



CareFirst BlueCross
BlueShield

Welcome

Welcome to your plan for healthy living

From preventive services to maintain your health, to our extensive network of providers and resources, CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively, CareFirst) are there when you need care. We will work together to help you get well, stay well and achieve any wellness goals you have in mind.

We know that health insurance is one of the most important decisions you make for you and your family—and we thank you for choosing CareFirst. This guide will help you understand your plan benefits and all the services available to you as a CareFirst member.

Please keep and refer to this guide while you are enrolled in this plan.

How your plan works

Find out how your health plan works and how you can access the highest level of coverage.

What's covered

See how your benefits are paid, including any deductibles, copayments or coinsurance amounts that may apply to your plan.

Getting the most out of your plan

Take advantage of the added features you have as a CareFirst member:

- Wellness discount program offering discounts on fitness gear, gym memberships, healthy eating options and more.
- Online access to quickly find a doctor or search for benefits and claims.
- *My Care First* wellness website with health calculators, tracking tools and podcast videos on specific health topics.
- *Vitality* magazine with healthy recipes, preventive health care tips, and articles on nutrition, physical fitness, and stress management.



Managing your health care budget just got easier

With CareFirst's Treatment Cost Estimator, you can:

- Quickly estimate your total costs
- Avoid surprises and save money
- Plan ahead to control expenses
- Make the best care decisions for you

Visit **www.carefirst.com** to learn more!





Plan 1

BlueChoice HMO Open Access

An HMO Plan with No Referrals Required

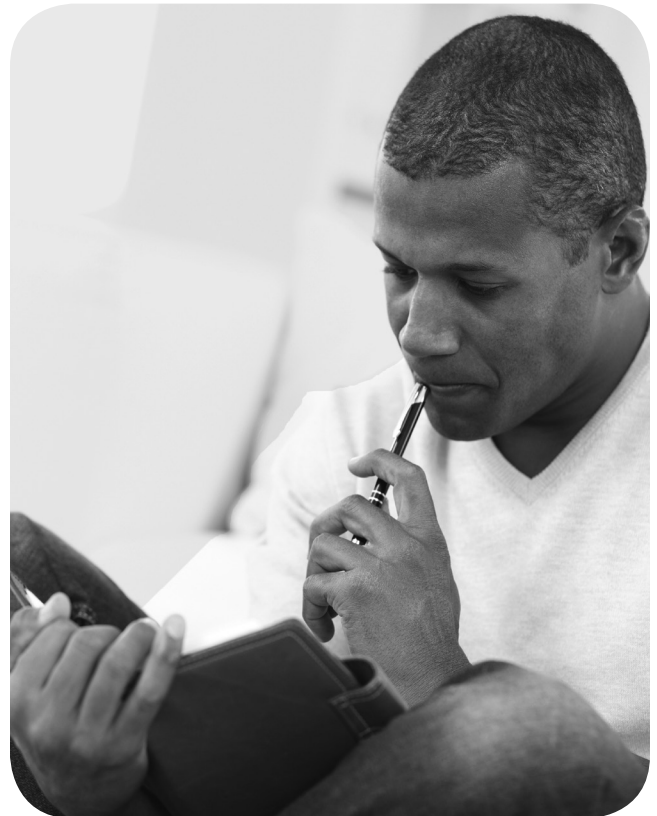
With a BlueChoice HMO *Open Access* plan, your primary care provider (PCP) provides preventive care and works with you to find specialty care using a large network of CareFirst BlueChoice specialists. However, unique to this plan is its Open Access feature which allows you to visit specialists directly without needing a referral from your PCP.

Benefits of BlueChoice HMO *Open Access*

- Choose from more than 37,000 providers, specialists and hospitals in Maryland, Washington, D.C. and Northern Virginia.
- HMO plans encourage you to establish a relationship with your PCP for consistent, quality care.
- No PCP referral required to see a specialist.
- Receive comprehensive coverage for preventive health care visits at no cost.
- Avoid the unwelcome surprise of high medical costs with predictable copays and deductibles (if applicable).
- Save time—you don't have to file a claim when you receive care from a CareFirst BlueChoice provider.
- Avoid balance billing when you receive care from a CareFirst BlueChoice provider.
- Access the Away From Home Care® program to enjoy plan benefits if you're out of the area for at least 90 days.

