CareFirst
Family of health care plans

BluePreferred PPO (National Plan)

SUMMARY OF BENEFITS

We're glad you're considering CareFirst BlueCross BlueShield. We know there's a lot of information to review when selecting a health plan. We hope this summary makes things a little easier.

This is a plan for people who:

- **Don't mind having a medical plan that has a deductible**
- **Want to see doctors outside the network and have a portion of their cost covered**
- **Travel internationally and would benefit from Global® Core coverage**

For more information about CareFirst plan options and resources, visit carefirst.com/dcgov.

24-Hour Nurse Advice Line

Get free advice from a registered nurse. Call 800-535-9700 to discuss your health questions and treatment options.

Blue Rewards and Wellness

You have access to a comprehensive wellness program that offers incentives for completing certain activities.

Virtual Care through CloseKnit

CloseKnit gives you 24/7 access to the support you deserve—from primary and urgent care to therapy and more* through your desktop or the convenient CloseKnit mobile app. The app can be downloaded from Apple App Store or Google Play.

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EMPLOYEE MONTHLY CONTRIBUTION		
Self Only	$221.09	
Self + One	$422.28	
Family	$647.79	
Services	**In-network You Pay[1,2]**	**Out-of-network You Pay[1,3]**
ANNUAL DEDUCTIBLE (Benefit period)[4]		
Individual	$750	$1,500
Family	$1,500	$3,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[5]		
Medical[6]	$1,500 Individual/$3,000 Family	$3,000 Individual/$6,000 Family
Prescription Drug[6]	$5,100 Individual/$10,200 Family	All 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*	25% of CareFirst member cost
Adult Physical Examination (including routine GYN visit)	No charge*	25% of CareFirst member cost
Breast Cancer Screening	No charge*	25% of CareFirst member cost
Pap Test	No charge*	25% of CareFirst member cost
Prostate Cancer Screening	No charge*	25% of CareFirst member cost
Colorectal Cancer Screening	No charge*	25% of CareFirst member cost

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Services	In-network You Pay[1,2]	Out-of-network You Pay[1,3]
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	$15 per visit	After deductible is met, 25% of CareFirst member cost
Imaging (MRA/MRS, MRI, PET & CAT scans)	After deductible is met, 15% of CareFirst member cost	After deductible is met, 25% of CareFirst member cost
Lab	After deductible is met, 15% of CareFirst member cost	After deductible is met, 25% of CareFirst member cost
X-ray	After deductible is met, 15% of CareFirst member cost	After deductible is met, 25% of CareFirst member cost
Allergy Testing	$15 per visit	After deductible is met, 25% of CareFirst member cost
Allergy Shots	$15 per visit	After deductible is met, 25% of CareFirst member cost
Physical, Speech and Occupational Therapy	After deductible is met, 15% of CareFirst member cost	After deductible is met, 25% of CareFirst member cost
Chiropractic	After deductible is met, 15% of CareFirst member cost	After deductible is met, 25% of CareFirst member cost
Acupuncture	After deductible is met, 15% of CareFirst member cost	After deductible is met, 25% of CareFirst member cost
EMERGENCY SERVICES		
Urgent Care Center	$25 per visit	After deductible is met, 25% of CareFirst member cost
Emergency Room—Facility Services	$100 per visit (waived if admitted)	$100 per visit (waived if admitted)
Emergency Room—Physician Services	No charge*	No charge*
Ambulance (if medically necessary)	No charge*	No charge*
HOSPITALIZATION (Members are responsible for applicable physician and facility fees)		
Outpatient Facility Services	After deductible is met, 15% of CareFirst member cost	After deductible is met, 25% of CareFirst member cost
Outpatient Physician Services	After deductible is met, 15% of CareFirst member cost	After deductible is met, 25% of CareFirst member cost
Inpatient Facility Services	After deductible is met, 15% of CareFirst member cost	After deductible is met, 25% of CareFirst member cost
Inpatient Physician Services	After deductible is met, 15% of CareFirst member cost	After deductible is met, 25% of CareFirst member cost
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 90 visits per episode of care)	After deductible is met, 15% of CareFirst member cost	After deductible is met, 25% of CareFirst member cost
Hospice (Inpatient—limited to maximum 180 day Hospice eligibility period; Outpatient—limited to 60 days per Hospice eligibility period)	After deductible is met, 15% of CareFirst member cost	After deductible is met, 25% of CareFirst member cost
Skilled Nursing Facility (limited to 60 days/benefit period)	After deductible is met, 15% of CareFirst member cost	After deductible is met, 25% of CareFirst member cost
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	After deductible is met, 25% of CareFirst member cost
Delivery and Facility Services	After deductible is met, 15% of CareFirst member cost	After deductible is met, 25% of CareFirst member cost
Nursery Care of Newborn	After deductible is met, 15% of CareFirst member cost	After deductible is met, 25% of CareFirst member cost
Artificial and Intrauterine Insemination (limited to 6 attempts per live birth)	After deductible is met, 50% of CareFirst member cost	Not covered
Assisted Reproductive Technology[7] (limited to 3 attempts per live birth; and a lifetime maximum benefit of $100,000)	After deductible is met, 50% of CareFirst member cost	Not covered

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MENTAL HEALTH AND SUBSTANCE USE DISORDER (Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	After deductible is met, 15% of CareFirst member cost	After deductible is met, 25% of CareFirst member cost
Inpatient Physician Services	After deductible is met, 15% of CareFirst member cost	After deductible is met, 25% of CareFirst member cost
Outpatient Facility Services	No charge*	After deductible is met, 25% of CareFirst member cost
Outpatient Physician Services	No charge*	After deductible is met, 25% of CareFirst member cost
Office Visits	$15 per visit	After deductible is met, 25% of CareFirst member cost
Medication Management	$15 per visit	After deductible is met, 25% of CareFirst member cost
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	After deductible is met, 15% of CareFirst member cost	After deductible is met, 25% of CareFirst member cost
Hearing Aids for ages 0-18 (limited to 1 hearing aid per hearing impaired ear every 3 years)	Not covered	Not covered
VISION		
Routine Exam (limited to 1 visit/ benefit period)	$10 per visit at participating vision provider	CareFirst pays $33, you pay balance
Eyeglasses and Contact Lenses	Discounts from participating vision centers	Not covered

Note: CareFirst member cost 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.
[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 separate out-of-pocket maximums for medical and drug expenses which accumulate independently.
[7] Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis. Assisted Reproductive Technologies ("ART") are also sometimes referred to as Advanced Reproductive Technologies. Coverage under the policy includes benefits for In Vitro Fertilization and other forms of ART

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. 1/19); DC/CF/BP/EOC (R. 11/09); DC/GHMSI/DOL APPEAL (R. 1/17); DC/CF/BP/DOCS (7/08); DC/CF/BP/SOB (7/08); DC/CF/SOB HDHP (R. 7/08); DC/CF/RX3 (R. 1/18); DC/CF/LG/INCENT (R. 1/19); DC/CF/ATTC (R. 1/10) and any amendments.

Notice of Nondiscrimination and Availability of Language Assistance Services
CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all of their corporate affiliates comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-258-6518.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855-258-6518.