HealthyBlue Advantage $1,500 *Summary of Benefits*

Services	In-Network[1]	Out-of-Network[2]
HEALTHY REWARD		
Visit www.carefirst.com/healthyblue for more information.	Earn $300 per adult and up to $700 per family toward reducing your deductible for completing 3 simple steps.	
ANNUAL DEDUCTIBLE (BENEFIT PERIOD)[3]		
Individual	$1,500	$3,000
Family	$3,000	$6,000
ANNUAL OUT-OF-POCKET MAXIMUM (BENEFIT PERIOD)[4]		
Individual	$5,500	$7,500
Family	$11,000	$15,000
LIFETIME MAXIMUM		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	No charge* after deductible
Adult Physical Examination	No charge*	No charge* after deductible
Routine GYN Visits	No charge*	No charge* after deductible
Mammograms	No charge*	No charge*
Pap Test	No charge*	No charge*
Cancer Screening (Prostate and Colorectal)	No charge*	No charge* after deductible
OFFICE VISITS, LABS & TESTING		
Facility fee for services rendered in a hospital setting[5]	$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
Diagnostic Services/Lab Tests (LabCorp only)[5]	No charge*	Deductible, then $50 per visit
X-ray (Freestanding Facility only)[5]	No charge*	Deductible, then $50 per visit
Allergy Testing & Shots[5]	No charge* PCP/$30 Specialist per visit	Deductible, then $50 per visit
Outpatient Physical, Speech and Occupational Therapy[5]	$30 per visit	Deductible, then $50 per visit
Outpatient Chiropractic[5]	$30 per visit	Deductible, then $50 per visit
EMERGENCY CARE AND URGENT CARE		
Urgent Care Center	$50 per visit	Paid as in-network
Hospital Emergency Room (waived if admitted)	$200 per visit	Paid as in-network
Emergency Room–Professional Services	No charge*	Paid as in-network
Ambulance (if medically necessary)	$50 per service	$50 per service
HOSPITALIZATION		
Outpatient Facility Non-Surgery (Hospital Facility)	$50 per visit	Deductible, then $100 per visit
Outpatient Facility Surgery (Freestanding Facility)	$100 per visit	Deductible, then $500 per visit
Outpatient Facility Surgery (Hospital Facility)	Deductible, then $300 per visit	Deductible, then $500 per visit
Outpatient Physician Services	No charge* after deductible	Deductible, then $50 per visit
Inpatient Facility Services	Deductible, then $300 per admission	Deductible, then $500 per admission
Inpatient Physician Services	No charge* after deductible	Deductible, then $50 per visit
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 90 visits/episode of care)	Deductible, then $30 per visit	Deductible, then $50 per visit
Hospice (limited to 60 days inpatient and 180 days outpatient/hospice eligibility period)	Deductible, then $30 per visit	Deductible, then $50 per visit
Skilled Nursing Facility (limited to 60 days/admission)	Deductible, then $30 per admission	Deductible, then $50 per admission

Services	In-Network You Pay[1]	Out-of-Network You Pay[2]
MATERNITY		
Prenatal and Postnatal Office Visits[5]	No charge*	Deductible, then $50 per visit
Delivery and Facility Services	Deductible, then $300 per admission	Deductible, then $500 per admission
Nursery Care of Newborn	No charge* after deductible	Deductible, then $50 per visit
Artificial Insemination[6]	Not covered	Not covered
In Vitro Fertilization Procedures[6]	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Facility Services	Deductible, then $300 per admission	Deductible, then $500 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[5]	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[5]	No charge*	Deductible, then $50 per visit
MISCELLANEOUS		
Durable Medical Equipment	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Acupuncture[5]	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)
Hearing Aids	Not covered	Not covered
PRESCRIPTION DRUGS[7]		
Preventive Drugs	No charge*	
Generic Drugs	No charge*	
Preferred Brand Drugs	34-day supply-$45; 90-day supply-$90	
Non-Preferred Brand Drugs	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
PEDIATRIC DENTAL (UNDER 19)		
Dental Deductible	$25	$50
Class I Preventive & Diagnostic Services	No charge*	20% of Allowed Benefit
Class II Basic Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Class III Major Services–Surgical	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Class IV Major Services–Restorative	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

* No copayment or coinsurance.

[1] When covered services are rendered in the CareFirst BlueChoice service area, by a provider in the CareFirst BlueChoice Provider network, care is reimbursed at the in-network level. In-network benefits are based on the CareFirst BlueChoice Allowed Benefit that is generally the contracted rates or fee schedules that CareFirst BlueChoice providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueChoice, Inc., however, in certain circumstances, an allowance may be established by law. Outside of the CareFirst BlueChoice service area, when covered services are rendered by a provider in the preferred provider network, care is also covered at the in-network level. These in-network benefits are based on the contracted rates or fee schedules that preferred providers have agreed to accept as payment for covered services that are established by the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.

[2] When covered services are rendered by a provider that is not in the CareFirst BlueChoice network, or is not in the preferred provider network outside of CareFirst BlueChoice service area, the care is reimbursed as out-of-network. Out-of-network benefits are based on the Allowed Benefit that is generally the contracted rates or fee schedules that are established by CareFirst BlueChoice, or the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law. When services are rendered by non-participating or non-preferred providers, the member may be responsible for charges in excess of the Allowed Benefit.

[3] The deductible can be met entirely by one Member or by combining eligible expenses of two or more members. There is no Individual Deductible with Family Coverage. The Family Deductible must be reached before CareFirst BlueChoice pays benefits for any Member who has other than Individual Coverage. Please refer to your Evidence of Coverage to determine your coverage level.

[4] The Out-of-Pocket Maximum can be met entirely by one Member or by combining eligible expenses of two or more members. There is no Individual Out-of-Pocket Maximum with Family Coverage. The Family Out-of-Pocket Maximum must be reached before CareFirst BlueChoice pays benefits for any Member who has other than Individual Coverage. Please refer to your Evidence of Coverage to determine your coverage level.

[5] An additional facility copay and/or coinsurance may apply to services rendered in a hospital setting.

[6] Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis.

[7] 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.

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: ON SHOP-DC/CFBC/SHOP/GC (1/14); DC/CFBC/SHOP/ADV IN/EOC (1/14); DC/CFBC/HB/SHOP/EXC/DOCS (1/14); DC/CFBC/SHOP/HB ADV 1500 IN/SOB (1/14); DC/CFBC/SHOP/ELIG (1/14); DC/CFBC/DOL APPEAL (R. 7/11); DC/CF/SHOP/GC (1/14); DC/CF/SHOP/ADV OON/EOC (1/14); DC/CF/SHOP/EXC/DOCS (1/14); DC/CF/SHOP/HB ADV 1500/SOB (1/14); DC/CF/SHOP/ELIG (1/14); DC/GHMSI/DOL APPEAL (R. 11/11)

OFF SHOP-DC/CFBC/GC (1/14); DC/CFBC/ADV IN/EOC (1/14); DC/CFBC/HB/ADV/DOCS (1/14); DC/CFBC/HB ADV 1500 IN/SOB (1/14); DC/CFBC/ELIG (1/14); DC/CFBC/DOL APPEAL (R. 7/11); DC/CF/GC (1/14); DC/CF/OON/EOC (1/14); DC/CF/DOCS (1/14); DC/CF/HB ADV 1500/SOB (1/14); DC/CF/ELIG (1/14); DC/GHMSI/DOL APPEAL (R. 11/11); and any Amendments.

HealthyBlue

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SUM2140-1P (4/14) ■ DC ■ 2-50 Gold