How your plan works

Establishing a relationship with one provider is the best way for you to receive consistent, quality health care. When you enroll in a BlueChoice HMO *Open Access* plan, you will select a PCP to manage your primary medical care. Make sure you select a PCP for not only yourself but each of your family members as well. Your PCP must participate in the CareFirst BlueChoice provider network



The BlueChoice HMO plan achieved a “Commendable” rating from the National Committee for Quality Assurance (NCQA).



and must specialize in either family practice, general practice, pediatrics or internal medicine.

To ensure you receive the highest level of benefits (and pay the lowest out-of-pocket cost), you should first call your PCP when you need care.

Your PCP will:

- Provide basic medical care.
- Prescribe any medications you need.
- Maintain your medical history.
- Work with you to determine when you should see a specialist.
- Assist you in the selection of a specialist, if needed.

While traditional HMO plans require you to obtain a written referral from your PCP before seeing a specialist, this plan has an Open Access feature, so you have direct access to CareFirst BlueChoice specialists without needing a written referral from your PCP. Make sure you only receive care from a CareFirst BlueChoice provider or you will not be covered, with the exception of emergency services and follow-up care after emergency surgery.

Your benefits

Step 1: Meet your deductible (if applicable)

If your plan requires you to meet a deductible, you will be responsible for the entire cost of services up to the amount of your deductible. Once your deductible is satisfied, your BlueChoice HMO *Open Access* coverage will become available to you. Some services do not require you to meet a deductible first.

If more than one person is covered under your plan, once the total deductible amount is satisfied, the plan will start to make payments for everyone covered. Deductible requirements can vary based on your coverage level (e.g. individual, family) as well as the specific plan selected. Members should refer to their Evidence of Coverage for detailed deductible information.

Step 2: Your plan will start to pay for services

After you satisfy your deductible (if applicable), your plan will start to pay for covered services, as long as you visit participating CareFirst BlueChoice providers and facilities. Please remember, depending on your particular plan, you may have to pay a copay or coinsurance when you receive care.

Step 3: Your out-of-pocket maximum

Your out-of-pocket maximum is the maximum amount you pay during your benefit period. Should you ever reach your out-of-pocket maximum, CareFirst BlueChoice, Inc. will then pay 100% of the allowed benefit for most covered services for the remainder of the benefit period. Any amount you pay toward your deductible (if applicable) and most copays and/or coinsurance will count toward your out-of-pocket maximum.

If more than one person is covered under your BlueChoice HMO *Open Access* plan, once the total out-of-pocket maximum is satisfied, no copays or coinsurance amounts will be required for anyone covered under your plan. Out-of-pocket maximum requirements vary based on your coverage level (e.g. individual, family). Members should refer to their Certificate or Evidence of Coverage for detailed out-of-pocket maximum information.

Laboratory services

To receive the maximum laboratory benefit from your BlueChoice HMO *Open Access* plan, you must use a LabCorp® facility for any laboratory services. Services performed at a facility that is not part of the LabCorp network may not be covered under your plan. Also, any lab work performed in an outpatient hospital setting will require a prior authorization from your PCP.

LabCorp has approximately 100 locations throughout Maryland, Washington, D.C. and Northern Virginia. To locate the LabCorp patient service center near you, call (888) LAB-CORP or visit www.labcorp.com.



Out-of-area coverage

Out-of-area coverage is limited to emergency or urgent care only. However, members and their covered dependents planning to be out of the CareFirst BlueChoice, Inc. service area for at least 90 consecutive days may be able to take advantage of a special program, Away From Home Care®.

This program allows temporary benefits through another Blue Cross and Blue Shield affiliated HMO. It provides coverage for routine services and is perfect for extended out-of-town business or travel, semesters at school or families living apart. For more information on Away From Home Care, please call Member Services at the phone number listed on your identification card.

Important terms

Allowed benefit is the dollar amount CareFirst BlueChoice, Inc. allows for the particular service in effect on the date that service is rendered.

Copay is a fixed dollar amount a member must pay for a covered service.

Coinsurance is a percentage of the doctor's charge or allowed benefit a member must pay for a covered service.

