,000	\$6,000
LIFETIME MAXIMUM	None	
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months	\$10 per visit	20% of Allowed Benefit
24 months-13 years (immunization visit)	\$10 per visit	20% of Allowed Benefit
24 months-13 years (non-immunization visit)	\$10 per visit	20% of Allowed Benefit
14-17 years	\$10 per visit	20% of Allowed Benefit
Adult Physical Examination	\$10 per visit	Deductible, then 20% of Allowed Benefit
Routine GYN Visits	\$10 per visit	Deductible, then 20% of Allowed Benefit
Mammograms	No charge ⁷	CareFirst pays 100% of Allowed Benefit
Cancer Screening		
Pap Test and Prostate	No charge ⁷	CareFirst pays 100% of Allowed Benefit
Colorectal	No charge ⁷	CareFirst pays 100% of Allowed Benefit
OFFICE VISITS, LABS & TESTING		
Office Visits for Illness	\$10 per visit	Deductible, then 20% of Allowed Benefit
Diagnostic Services	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit
X-rays and Lab Tests	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit
Allergy Testing	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit
Allergy Shots	\$5 per visit	Deductible, then 20% of Allowed Benefit
Outpatient Physical, Speech and Occupational Therapy	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit
Outpatient Spinal Manipulation	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit
EMERGENCY CARE AND URGENT CARE		
Physician's Office	\$10 per visit	Deductible, then 20% of Allowed Benefit
Urgent Care Center	\$10 per visit	Paid as in-network
Hospital Emergency Room (limited to emergency service)	Deductible, plus \$50 per visit (copay waived if admitted)	Paid as in-network
Ambulance ⁶ (if medically necessary)	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit
HOSPITALIZATION		
Inpatient Facility Services	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit
Outpatient Facility Services	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 40 visits per benefit period)	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit
Hospice (limited to a maximum 180 day eligibility period)	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit
Skilled Nursing Facility (limited to 60 days per benefit period)	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit

Services	Preferred Providers In-Network You Pay ²	Non-Preferred Providers Out-of-Network You Pay ³
MATERNITY⁸		
Prenatal and Postnatal Office Visits	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit
Delivery and Facility Services	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit
Nursery Care of Newborn	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit
Artificial Insemination ¹	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit
Initial Office Consultation(s) for Infertility Services/Procedures	\$10 per visit	Deductible, then 20% of Allowed Benefit
In Vitro Fertilization Procedures ¹	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit
MENTAL HEALTH & SUBSTANCE ABUSE		
Inpatient Facility Services	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit
Outpatient Services Visits 1 – 5 Visits 6 – 30 Visits 31 and over	No charge ⁷ after deductible Deductible, then 20% of Preferred Provider Allowance Deductible, then 50% of Preferred Provider Allowance	Deductible, then 20% of Allowed Benefit Deductible, then 35% of Allowed Benefit Deductible, then 50% of Allowed Benefit
Partial Hospitalization	\$10 per visit	Deductible, then 20% of Allowed Benefit
Medication Management Visit	\$10 per visit	Deductible, then 20% of Allowed Benefit
MISCELLANEOUS		
Durable Medical Equipment	No charge ⁷ after deductible	Deductible, then 20% of Allowed Benefit
Acupuncture	Not covered (except when approved or authorized by CareFirst when used for anesthesia)	Not covered (except when approved or authorized by CareFirst when used for anesthesia)
Transplants	Covered as stated in the Evidence of Coverage	Covered as stated in the Evidence of Coverage
Hearing Aids for ages 0-18 (limited to \$1,400 max per hearing aid every 3 years)	No charge ⁷	No charge ⁷
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

¹ 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. However, assisted reproduction (AI & IVF) services performed as treatment options for infertility are only available under the terms of the members contract. Preauthorization required.

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 Preferred Provider Allowance. The Preferred Provider Allowance 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.

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 Participating Providers have agreed to accept as payment of covered services. These payments are established by CareFirst, however, in certain circumstances, an allowance may be established by law. When services are rendered by Non-Participating Providers, charges in excess of the Allowed Benefit are the member's responsibility.

⁴ If you have Individual and Adult or Individual and Child(ren) coverage, each Member must satisfy his/her own deductible by meeting the individual deductible. If you have family coverage, all Members' individual deductibles will be combined to meet the family deductible; however, no individual Member may contribute more than the individual deductible amount.

⁵ If you have Individual and Adult or Individual and Child(ren) coverage, each Member must satisfy his/her own out-of-pocket limit by meeting the individual out-of-pocket limit. If you have family coverage, all Members' individual out-of-pocket limits will be combined to meet the family out-of-pocket limit; however, no individual Member may contribute more than the individual out-of-pocket amount.

⁶ Please note that Ambulance Providers will always be paid at the in-network coinsurance level. Some of these providers do not have a contract with CareFirst and may bill Members for charges above the Allowed Benefit.

⁷ No copayments or coinsurance.

⁸ Please refer to your Evidence of Coverage and Schedule of Benefits to determine your coverage level.

⁹ Copayment or portion of deductible may be required at the point of sale while in the deductible period. Member will never be required to pay more than CareFirst's Allowed Benefit for service rendered.

