HDHP Basic Summary of Benefits

Danfoss

Integrated Deductible

Services	In-network You Pay[1,2]	Out-of-network You Pay[1,3]
	Visit carefirst.com/doctor to locate providers	
24-HOUR NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **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 **carefirst.com/myaccount** for more information.	You have access to a comprehensive well-being 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	$3,000	$3,000
Family	$6,000 (embedded individual deductible of $3,300 for family plan)	$6,000 (embedded individual deductible of $3,300 for family plan)
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[5]		
Medical[6]	$5,500 Individual/$11,000 Family	$5,500 Individual/$11,000 Family
LIFETIME MAXIMUM BENEFIT		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	Deductible, then 40% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	No charge*	Deductible, then 40% of Allowed Benefit
Breast Cancer Screening	No charge*	Deductible, then 40% of Allowed Benefit
Pap Test	No charge*	Deductible, then 40% of Allowed Benefit
Prostate Cancer Screening	No charge*	Deductible, then 40% of Allowed Benefit
Colorectal Cancer Screening	No charge*	Deductible, then 40% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness[7,8]	Virtual Connect through CloseKnit—No charge* (closeknithealth.com) All other providers—Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Lab	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
X-ray	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Allergy Testing	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Allergy Shots	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Physical, Speech and Occupational Therapy (limited to 60 visits combined PT/ST/OT)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Chiropractic (limited to 24 visits per benefit period)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Acupuncture	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit

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EMERGENCY SERVICES		
Urgent Care Center	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Emergency Room—Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Emergency Room—Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Ambulance (if medically necessary)	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
HOSPITALIZATION—(Members are responsible for both physician and facility fees)		
Outpatient—Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Outpatient—Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Inpatient—Facility Services	Deductible, then 20% of Allowed Benefit (prior authorization required)	Deductible, then 40% of Allowed Benefit (prior authorization required)
Inpatient—Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 100 visits per benefit period)	Deductible, then 20% of Allowed Benefit (prior authorization required)	Deductible, then 40% of Allowed Benefit (prior authorization required)
Hospice	Deductible, then 20% of Allowed Benefit (prior authorization required)	Deductible, then 40% of Allowed Benefit (prior authorization required)
Skilled Nursing Facility	Deductible, then 20% of Allowed Benefit (prior authorization required)	Deductible, then 40% of Allowed Benefit (prior authorization required)
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then 40% of Allowed Benefit
Delivery and Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Nursery Care of Newborn	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Artificial and Intrauterine Insemination[9] (limited to $30,000 lifetime maximum)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
In Vitro Fertilization Procedures[9] (limited to $30,000 lifetime maximum)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for both physician and facility fees)		
Office Visits[7,8]	Virtual Connect through CloseKnit—No charge* (closeknithealth.com) All other providers—Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Outpatient—Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Outpatient—Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Inpatient—Facility Services	Deductible, then 20% of Allowed Benefit (prior authorization required)	Deductible, then 40% of Allowed Benefit (prior authorization required)
Inpatient—Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Medication Management	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 20% of Allowed Benefit (prior authorization required for over $1,000)	Deductible, then 40% of Allowed Benefit (prior authorization required for over $1,000)
Hearing Aids for ages 0–18 ($5,000 maximum per benefit period)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit

Note: Allowed Benefit is the fee that participating, in-network providers have agreed to accept for a particular covered 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] 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.
[6] Plan has an integrated medical and prescription drug out-of-pocket maximum.
[7] "Telemedicine Services" refers to the use of a combination of interactive audio, including audio-only telephone conversation between a health care provider and the Member when required by law, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Use of e-mail, online questionnaires or Fax is not considered a telemedicine service.
[8] 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 telehealth services to CareFirst members.
[9] Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and treatment options for infertility. Prior authorization required.

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: MD/CF/GC (R. 1/13); MD/BP/EOC (10/07); MD/GHMSI/DOL APPEAL (R. 9/11); MD/BP/DOCS (10/07); MD/CF/BP/SOB (R. 4/08); MD/CF/RX (R. 1/18); MD/CF/PPO/INCENT (R. 1/19); MD/CF/ATTC (R. 7/09) and any amendments. CFMI/51+/GC (R. 1/13); CFMI/51+/EOC (4/09); CFMI/DOL APPEAL (R. 9/11); CFMI/51+/DOCS (4/09); CFMI/51+/PPO SOB (4/09); CFMI/VISION RIDER (10/11); CFMI/RX (R. 1/18); CFMI/51+/ELIG (R. 1/10); CFMI/PPO/INCENT (R. 1/19) and any amendments.

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