These benefits are issued under policy form numbers:

DC: DC/CFBC/GC (R. 1/09), DC/BC/EOC 2/02, DC/BC/DOC 2/02, DC/BC-OOP/SOB (R. 7/07), DC/CFBC/ATTC (R. 1/07) and any amendments.

MD NON-MSGR: MD/CFBC/GC (R.10/07); MD/CFBC/DOCS (R.4/08); MD/CFBC/EOC (R. 4/08); MD/CFBC/ELIG (R. 1/08); MD/BC-OOP/SOB (R. 4/08); and any amendments.

MD MSGR: MD/CFBC/MSGR/GC (7/14); MD/CFBC/MSGR/EOC (R. 7/08); MD/CFBC/MSGR/DOCS (7/14); MD/CFBC/MSGR/SOB/CORE (7/14) and any amendments.

VA: VA/CFBC/GC (R. 1/09), VA/CFBC/EOC (R. 1/06); VA/CC/DOC 5/01; VA/BC-OOP/SOB (R. 6/04); VA/CFBC/ATTC (R. 1/07) and any amendments.



HSA & HRA Compatible Plans

A Guide to How an HSA or HRA Compatible Plan Works

Your CareFirst BlueCross BlueShield (CareFirst) or CareFirst BlueChoice, Inc. (CareFirst BlueChoice) HSA/HRA compatible health plan is a high deductible health plan. The plan meets all of the requirements you need to establish your own Health Savings Account (HSA), or if your employer offers it, a Health Reimbursement Arrangement (HRA). This means it complies with IRS regulations, thus allowing you, your employer, or both to set up a medical funding arrangement or account to help fund your out-of-pocket costs.

These medical funding arrangements or accounts put you, the consumer, in the driver's seat. Your medical savings arrangement or account allows you to make the decision on where and how to spend your health care funds, while still benefiting from the Blue Cross and Blue Shield provider discounts.

Your employer may establish a Health Savings Account for you and your family, or you may be able to open one yourself from a local participating bank. With the Health Reimbursement Arrangement, your employer sets aside a specific amount of money for you each benefit year.

Here's how the HSA works:

- An HSA can be funded by you, your employer or both.
- You then use the money in your account to pay the full or discounted cost of covered services.
- The amount in your account is applied toward your health care expenses. If you use all of your account funds before meeting your deductible, you will then be responsible for any remaining balance of your deductible.
- Once you meet your deductible, your CareFirst or CareFirst BlueChoice health coverage begins. You will then pay a percentage of the cost of your care (called the coinsurance or copays) for medical covered services and a coinsurance or copay for prescription drugs.
- Funds in an HSA are completely portable, so if you change jobs or stop working, the funds stay with you (or you may set up your own HSA account if not offered by your employer).

- There are no "use it or lose it" rules like there are with Flexible Spending Accounts—unspent money stays in the HSA from year-to-year.
- Qualified HSA funds can be invested.

Amounts paid from an HSA are not taxed as long as they are used to pay for qualified health care expenses. You can decide how much to contribute, up to the difference between your health plan's annual deductible and the amount that your employer contributes towards the fund.

Here's how the HRA works:

- An HRA is funded by your employer.
- Each year, your employer makes a contribution toward your HRA.
- You then use the money to pay the cost of covered services.
- The amount is applied toward your health care expenses. If you use all of your funds before meeting your deductible, you will then be responsible for any remaining balance of your deductible.
- Once you meet your deductible, your CareFirst or CareFirst BlueChoice health coverage begins. You will then pay a percentage of the cost of your care (called the coinsurance or copays) for medical covered services, and depending on your plan, a copay for prescription drugs.
- Any remaining balance in your account at the end of the benefit year automatically (if employer allows) rolls over to the next year and is added to the annual contribution made by your employer.

HSA & HRA Compatible Plans

A Guide to How an HSA or HRA Compatible Plan Works

The greater the balance, the less you have to pay out-of-pocket.

- Dollars can be used to pay for any covered services received by any family member covered under the plan.
- If you choose another plan or leave the company without continuing your coverage, the balance returns to your employer.

