BluePreferred Summary of Benefits

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
	Visit www.carefirst.com/doctor to locate providers and facilities	
24-HOUR NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **www.carefirst.com/needcare** to learn more about your options for care.	When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health questions and treatment options.	
WELLBEING PROGRAM & BLUE REWARDS		
Visit **www.carefirst.com/wellbeing** for more information.	You have access to a comprehensive wellbeing program as part of your medical plan. You also have Blue Rewards, an incentive program where you can get rewarded for completing certain activities.	
ANNUAL DEDUCTIBLE (Benefit period)[4]		
Individual	None	$500
Family	None	$1,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[5]		
Medical[6]	$2,000 Individual/$4,000 Family	$3,000 Individual/$6,000 Family
Prescription Drug[6]	$4,500 Individual/$9,000 Family	All drug costs are subject to in-network out-of-pocket maximum
LIFETIME MAXIMUM BENEFIT		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	Plan pays 100% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	No charge*	Deductible, then 20% of Allowed Benefit
Breast Cancer Screening	No charge*	Plan pays 100% of Allowed Benefit
Pap Test	No charge*	Plan pays 100% of Allowed Benefit
Prostate Cancer Screening	No charge*	Plan pays 100% of Allowed Benefit
Colorectal Cancer Screening	No charge*	Deductible, then 20% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	Virtual Connect Plus through selected providers, including CloseKnit[7] - No charge* (**www.carefirst.com/virtualconnect**) All other providers - $20 per visit	Deductible, then 20% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans)	No charge*	Deductible, then 20% of Allowed Benefit
Lab	No charge*	Deductible, then 20% of Allowed Benefit
X-ray	No charge*	Deductible, then 20% of Allowed Benefit
Allergy Testing	No charge*	Deductible, then 20% of Allowed Benefit
Allergy Shots	$5 per visit	Deductible, then 20% of Allowed Benefit
Physical, Speech and Occupational Therapy	$15 per visit	Deductible, then 20% of Allowed Benefit
Chiropractic	$15 per visit	Deductible, then 20% of Allowed Benefit
Acupuncture (limited to 20 visits/benefit period)	$15 per visit	Deductible, then 20% of Allowed Benefit

BluePreferred Summary of Benefits

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
EMERGENCY SERVICES		
Urgent Care Center	$20 per visit	In-network deductible, then 20% of Allowed Benefit
Emergency Room—Facility Services	$50 per visit (waived if admitted)	$50 per visit (waived if admitted)
Emergency Room—Physician Services	No charge*	No charge*
Ambulance (if medically necessary)	No charge*	In-network deductible, then 20% of Allowed Benefit
HOSPITALIZATION—(Members are responsible for applicable physician and facility fees)		
Outpatient Facility Services	No charge*	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge*	Deductible, then 20% of Allowed Benefit
Inpatient Facility Services	No charge*	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	No charge*	Deductible, then 20% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 90 visits per episode of care)	No charge*	Deductible, then 20% of Allowed Benefit
Hospice (Inpatient—limited to 60 days per hospice eligibility period; Outpatient—limited to 180 day hospice eligibility period)	No charge*	Deductible, then 20% of Allowed Benefit
Skilled Nursing Facility (limited to 60 days/benefit period)	No charge*	Deductible, then 20% of Allowed Benefit
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then 20% of Allowed Benefit
Delivery and Facility Services	No charge*	Deductible, then 20% of Allowed Benefit
Nursery Care of Newborn	No charge*	Deductible, then 20% of Allowed Benefit
Artificial and Intrauterine Insemination[8,9]	Benefits are available to the same extent as benefits provided for other services	Benefits are available to the same extent as benefits provided for other services
In Vitro Fertilization Procedures[8,9]	Benefits are available to the same extent as benefits provided for other services	Benefits are available to the same extent as benefits provided for other services
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	No charge*	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	No charge*	Deductible, then 20% of Allowed Benefit
Outpatient Facility Services	No charge*	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge*	Deductible, then 20% of Allowed Benefit
Office Visits	Virtual Connect Plus through selected providers, including CloseKnit[7]- No charge* (**www.carefirst.com/virtualconnect**) All other providers - No charge*	Deductible, then 20% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	No charge*	Deductible, then 20% of Allowed Benefit
Hearing Aids for ages 0-18	Not covered	Not covered
VISION		
Routine Exam (limited to 1 visit/benefit period)	$10 per visit at participating vision provider	Total charge minus $33 Allowed Benefit
Eyeglasses and Contact Lenses	Discounts from participating vision centers	Not covered

BluePreferred Summary of Benefits

Note: Allowed Benefit is the fee that participating providers in the network have agreed to accept for a particular service. The participating 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 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 Allowed Benefit. The Allowed Benefit 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, the Allowed Benefit for a Preferred Provider 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 Preferred Providers have agreed to accept as payment of covered services. These payments are established by CareFirst, however, in certain circumstances, the Allowed Benefit for an out-of-network provider may be established by law. When services are rendered by Non-Preferred Providers, charges in excess of the Allowed Benefit are the member's responsibility.

4 For family coverage only: When one family member meets the individual deductible, they can start receiving benefits. Each family member cannot contribute more than the individual deductible amount. The family deductible must be met before the remaining family members can start receiving benefits.

5 For family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit. The out-of-pocket maximum includes deductibles, copays and coinsurance.

6 Plan has separate out-of-pocket maximums for medical and drug expenses which accumulate independently.

7 CloseKnit is a registered Trademark owned by, and is the trade name of, Atlas Health, LLC. Atlas Health, LLC d/b/a CloseKnit does not provide Blue Cross Blue Shield products or services and is providing in person and telehealth services to CareFirst members. Atlas Health, LLC is a corporate affiliate within the CareFirst, Inc. corporate umbrella of companies.

8 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.

9 Infertility services will be paid the same as other medical services including Office Visits, Surgery, General Ancillary, Lab, and Radiology benefits.

Not all services and procedures are covered by your benefits contract. This 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: DC/CF/GC (R. 1/24); DC/CF/LG/PPO/EOC (1/25); DC/GHMSI/DOL APPEAL (R. 1/22); DC/CF/LG/DOCS (1/25); DC/CF/LG//PPO/SOB (1/25); DC/CF/RX3 (R. 1/25); DC/CF/LG/SELECT PROV (1/25); DC/CF/LG/INCENT (R. 1/25) and any amendments.

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