# BluePreferred • HSA

## Integrated Deductible

| SERVICES | Preferred Providers In-Network You Pay[2] | Non-Preferred Providers Out-Of-Network You Pay[3] |
|---|---|---|
| **ANNUAL DEDUCTIBLE (Calendar year)[4,8]** | | |
| Individual | $1,200 | $2,400 |
| Individual & Child(ren)[5] | $2,400 | $4,800 |
| Individual & Adult | $2,400 | $4,800 |
| Family | $2,400 | $4,800 |
| **ANNUAL OUT-OF-POCKET LIMIT (Calendar year)[4]** | | |
| Individual | $2,400 | $4,800 |
| Individual & Child(ren)[5] | $4,800 | $9,600 |
| Individual & Adult | $4,800 | $9,600 |
| Family | $4,800 | $9,600 |
| **LIFETIME MAXIMUM** | Unlimited | |
| **PREVENTIVE SERVICES** | | |
| Well-Child Care | | |
| 0-24 months | No charge[7] | Plan pays 100% of Allowed Benefit |
| 24 months-13 years (immunization visit) | No charge[7] | Plan pays 100% of Allowed Benefit |
| 24 months-13 years (non-immunization visit) | No charge[7] | Plan pays 100% of Allowed Benefit |
| 14-17 years | No charge[7] | Plan pays 100% of Allowed Benefit |
| Adult Physical Examination | No charge[7] | 20% of Allowed Benefit |
| Routine GYN Visits | No charge[7] | 20% of Allowed Benefit |
| Mammograms | No charge[7] | Plan pays 100% of Allowed Benefit |
| Cancer Screening (Pap Test, Prostate and Colorectal) | No charge[7] | Plan pays 100% of Allowed Benefit |
| **OFFICE VISITS, LABS & TESTING** | | |
| Office Visits for Illness | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| Diagnostic Services | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| X-ray and Lab Tests | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| Allergy Testing | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| Allergy Shots | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| Outpatient Physical, Speech and Occupational Therapy | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| Outpatient Chiropractic | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| **EMERGENCY CARE AND URGENT CARE** | | |
| Physician's Office | No charge[7] after deductible is met | Paid as in-network |
| Urgent Care Center | No charge[7] after deductible is met | Paid as in-network |
| Hospital Emergency Room (limited to emergency services) | $100 copay, then deductible (copay waived if admitted) | Paid as in-network |
| Ambulance[6] (if medically necessary) | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| **HOSPITALIZATION** | | |
| Inpatient Facility Services | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| Outpatient Facility Services | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| Inpatient Physician Services | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| Outpatient Physician Services | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |

Virginia Groups

| SERVICES | Preferred Providers In-Network You Pay[2] | Non-Preferred Providers Out-Of-Network You Pay[3] |
|---|---|---|
| **HOSPITAL ALTERNATIVES** | | |
| Home Health Care (limited to 90 visits per episode of care) | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| Hospice (limited to a maximum 180 day Hospice eligibility period) | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| Skilled Nursing Facility (limited to 60 days per calendar year) | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| **MATERNITY** | | |
| Prenatal and Postnatal Office Visits | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| Delivery and Facility Services | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| Nursery Care of Newborn | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| Initial Office Consultation(s) for Infertility Services/Procedures | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| Artificial Insemination[1] | Not covered | Not covered |
| In Vitro Fertilization Procedures[1] | Not covered | Not covered |
| **MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)** | | |
| Inpatient Facility Services | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| Inpatient Physician Services | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| Outpatient Services (MH) | | |
| Visits 1 – 5 | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| Visits 6 – 20 | Deductible, then 50% of Allowed Benefit | Deductible, then 50% of Allowed Benefit |
| Outpatient Services (SA) | | |
| Visits 1 – 5 | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| Visits 6 – 20 | Deductible, then 50% of Allowed Benefit | Deductible, then 50% of Allowed Benefit |
| Partial Hospitalization (limited to 15 days per calendar year) | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| Medication Management Visit | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| **MISCELLANEOUS** | | |
| Durable Medical Equipment | No charge[7] after deductible is met | Deductible, then 20% of Allowed Benefit |
| Acupuncture | Not covered, only when plan approved for anesthesia | Not covered, only when plan approved 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 | Not covered | Not covered |
| **VISION** | Not covered | 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.)

[1] 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 & IVF) services performed as treatment option 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] The deductible can be met entirely by one Member or by combining eligible expenses of two or more Members. The Out-of-Pocket can be met in the same way.

[5] Please refer to your Evidence of Coverage to determine your coverage level.

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

## EXCLUSIONS

**10.1 Medical Necessity and Appropriateness.** Benefits will not be provided for services, tests, procedures or supplies which we determine are not medically necessary for the prevention, diagnosis or treatment of your illness, injury or condition. Although a service or supply is listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in your particular case. A service or supply is medically necessary and appropriate only if, in our judgment, it is:

a. Necessary and appropriate for the symptom, diagnosis, prevention or treatment of your illness, injury or condition;
b. Consistent with the symptom, diagnosis, prevention or treatment of your illness, injury or condition;
c. The most appropriate supply, treatment or level of service that can be provided safely to you and, if your are an inpatient, cannot be provided safely on an outpatient basis; and
d. Not primarily for your convenience or the convenience of the provider.

Services, supplies, and accommodations will not automatically be considered Medically Necessary because they were prescribed by an Eligible Provider. We may consult with professional medical consultants, peer review committees, or other appropriate sources for recommendations on whether the services, supplies, or accommodations you receive are Medically Necessary.