How your deductible works

Your CareFirst or CareFirst BlueChoice health plan has an annual deductible that you must satisfy before your health coverage begins. While you need to meet a deductible each benefit year, the money spent from your HSA or HRA on certain eligible health care expenses will count toward meeting that deductible. Most plans cover routine preventive care at 100%, or for a predictable copay or coinsurance. This applies to such benefits as well-child visits, adult physicals and cancer screenings. Once your deductible is met, you may then pay a percentage of the cost of your care (called the copay or coinsurance) for all covered services, and depending on your plan, a copay for prescription drugs.

The more you know, the better you can manage your health care needs. With our HSA and HRA compatible

plans, you can tap into the power of the Internet to help manage your benefits.

We offer online tools which allow you to:

- Check the status of a claim
- Compare hospitals
- Request a member ID card
- Confirm or review eligibility
- Find a doctor
- Access health and wellness information
- Compare prescription drug costs

Our prescription drug web site provides you with specific details on prescription drug coverage along with the ability to conduct price inquiries and compare the cost of generic drugs versus brand name products. You can use the site to calculate daily and annual drug costs, search for pharmacies and compare the cost of retail and mail order options. Just visit www.carefirst.com/rx.

A toll-free help line and member education programs are also available.

NOTE: Since your plan may include a combined medical and prescription drug deductible, you will be required to pay the full discounted cost of your prescription drugs until you meet your deductible.

Disclaimer

The Health Savings Account is not an insurance program, but a financial savings account. CareFirst BlueCross BlueShield and CareFirst BlueChoice, through its vendors, provides administrative services only for the Account and is not liable for any account balances. The Account may be used for qualified medical expenses as defined in the employer's plan document. Account balances are unfunded liabilities of the employer. They are not vested benefits and may be reduced or withdrawn at any time, at the option of your employer. The employer's plan document terms prevail over any inconsistencies in any verbal, written, or electronic information provided by CareFirst BlueCross BlueShield and CareFirst BlueChoice.

How CareFirst and CareFirst BlueChoice handle discounts:

When a provider signs a contract to provide services to CareFirst and CareFirst BlueChoice members, he/she is also agreeing to accept reimbursement established by CareFirst and CareFirst BlueChoice as payment in full. The amount that CareFirst and CareFirst BlueChoice pays its providers for covered services is called the allowed benefit. The difference between the provider's actual charge for services and the allowed benefit by CareFirst and CareFirst BlueChoice is called the discount savings. Member deductibles and coinsurance are based on the lower of the allowed benefit and/or the provider's actual charge.

CareFirst and CareFirst BlueChoice may retain a portion of the discount savings as part of its fees. The discount

savings may take several forms, such as BlueCard® network access fees and other provider discounts that have been negotiated by CareFirst and CareFirst BlueChoice. The specific amount that we retain has been agreed upon by CareFirst and CareFirst BlueChoice and your employer. For more information, please refer to your member contract.

Not all services and procedures are covered by your benefits contract. This plan is for comparison purposes only and does not create rights not given through the benefit plan.

The CareFirst benefits are issued under policy form numbers:

MSGR: COC-NCA (MSGR) REV (7/14); MD/CF/MSGR/DOCS (7/14); MD/CF/MSGR/SOB/PPO/CORE (7/14); MD/CF/MSGR/SOB/PPO/ENHANCE (7/14);

MD/CF/MSGR/SOB/PPO/HSA/CORE (7/14); MD/CF/MSGR/SOB/PPO/HSA/ENHANCE (7/14); MD/CF/MSGR/SOB/PPO/HRA (7/14); MD/CFBC/MSGR/EOC (7/14); MD/CFBC/MSGR/DOCS (7/14); MD/CFBC/MSGR/SOB/CORE (7/14); MD/CFBC/MSGR/SOB/ENHANCE (7/14); MD/CFBC/MSGR/HSA/SOB/CORE (7/14); MD/CFBC/MSGR/HSA/ENHANCE (7/14); MD/CFBC/MSGR/HSA/OOP/OA (7/14)

MD (Non-MSGR): GC-M; GPS/M; COC/M; DOCS-PPO/M; ELIG-MD; MD/CF/SOB HDHP (7/14); MD/CF/CDH RX (7/14); MD/CF/MANDATES 10/00 HDHP (R. 12/04); MD/CFBC/GC (R. 7/03); MD/CFBC/EOC (R. 7/03); MD/CFBC/DOCS (R. 7/03); MD/BC-OOP/SOB HDHP (7/14); MD/CFBC/ELIG (R. 5/05); MD/CFBC/ADD SERV AMEND (7/14);

