BluePreferred Summary of Benefits

Smithsonian Institution

<table>
<thead>
<tr>
<th>Services</th>
<th>In-Network You Pay</th>
<th>Out-of-Network You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-HOUR NURSE ADVICE LINE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free advice from a registered nurse. Visit <a href="http://www.carefirst.com/needcare">www.carefirst.com/needcare</a> to learn more about your options for care.</td>
<td>When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health questions and treatment options.</td>
<td></td>
</tr>
<tr>
<td>WELLNESS PROGRAM &amp; BLUE REWARDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visit <a href="http://www.carefirst.com/myaccount">www.carefirst.com/myaccount</a> for more information.</td>
<td>You have access to a comprehensive wellness program as part of your medical plan. You also have Blue Rewards, an incentive program where you can get rewarded for completing certain activities.</td>
<td></td>
</tr>
<tr>
<td>ANNUAL DEDUCTIBLE (Benefit period)⁴</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Individual</td>
<td>$500</td>
<td>$1000</td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)³</td>
<td>$1,500 Individual/$3,000 Family</td>
<td>$3,000 Individual/$6,000 Family</td>
</tr>
<tr>
<td>Prescription Drug⁶</td>
<td>$4,500 Individual/$9,000 Family</td>
<td>All drug costs are subject to in-network out-of-pocket maximum</td>
</tr>
<tr>
<td>LIFETIME MAXIMUM BENEFIT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>PREVENTIVE SERVICES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-Child Care (including exams &amp; immunizations)</td>
<td>No charge*</td>
<td>CareFirst pays 100% of Allowed Benefit</td>
</tr>
<tr>
<td>Adult Physical Examination (including routine GYN visit)</td>
<td>No charge*</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>No charge*</td>
<td>CareFirst pays 100% of Allowed Benefit</td>
</tr>
<tr>
<td>Pap Test</td>
<td>No charge*</td>
<td>30% of Allowed Benefit</td>
</tr>
<tr>
<td>Prostate Cancer Screening</td>
<td>No charge*</td>
<td>CareFirst pays 100% of Allowed Benefit</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>No charge*</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>OFFICE VISITS, LABS AND TESTING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits for Illness</td>
<td>$20 per visit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Imaging (MRA/MRS, MRI, PET &amp; CAT scans)</td>
<td>Deductible, then 10% of Allowed Benefit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Lab</td>
<td>Deductible, then 10% of Allowed Benefit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>X-ray</td>
<td>Deductible, then 10% of Allowed Benefit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>Deductible, then 10% of Allowed Benefit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Allergy Shots</td>
<td>$5 per visit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Physical, Speech and Occupational Therapy</td>
<td>$20 per visit (limited to 30 visits/condition/benefit period)</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Chiropractic (limited to 20 visits/benefits period)</td>
<td>$20 per visit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Not covered (except when approved or authorized by Plan for Anesthesia).</td>
<td>Not covered (except when approved or authorized by Plan for Anesthesia).</td>
</tr>
<tr>
<td>Services</td>
<td>In-Network You Pay&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>Out-of-Network You Pay&lt;sup&gt;1,3&lt;/sup&gt;</td>
</tr>
<tr>
<td>--------------------------------------</td>
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</tr>
<tr>
<td><strong>EMERGENCY SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>$20 per visit</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Emergency Room—Facility Services</td>
<td>$100 per visit (waived if admitted)</td>
<td>$100 per visit (waived if admitted)</td>
</tr>
<tr>
<td>Emergency Room—Physician Services</td>
<td>No charge*</td>
<td>CareFirst pays 100% of Allowed Benefit</td>
</tr>
<tr>
<td>Ambulance (if medically necessary)</td>
<td>Deductible, then 10% of Allowed Benefit</td>
<td>In-network deductible, then 10% of Allowed Benefit</td>
</tr>
<tr>
<td><strong>HOSPITALIZATION</strong>—(Members are responsible for applicable physician and facility fees)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>No charge*</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Outpatient Physician Services</td>
<td>$20 per visit</td>
<td>Paid the same as other surgical procedures</td>
</tr>
<tr>
<td>Surgical Treatment of Morbid Obesity</td>
<td>Paid the same as other surgical procedures</td>
<td>Paid the same as other surgical procedures</td>
</tr>
<tr>
<td>Inpatient Facility Services</td>
<td>No charge*</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Inpatient Physician Services</td>
<td>No charge*</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td><strong>HOSPITAL ALTERNATIVES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Deductible, then 10% of Allowed Benefit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Hospice (limited to 90 visits per episode of care)</td>
<td>Deductible, then 10% of Allowed Benefit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Skilled Nursing Facility (limited to 60 days/benefit period)</td>
<td>Deductible, then 10% of Allowed Benefit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td><strong>MATERNITY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Prenatal and Postnatal Office Visits</td>
<td>No charge*</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Delivery and Facility Services</td>
<td>No charge*</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Nursery Care of Newborn</td>
<td>No charge*</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Artificial and Intrauterine Insemination&lt;sup&gt;7&lt;/sup&gt;</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>In Vitro Fertilization Procedures&lt;sup&gt;7&lt;/sup&gt;</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>MENTAL HEALTH AND SUBSTANCE USE DISORDER</strong>—(Members are responsible for applicable physician and facility fees)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility Services</td>
<td>No charge*</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Inpatient Physician Services</td>
<td>No charge*</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>No charge*</td>
<td>Deductible, then 30% of Allowed Benefit</td>
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<tr>
<td>Outpatient Physician Services</td>
<td>No charge*</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Office Visits</td>
<td>$20 per visit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Medication Management</td>
<td>$20 per visit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td><strong>MEDICAL DEVICES AND SUPPLIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Deductible, then 10% of Allowed Benefit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Hearing Aids for ages 0-18 (for ages 0-18)</td>
<td>Deductible, then 10% of Allowed Benefit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td><strong>VISION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Exam (limited to 1 visit/benefit period)</td>
<td>$10 per visit at participating vision provider</td>
<td>CareFirst pays $33, you pay balance</td>
</tr>
<tr>
<td>Eyeglasses and Contact Lenses</td>
<td>Discounts from participating Vision Centers</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
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.
- When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.
- 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 coinsurcances 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.
- 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 coinsurcances 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.
- 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.
- 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.
- Plan has a separate out-of-pocket maximum for medical and drug expenses which accumulate independently.
- Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. Preauthorization 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: 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/RXS (R. 1/18); DC/CF/LG/INCENT (R. 1/19); DC/CF/ATTC (R. 1/10) and any amendments.