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.

MD/CF/GC (R. 10/07); MD/BP/EOC (10/07); MD/BP/DOCS (10/07); MD/CF/PPO/SOB (4/08); MD/CF/ATTC (R. 1/08); MD/CF/RX (R. 1/08); MD/CF/VISION (R. 1/06) and any amendments. HSA products: MD/CF/GC (R. 10/07); MD/BP/EOC (10/07); MD/BP/DOCS (10/07); MD/CF/PPO/SOB (4/08); MD/CF/ATTC (R.1/08); MD/CF/RX (R. 1/08) and any amendments.



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Prescription Drug Program

\$0 Deductible ■ \$15/35/60 Retail Copays
50% Injectables Coinsurance*

The Four Tier Prescription Drug Program

This program is based on the CareFirst BlueCross BlueShield (CareFirst) or CareFirst BlueChoice, Inc. (CareFirst BlueChoice) preferred drug list, which is made up of all generic prescription drugs (Tier 1) and preferred brand name prescription drugs (Tier 2). Your participating physician has a complete copy of the CareFirst or CareFirst BlueChoice preferred drug list. The preferred drug list changes frequently in response to Food and Drug Administration (FDA) requirements. The list is also adjusted when a generic drug is introduced for a brand name drug. When that happens, the generic drug will be added to the Tier 1 list and the brand name drug will move from Tier 2 to Tier 3.

How Do I Use My Benefit?

Talk to your doctor when you are prescribed medications to see if you are using drugs that are on the preferred drug list – these are also known as Tier 1 or Tier 2 drugs. You will save the most money if you can take those medications. You can get your prescription filled by using the retail or mail order programs. If you have questions about your coverage, call Argus Health Systems at (800) 241-3371.

Retail Program

The retail program provides up to a 34-day supply of medication. Simply present your prescription drug identification card at a participating pharmacy nationwide and pay the appropriate copayment for your medication.

Mail Order Program

The mail service program is a convenient way for you to order medications. Your prescription is reviewed and dispensed by registered pharmacists and mailed directly to your home. Call Walgreens Mail Service at (800) 745-6285 for more information.

Maintenance Drugs

Up to a 90-day supply of maintenance drugs are available through mail order or retail pharmacy at twice the appropriate copayment for your medications. Maintenance medication is a prescription drug anticipated to be required for 6 months or more to treat a chronic condition.

* *Injectables = Self-Administered Injectables.*



Access www.carefirst.com/rx for more information and for the most up-to-date preferred drug list.

Prescription Drug Program

Summary of Benefits

Plan Feature	Amount	Description
Deductible	None	Your benefit does not have a deductible.
Out-of-Pocket Maximum	None	Your benefit does not have a family deductible maximum.
Generic Drugs (Tier 1) (up to a 34-day supply)	\$15	All generic drugs are covered at this copay level.
Preferred Brand Name Drugs (Tier 2) (up to a 34-day supply)	\$35	All preferred brand name drugs are covered at this copay level.
Non-Preferred Brand Name Drugs (Tier 3) (up to a 34-day supply)	\$60	All non-preferred brand name drugs are covered at this copay level. These drugs are not on the preferred drug list. Check the online preferred drug list to see if there is an alternative drug available. Discuss using alternatives with your physician or pharmacist.
Self-Administered Injectables (excluding insulin) (Tier 4) (up to a 34-day supply)	50% coinsurance up to a maximum payment of \$100	All Self-Administered Injectable drugs (excluding insulin) are covered at this payment level. Insulin is covered at appropriate copay level.
Annual Maximum	N/A	Your benefit does not have an annual benefit maximum.
Maintenance Copays (up to a 90-day supply)	generic: \$30 preferred: \$70 non-preferred: \$120 Self-Administered Injectables: 50% coinsurance, up to a maximum payment of \$200	Maintenance drugs of up to a 90-day supply are available for twice the copay only through the mail service or retail pharmacy. Injectables (excluding insulin) are covered at 50% coinsurance up to a maximum payment of \$200.
Generic Substitution	Yes	If you choose a non-preferred brand name drug (Tier 3) over its generic equivalent (Tier 1) you will pay the highest copay PLUS the difference in cost between the non-preferred brand name drug and the generic drug up to the cost of the prescription.
Prior Authorization	Yes	Some prescription drugs require Prior Authorization. Prior Authorization is a tool used to ensure that you will achieve the maximum clinical benefit from the use of specific targeted drugs. Your physician or pharmacist must call (800) 294-5979 to begin the prior authorization process. For the most up-to-date prior authorization list, visit the prescription drug web site at www.carefirst.com/rx .

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Policy Form Numbers: MD/CFBC/RX3 (R. 1/04) • MD/CF/RX3 (R. 1/04)

Did You Know?

- If the cost of your medication is less than your copayment, you pay the cost of the medication.
- A generic drug is a prescription drug that by law must have the equivalent chemical composition as a specific brand name prescription drug.
- You can use your prescription drug card at more than 59,000 participating pharmacies nationwide.
- Frequently asked questions about your prescription benefits are available at www.carefirst.com/rx.



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