MD/CFBC HDHP/LL AMEND (7/14); MD/CFBC/HDHP RX (7/14); MD/CFBC/GC (R. 7/03); MD/CFBC EOC (R. 7/03); MD/CFBC/DOCS (R. 7/03); MD/BC-OOP/SOB HDHP (7/14); MD/CFBC/ELIG (R. 5/05); MD/CFBC/ADD SERV AMEND (7/14); MD/CFBC HDHP/LL AMEND (7/14); MD/CFBC/HDHP RX (7/14); CCH/NCA GC/MO; CCH/NCA COC/MO; DOCS/M; MD/CMM/SOB HDHP (7/14); MD/CF/ATTC (R. 5/05); MD/CFBC/ADD SERV AMEND (7/14); MD/CFBC/HDHP RX (7/14) and any amendments.

DC: GC-A/DC-6/94; GPS-DC-6/95; DC/CERT-9/96; DC/PPO-A-8/96; DC/NCA/ELIG-C 6/97; DC/CF/SOB HDHP (7/14); DC/CF/CDH RX (7/14); DC/CF/WIG HDHP (R. 12/04); DC/BC/GC 2/02; DC/BC/EOC 2/02; DC/BC/DOC 2/02; DC/CFBC/ATTC (R. 5/05); DC/BC-OOP/HDHP SOB (7/14); DC/CFBC/HDHP RX (7/14); DC/BC/GC 2/02; DC/BC/EOC 2/02; DC/BC/DOC 2/02; DC/CFBC/ATTC (R. 5/05); DC/BC-OOP/HDHP SOB (7/14); DC/CCH/NCA COC 8/96; DC/DOCS-8/96; DC/CF/ATTC (R. 5/05); DC/CCH/NCA GC 9/96; DC/CMM/SOB HDHP (7/14); DC/CF/CDH RX (R. 9/06) and any amendments.

VA: GC-A-4/95; GPS-F1-4/95; VA/CERT-5/96; PPP-A-5/95; VA/NCA/ELIG-C 5/97; VA/CF/SOB HDHP (7/14); VA/CF/CDH RX (7/14); VA/CF/WIG HDHP (R. 12/04); VA/CC/GC 5/01; VA/CFBC/EOC (R. 1/06); VA/CC/DOC 5/01; VA/BC-OOP/SOB HDHP (7/14); VA/CFBC/ATTC (R. 5/05); VA/CFBC/HDHP RX-9/06; VA/CC/GC 5/01; VA/CFBC/EOC (R. 1/06); VA/CC/DOC 5/01; VA/BC-OOP/SOB HDHP (7/14); VA/CFBC/ATTC (R. 5/05); CCH/NCA GC 5/95; CCH/NCA-CERT-5/95; CMM-A-4/95; VA/CMM/SOB HDHP-9/06; VA/CF/ATTC (R. 5/05); VA/CF/CDH RX (R. 9/06) and any amendments or riders.



The CareFirst BlueCross BlueShield family of health care plans

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are both independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.

HSA and HRA Compatible Plans

How your compatible plans work

Your employer has chosen to offer you a CareFirst “compatible” health plan. This means that it meets all the IRS regulations needed to allow you to establish a Health Savings Account (HSA) either on your own or through your employer. These plans can also be used with a Health Reimbursement Arrangement (HRA) if offered by your employer.

Compatible health plans allow you or your employer to set up a medical savings account, such as an HSA or an HRA, to help you pay for out-of-pocket medical costs on a tax-preferred basis. These plans were designed to put you, the consumer, in the driver’s seat, by empowering you to make decisions on where, when and how to spend your health care funds, while still enjoying the benefits of a CareFirst health plan.

Your annual deductible

Your CareFirst health plan has an annual deductible that you must satisfy before most of your health coverage begins. This deductible starts over at the beginning of each plan year. This means that if your plan includes a \$2,400 annual deductible, you will be required to meet the \$2,400 deductible each year before your health care benefits begin.

