

BluePreferred

SMITHSONIAN INSTITUTION

Summary of Benefits

SERVICES	Preferred Providers In-Network You Pay ²	Non-Preferred Providers Out-Of-Network You Pay ³
ANNUAL DEDUCTIBLE (Calendar year)⁴		
Individual	None	\$300
Individual & Child(ren) ⁷	None	\$600
Individual & Adult	None	\$600
Family	None	\$600
ANNUAL OUT-OF-POCKET LIMIT (Calendar year)⁵		
Individual	\$1,500	\$3,000
Individual & Child(ren) ⁷	\$3,000	\$6,000
Individual & Adult	\$3,000	\$6,000
Family	\$3,000	\$6,000
LIFETIME MAXIMUM	None	
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months	No charge ⁶	Plan pays 100% of Allowed Benefit
24 months-13 years (immunization visit)	No charge ⁶	Plan pays 100% of Allowed Benefit
24 months-13 years (non-immunization visit)	No charge ⁶	Plan pays 100% of Allowed Benefit
14-17 years	No charge ⁶	Plan pays 100% of Allowed Benefit
Adult Physical Examination	\$10 per visit	Deductible, then 30% of Allowed Benefit
Routine GYN Visits	\$10 per visit	Deductible, then 30% of Allowed Benefit
Mammograms	No charge ⁶	Plan pays 100% of Allowed Benefit
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge ⁶	Plan pays 100% of Allowed Benefit
OFFICE VISITS, LABS & TESTING		
Office Visits for Illness	\$10 per visit	Deductible, then 30% of Allowed Benefit
Diagnostic Services	10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
X-ray and Lab Tests	10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Allergy Testing	10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Allergy Shots	\$5 per visit	Deductible, then 30% of Allowed Benefit
Outpatient Physical, Speech and Occupational Therapy	\$15 per visit	Deductible, then 30% of Allowed Benefit
Outpatient Chiropractic	\$15 per visit	Deductible, then 30% of Allowed Benefit
EMERGENCY CARE AND URGENT CARE		
Physician's Office	\$10 per visit	Paid as in-network
Urgent Care Center	\$10 per visit	Paid as in-network
Hospital Emergency Room (limited to emergency services)	\$50 per visit (copay waived if admitted)	Paid as in-network
Ambulance (if medically necessary)	10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
HOSPITALIZATION		
Inpatient Facility Services	No charge ⁶	Deductible, then 30% of Allowed Benefit
Outpatient Facility Services	No charge ⁶	Deductible, then 30% of Allowed Benefit
Inpatient Physician Services	No charge ⁶	Deductible, then 30% of Allowed Benefit
Outpatient Physician Services	No charge ⁶	Deductible, then 30% of Allowed Benefit

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)	10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Hospice (limited to a maximum 180 day Hospice eligibility period)	10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Skilled Nursing Facility (limited to 60 days per calendar year)	10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
MATERNITY		
Prenatal and Postnatal Office Visits	10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Delivery and Facility Services	No Charge ⁶	Deductible, then 30% of Allowed Benefit
Nursery Care of Newborn	No Charge ⁶	Deductible, then 30% 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 Services (MH)	No Charge ⁶	Deductible, then 30% of Allowed Benefit
Inpatient Services (SA) (limited to 30 days per calendar year)	No Charge ⁶	Deductible, then 30% of Allowed Benefit
Outpatient Services (MH) Visits 1 – 40 Visits 41 and over	25% of Preferred Provider Allowance 40% of Preferred Provider Allowance	Deductible, then 25% of Allowed Benefit Deductible, then 40% of Allowed Benefit
Outpatient Services (SA) (limited to 30 visits per calendar year)	10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Partial Hospitalization	10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Medication Management Visit	10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
MISCELLANEOUS		
Durable Medical Equipment	10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Acupuncture	Only when Plan approved for anesthesia	Only when Plan approved for anesthesia
Transplants	Covered as stated in Evidence of Coverage	Covered as stated in Evidence of Coverage
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 for optometrist or ophthalmologist
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers	Not covered

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 you have care rendered by a provider in the Preferred Provider network. 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 you have care 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 If you have two-party coverage, each Member must satisfy his/her own deductible by meeting the individual deductible. If you have family coverage, all Members' individual deductibles will be combined to meet the family deductible; however, no individual Member may contribute more than the individual deductible amount.

⁵ If you have two-party coverage, each Member must satisfy his/her own out-of-pocket limit by meeting the individual out-of-pocket Limit. If you have family coverage, all Members' individual out-of-pocket limits will be combined to meet the family out-of-pocket limit; however, no individual Member may contribute more than the individual out-of-pocket amount.

⁶ No copayments or coinsurance.

⁷ Please refer to your Evidence of Coverage to determine your coverage level.

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/DC-6/95 • GPS-DC -6/95 • DC/CERT-9/96 • DC/PPO-A-8/96 • D-CMM/MM ATTB-8/95 • DC/NCA/ELIG0-C 6/97 and any amendments.