**10.2 Accepted Medical Practice.** Benefits will not be provided for any treatment, procedure, facility, equipment, drug, drug usage, device or supply which, in our judgment, is experimental, investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment. A service or supply is deemed to be experimental or investigational if:

a. A preponderance of scientific data, such as controlled studies in peer-reviewed journals or literature, has not demonstrated that its use results in an improved net health outcome for a specific diagnosis;
b. It is not in accordance with generally accepted standards of medical practice; or
c. It does not have federal or other required governmental agency approval at the time it is received.

**10.3 Free Care.** Payment will not be made for services which, if you were not covered under the Group Contract, would have been provided without charge, including any charge or any portion of a charge which, by law, the provider is not permitted to bill to or collect from the patient directly.

**10.4 Routine Care of Feet.** Benefits will not be provided for any services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet or partial removal of a nail without the removal of its matrix. However, benefits will be provided for these services if we determine that medical attention was medically necessary because of a medical condition affecting the feet, such as severe diabetes and, that all other conditions for coverage have been met.

**10.5 Dental Care.** Except as provided in section 3.9, benefits will not be provided for any other type of dental care including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess, removal of impacted teeth, orthodontia, false teeth or any other dental services or supplies, unless provided in a separate Rider or Endorsement to this Agreement.

**10.6 Oral Surgery.**

1. Medically Necessary procedures, as determined by the Plan, to attain functional capacity, correct a congenital anomaly, reduce a dislocation, repair a fracture, excise tumors, cysts or exostoses, or drain abscesses with cellulitis and are performed on sound natural teeth and supporting structures, lips, tongue, roof and floor of the mouth, accessory sinuses, salivary glands or ducts, and jaws.

   Medically Necessary procedures, as determined by the Plan, needed as a result of an accidental injury, when the Member requests oral surgical services or the need for oral surgical services is identified in the patient's medical records within 60 days of the accident. Benefits for such oral surgical services shall be provided up to three (3) years from the date of injury.
2. Surgical treatment for temporomandibular joint syndrome (TMJ) if there is clearly demonstrable radiographic evidence of joint abnormality due to an illness.
3. All other procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae for cosmetic purposes or for correction of malocclusion are excluded.

**10.7 Cosmetic Services.** Benefits will not be provided for cosmetic surgery (except benefits for Reconstructive Breast Surgery and the treatment of morbid obesity) or other services primarily intended to correct, change or improve appearances. Cosmetic means a service or supply which is provided with the primary intent of improving appearances and not for the purpose of restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention as determined by the Plan.

**10.8 Prescription Drugs.** Except as provided in a separate rider or endorsement to this Agreement, benefits will not be provided for prescription drugs, unless administered to you in the course of covered outpatient or inpatient treatment. Take-home prescriptions or medications, including self-administered injections which can be administered by the patient or by an average individual who does not have medical training, or medications which do not medically require administration by or under the direction of a physician are not covered, except as may be provided in a separate rider or endorsement to this Agreement, even though they may be dispensed or administered in a physician or provider office or facility.

**10.9 Organ Transplants.** Organ transplant procedures, including complications resulting from any such procedure, and services or supplies related to any organ transplant procedure such as, but not limited to, high dose chemotherapy, radiation therapy or any other form of therapy, or immunosuppressive drugs are not covered, except as provided in sections 3.10 and 3.11.

**10.10 Other Exclusions.** Benefits will not be provided for the following:

a. Services or supplies received before the effective date of your coverage under this Certificate.
b. Treatment of sexual dysfunctions or inadequacies except for surgical implants for impotence (medical therapy and psychiatric treatment are not covered).
c. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
d. Weight reduction or obesity treatment.
e. Speech therapy, occupational therapy or physical therapy that is maintenance therapy for a chronic disease or condition or nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.
f. Fees and charges relating to fitness programs, weight loss or weight control programs, physical, pulmonary conditioning programs or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education. Cardiac rehabilitation programs are covered as described in section 4.3.f.
g. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof.
h. Services to the extent they are covered by any governmental unit, except in Veteran's Administration or armed forces facilities for services received, such as for non-service connected disabilities, for which the recipient is liable. Services or supplies for injuries or diseases related to a covered person's job to the extent the covered person is required to be covered by a workers' compensation law. Services or supplies resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
i. Services that are beyond the scope of the license of the provider performing the service.
j. Except for covered ambulance services, travel, whether or not recommended by an Eligible Provider.
k. Services or supplies for conditions that State or local laws, regulation, ordinances, or similar provisions require to be provided in a public institution.
l. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.
m. Contraceptive devices.
n. Assistive reproductive procedures, including artificial insemination, in vitro fertilization, embryo or ovum transplants and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.
o. Partial removal of a nail without the removal of the matrix.
p. Services solely on court order or as a condition of parole or probation unless approved by the Plan.
q. Any illness or injury caused by war, declared or undeclared, including armed aggression.
r. Any service, supply or procedure which is not specifically listed in your Certificate as a covered benefit.

Not all services and procedures are covered by your benefits contract. This list is a summary and is not intended to itemize every procedure not covered by CareFirst BlueCross BlueShield. 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:
GC-A-4/95; GPS-FI-4/95; VA/CERT-5/96; PPP-A-5/95; VA/NCA/ELIG-C 5/97;
VA/CF/SOB HDHP (12/04); VA/CF/CDH RX (1/05); VA/CF/WIG HDHP (R. 12/04) and any amendments.

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