Because we want you to stay healthy, preventive care is not subject to the deductible. This includes routine physicals, routine GYN visits, well-child care and cancer screenings, as well as the lab tests associated with these preventive visits. These services are usually either covered in full or subject only to a predictable copay. Your summary of benefits will provide you with more details.

Paying for out-of-pocket costs

If you or your employer have set-up a medical savings account for your CareFirst compatible plan, you may use the money in your account to pay for the health care expenses that count toward meeting your deductible. For example, if you go to the doctor because of an illness, the cost of that visit will be applied to your annual deductible and you can use your HSA or HRA funds to pay for that service.



Compatible plans

A CareFirst “compatible” plan meets the requirements necessary to combine it with either a Health Savings Account or a Health Reimbursement Arrangement.

Services covered by your CareFirst health plan

If during the course of your plan year you reach your annual deductible, your CareFirst health plan will kick-in and you will receive the benefits for all covered services as outlined in your summary of benefits. You may still have some out-of-pocket expenses in the form of coinsurance or copays.

- A copay is a fixed amount you contribute toward a service.
- Coinsurance is a percentage of the cost of the service.

If funds remain in your HSA or HRA after meeting the deductible, you can use the funds to cover these out-of-pocket expenses.



Combined medical and Rx deductible

All HSA-compatible plans, and some HRA-compatible plans, include a combined medical and prescription drug deductible. For this type of plan, you will be required to pay the full cost of your prescription drugs until you meet your deductible. The amount you pay will reflect the discounted price negotiated by CareFirst.

If you are used to only paying a copayment for prescription drugs, the price of some drugs may surprise you as they can be very expensive. Before filling your prescription, try out CareFirst's Drug Pricing tool available on www.carefirst.com (go to *My Account*) to investigate potential alternatives that you can discuss with your doctor or pharmacist that may save you money.



BlueChoice HMO

Open Access HRA/HSA

Integrated Deductible

Summary of Benefits

Services	In-Network You Pay ¹
	Visit www.carefirst.com/doctor to locate providers
FIRSTHELP—24/7 NURSE ADVICE LINE	
Free advice from a registered nurse. Visit www.carefirst.com/needcare 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.
BLUE REWARDS	
Visit www.carefirst.com/bluerewards for more information	Blue Rewards is an incentive program where you can earn up to \$600 for taking an active role in getting healthy and staying healthy.
ANNUAL DEDUCTIBLE (Benefit period)²	
Individual	\$1,500
Family	\$3,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)³	
Medical ⁴	\$3,000 Individual/\$6,550 Family
Prescription Drug ⁴	Combined with in-network medical out-of-pocket maximum
LIFETIME MAXIMUM BENEFIT	
Lifetime Maximum	None
PREVENTIVE SERVICES	
Well-Child Care (including exams & immunizations)	No charge*
Adult Physical Examination (including routine GYN visit)	No charge*
Breast Cancer Screening	No charge*
Pap Test	No charge*
Prostate Cancer Screening	No charge*
Colorectal Cancer Screening	No charge*
OFFICE VISITS, LABS AND TESTING	
Office Visits for Illness	Deductible, then \$10 PCP/\$20 Specialist per visit
Imaging (MRA/MRS, MRI, PET & CAT scans) ⁵	No charge* after deductible
Lab ⁵	No charge* after deductible
X-ray ⁵	No charge* after deductible
Allergy Testing	Deductible, then \$10 PCP/\$20 Specialist per visit
Allergy Shots	Deductible, then \$10 PCP/\$20 Specialist per visit
Physical, Speech and Occupational Therapy ⁶ (limited to 30 visits/condition/benefit period)	Deductible, then \$20 per visit
Chiropractic (limited to 20 visits/benefit period)	Deductible, then \$20 per visit
Acupuncture	Not covered (except when approved or authorized by Plan when used for anesthesia)
EMERGENCY SERVICES	
Urgent Care Center	Deductible, then \$20 per visit
Emergency Room—Facility Services	Deductible, then \$100 per visit (waived if admitted)
Emergency Room—Physician Services	No charge* after deductible
Ambulance (if medically necessary)	No charge* after deductible

