BluePreferred HSA Value Plan Summary of Benefits

Blackboard Inc.

Integrated Deductible

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
	Visit carefirst.com/blackboardcs to locate providers	
FIRSTHELP—24/7 NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **carefirst.com/blackboardcs** to learn more about your options for care.	When your doctor is not available, call FirstHelp at 800-535-9700 to speak with a registered nurse about your health questions and treatment options.	
ANNUAL DEDUCTIBLE (Benefit period)[4]		
Individual	$4,000	$8,000
Family	$8,000	$16,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[5]		
Medical[6]	$5,500 Individual/$11,000 Family	$11,000 Individual/$22,000 Family
Prescription Drug[6]	Combined with in-network medical out-of-pocket maximum	All drug 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*	Deductible, then 50% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	No charge*	Deductible, then 50% of Allowed Benefit
Breast Cancer Screening	No charge*	Deductible, then 50% of Allowed Benefit
Pap Test	No charge*	Deductible, then 50% of Allowed Benefit
Prostate Cancer Screening	No charge*	Deductible, then 50% of Allowed Benefit
Colorectal Cancer Screening	No charge*	Deductible, then 50% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans)	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Lab	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
X-ray	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Allergy Testing	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Allergy Shots	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Physical, Speech and Occupational Therapy	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Chiropractic	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Acupuncture	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
EMERGENCY SERVICES**		
Urgent Care Center	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Emergency Room—Facility Services	Deductible, then 30% of Allowed Benefit	In-network deductible, then 30% of Allowed Benefit
Emergency Room—Physician Services	Deductible, then 30% of Allowed Benefit	In-network deductible, then 30% of Allowed Benefit
Ambulance (if medically necessary)	Deductible, then 30% of Allowed Benefit	In-network Deductible, then 30% of Allowed Benefit
HOSPITALIZATION (Members are responsible for applicable physician and facility fees)**		
Outpatient Facility Services	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Outpatient Physician Services	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Inpatient Facility Services	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Inpatient Physician Services	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 100 visits per episode of care)	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Hospice (limited for a maximum 180 day Hospice eligibility period)	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Skilled Nursing Facility (limited to 60 days/benefit period)	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
MATERNITY		
Prenatal and Postnatal Office Visits	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Delivery and Facility Services	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Nursery Care of Newborn	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Artificial and Intrauterine Insemination	Not covered	Not covered
In Vitro Fertilization Procedures	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE USE DISORDER (Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Inpatient Physician Services	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Outpatient Facility Services	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Outpatient Physician Services	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Office Visits	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Medication Management	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Hearing Aids	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: 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 copay/coinsurance and deductible (if applicable) and CareFirst will pay the remaining amount up to $50.

* No copayment or coinsurance.
** Services provided by out-of-network Radiologists, Anesthesiologists, Pathologists and Surgical Assistants will pay the same as in-network.
[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 as indicated above. 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. The out-of-pocket maximum includes deductibles, copays and coinsurance.
[6] Plan has an integrated medical and prescription drug out-of-pocket maximum.

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. 1/13); DC/CF/BP/EOC (R. 11/09); DC/GHMSI/DOL APPEAL (R. 11/11); DC/CF/BP/DOCS (7/08); DC/CF/SOB HDHP (R. 7/08); DC/CF/ATTC (R. 1/10); DC/CF/RX3 (R. 1/15); and any amendments.

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