BluePreferred Summary of Benefits

Natural Food Holdings

NFH Basic Plan

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
	Certain services require preauthorization. The failure to obtain pre-authorization will generally result in higher costs to you. Please see the Evidence of Coverage.	
	Visit carefirst.com/naturalfoods to locate providers	
24-HOUR NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **carefirst.com/naturalfoods** 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.	
ANNUAL MEDICAL DEDUCTIBLE (Benefit period)[4] (In-network and Out-of-network combined)		
Medical	$600 Individual/$1,200 Family	$1,200 Individual/$2,400 Family
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[5] (In-network and Out-of-network combined)		
Medical	$1,800 Individual/$3,600 Family	$3,600 Individual/$7,200 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	PCP—$30 copay Video Visit—No charge*	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	No charge*	Deductible, then 40% of Allowed Benefit
X-ray	No charge*	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
Speech Therapy (limited to 30 visits/benefit period); Physical & Occupational Therapy (limited to 60 combined visits/benefit period)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Chiropractic (limited to 12 visits/benefit period)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Acupuncture	Not covered (except when approved or authorized by Plan for Anesthesia).	Not covered (except when approved or authorized by Plan for Anesthesia).
EMERGENCY SERVICES		
Urgent Care Center	$30 per visit	Deductible, then 40% of Allowed Benefit
Emergency Room—Facility Services	Deductible, then 20% of Allowed Benefit	In-network deductible, then 20% of Allowed Benefit
Emergency Room—Physician Services	Deductible, then 20% of Allowed Benefit	In-network deductible, then 20% of Allowed Benefit
Ambulance (if medically necessary)	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
HOSPITALIZATION (Members are responsible for applicable 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	Deductible, then 40% of Allowed Benefit
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	Deductible, then 40% of Allowed Benefit
Hospice (limited to 185 days per lifetime)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Skilled Nursing Facility (limited to 100 days/benefit period)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
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
MENTAL HEALTH AND SUBSTANCE USE DISORDER (Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Inpatient Physician Services	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
Office Visits	No charge*	Deductible, then 40% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Hearing Aids for ages 0-18 (limited to 1 hearing aid per hearing impaired ear every 3 years)	Not covered	Not covered

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 PCP 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 which would otherwise be subject to the deductible. 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 which would otherwise be subject to the deductible. (In-network and Out-of-network combined)

[5] For Family coverage only: When one family member meets the individual out-of-pocket maximum, all 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 all 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. (In-network and Out-of-network combined)

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: 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/51+/RX (R. 7/12); CFMI/51+/ELIG (R. 1/10) and any amendments. 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/ATTC (R. 7/09); MD/CF/RX (R. 7/12) and any amendments.

CareFirst

Pharmacy Program Summary of Benefits

NFH—Basic Plan

Formulary 2 with The Advanced Control Specialty Formulary ■ 5-Tier

Plan Feature	Amount You Pay	Description
Deductible	$0	Your plan does not have a deductible
Out-of-Pocket Maximum	$4,800 Individual/$9,600 Family	If you reach your out-of-pocket maximum, CareFirst will pay 100% of the applicable allowed benefit for most covered services for the remainder of the year. All deductibles, copays, coinsurance and other eligible out-of-pocket costs count toward your out-of-pocket maximum, except balance billed amounts.
Preventive Drugs (up to a 30-day supply)	$0 (not subject to deductible)	Preventive drugs are a prescribed medication or items on CareFirst's Preventive Drug List.*
Generic Drugs (Tier 1) (up to a 31-day supply)	$10	Generic drug are covered at this copay level.
Preferred Brand Drugs (Tier 2) (up to a 31-day supply)	$30	All preferred brand drugs are covered at this copay level.
Non-preferred Brand Drugs (Tier 3) (up to a 31-day supply)	$60	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Discuss using alternatives with your physician or pharmacist.
Specialty Generic Drugs (up to a 31-day supply)	$10	**Must be filled through Exclusive Specialty Pharmacy Network.**
Preferred Specialty Drugs (Tier 4) (up to a 31-day supply)	$30	**Must be filled through Exclusive Specialty Pharmacy Network.**
Non-preferred Specialty Drugs (Tier 5) (up to a 31-day supply)	$60	All non-preferred brand drugs on this copay level are not on the Preferred Specialty Drug List.* Discuss using alternatives with your physician or pharmacist.
Prudent Rx Copay Program (enrollment required)	**$0 with The PrudentRx Copay Program** As part of your prescription plan, The PrudentRx Copay Program allows you to get all of your specialty medications at no cost to you. That means $0 out-of-pocket for any medications on your Specialty Drug List when you fill at a CVS Exclusive Specialty Pharmacy. PrudentRx will work with manufacturers to get copay card assistance[1] and will manage enrollment and renewals on your behalf. Even if there is no copay card program for your medication, your cost will be $0 for as long as you are enrolled in the program. The table below is an example of how the program works.	

Out-of-pocket cost if enrolled in the program	Out-of-pocket cost if not enrolled
Medication cost: $1,000 for a 30-day supply **Copay[2] responsibility (30%): $300** **Your out-of-pocket cost: $0** Amount applied to deductible: $0[3] Amount applied to out-of-pocket maximum: $0	Medication cost: $1,000 for a 30-day supply **Copay responsibility (30%)[2]: $300** **Your out-of-pocket cost: $300** Amount applied to deductible: $300[3] Amount applied to out-of-pocket maximum: $300**

All specialty drugs covered under the PrudentRx manufacturer copay assistance program are subject to 30% coinsurance if you do not participate in the program.

****Please note:** Example assumes the medication is an "essential health benefit," which allows your out-of-pocket cost to apply to your out-of-pocket maximum. Many specialty medications are considered "non-essential health benefits." For medications that are not essential health benefits,[4] amounts paid by you, a manufacturer or a plan sponsor will not apply to your out-of-pocket maximum.[5]

[1] Eligibility for third-party copay assistance program is dependent on the applicable terms and conditions required by that particular program and are subject to change. Copay assistance programs may not be used with any government payor plan.

[2] Copay, copayment or coinsurance means the amount a plan member is required to pay for a prescription in accordance with a Plan, which may be a perentage of the prescription price, a fixed amount or another charge, with the balance, if any, paid by a Plan.

[3] Only amounts paid by the member apply to the deductible. Amounts paid by manufacturers or others are not applied to the deductible.

[4] A self-funded Plan may define the items and services that qualify as "essential health benefits" by referencing any definition authorized by the U.S. Department of Health and Human Services, including any available state benchmark plan. There's an exception process to decide if a medication that's not an "essential health benefit" is medically necessary for a particular plan member.

[5] The out-of-pocket maximum is the total amount you must pay in a plan year for certain covered services called "essential health benefits." Once the specified out-of-pocket limit is reached, your health plan will pay 100 percent of the cost of these covered services. More information on the out-of-pocket limit is available in your plan benefit materials.

Plan Feature	Amount You Pay	Description
Maintenance Drugs (up to a 93-day supply)	**Retail copays:** ▪ Generic $10 ▪ Preferred Brand: $30 ▪ Non-preferred Brand: $60	**Non-Specialty Maintenance Drugs (Tiers 1, 2 and 3):** Up to a 93 day supply is available for two monthly copays through network Mail Service Pharmacy, a CVS Retail pharmacy, or a Walgreens Retail pharmacy.
	Mail order copays: ▪ Generic $20 ▪ Preferred Brand: $60 ▪ Non-preferred Brand: $120	
Mandatory Generic Substitution	If a provider prescribes a non-preferred brand drug when a generic is available, you will pay the non-preferred brand copay or coinsurance PLUS the cost difference between the generic and brand drug up to the cost of the prescription. If a generic version is not available, you will only pay the copay or coinsurance.	

Visit **carefirst.com/rx** *for the most up-to-date drug lists, including the prescription guidelines. Prescription guidelines indicate drugs that require your doctor to obtain prior authorization from CareFirst before they can be filled and drugs that can be filled in limited quantities.*

This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.
Policy Form Numbers: MD/CFBC/RX (R. 1/18) • CFMI/RX (R. 1/18) • CFMI/Matrix/PRESC DRUG (R. 1/18) • MD/CF/RX (R. 1/18)

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