Services	In-Network You Pay ¹
HOSPITALIZATION	
(Members are responsible for applicable physician and facility fees)	
Outpatient Facility Services	No charge* after deductible
Outpatient Physician Services	Deductible, then \$10 PCP/\$20 Specialist per visit
Inpatient Facility Services	Deductible, then \$250 per admission
Inpatient Physician Services	No charge* after deductible
HOSPITAL ALTERNATIVES	
Home Health Care	No charge* after deductible
Hospice	No charge* after deductible
Skilled Nursing Facility	No charge* after deductible
MATERNITY	
Preventive Prenatal and Postnatal Office Visits	No charge*
Delivery and Facility Services	Deductible, then \$250 per admission
Nursery Care of Newborn	No charge* after deductible
Artificial and Intrauterine Insemination ⁷	Not covered
In Vitro Fertilization Procedures ⁷	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE	
(Members are responsible for applicable physician and facility fees)	
Inpatient Facility Services	Deductible, then \$250 per admission
Inpatient Physician Services	No charge* after deductible
Outpatient Facility Services	No charge* after deductible
Outpatient Physician Services	No charge* after deductible
Office Visits	No charge* after deductible
Medication Management	No charge* after deductible
MEDICAL DEVICES AND SUPPLIES	
Durable Medical Equipment	Deductible, then 25% of Allowed Benefit
Hearing Aids	Not covered
VISION	
Routine Exam (limited to 1 visit/benefit period)	\$10 per visit at participating vision provider
Eyeglasses and Contact Lenses	Discounts from participating vision centers

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.

¹ When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.

² For family coverage only: The family deductible must be met before any member starts receiving benefits as indicated above. The deductible may be met by one member or any combination of members.

³ For family coverage only: The family out-of-pocket maximum must be met before any member's services will be covered at 100% up to the Allowed Benefit. The out-of-pocket maximum may be met by one member or any combination of members.

⁴ Plan has an integrated medical and prescription drug out-of-pocket maximum.

⁵ Members who reside in the CareFirst service area must use LabCorp as their Lab Test facility and freestanding facilities for Imaging and X-rays.

⁶ Visit Limitation does not apply to children ages 2-10 when Physical, Speech and Occupational Therapy is for treatment of Autism Spectrum Disorder.

⁷ 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.

These benefits are issued under policy form numbers: VA/CFBC/GC (R. 1/13), VA/CFBC/DOCS (R. 1/09), VA/CFBC/EOC (R. 1/09), VA/BC-OOP/SOB HDHP (R. 1/09), VA/CFBC/ATTC (R. 1/10), VA/CFBC/DOL APPEAL (R. 7/12), VA/CFBC/RX3 (R. 1/15), and any amendments.



CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. which is an independent licensee of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association.

Exclusions and Limitations

10.1 Coverage is Not Provided For:

- A. Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst BlueChoice.
- B. Services that are Experimental/Investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time the service in question is rendered, as determined by CareFirst BlueChoice.
- C. The cost of services that:
 - 1. Are furnished without charge; or
 - 2. Are normally furnished without charge to persons without health insurance coverage; or
 - 3. Would have been furnished without charge if the Member was not covered under the Evidence of Coverage or under any health insurance.
- D. Services that are not described as covered in the Evidence of Coverage or that do not meet all other conditions and criteria for coverage, as determined by CareFirst BlueChoice. Referral by a Primary Care Physician and/or the provision of services by a Contracting Provider does not, by itself, entitle a Member to benefits if the services are not covered or do not otherwise meet the conditions and criteria for coverage.
- E. Except for Emergency Services, Urgent Care and follow-up care after emergency surgery, benefits will not be provided for any service(s) provided to a Member by Non-Contracting Physicians or Non-Contracting Providers, unless written prior authorization is specifically obtained from CareFirst BlueChoice.
- F. Routine, palliative or cosmetic foot care (except for conditions determined by CareFirst BlueChoice to be Medically Necessary) including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
- G. Except for treatment for Accidental Injury or benefits for Oral Surgery as described above, dental care including extractions; treatment of cavities; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia, except for the treatment of a cleft lip or cleft palate; false teeth; or any other dental services or supplies. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
- H. Benefits will not be provided for cosmetic surgery (except as specifically provided for reconstructive breast surgery and reconstructive surgery as listed above) or other services primarily intended to correct, change or improve appearances.
- I. Treatment rendered by a health care provider who is a member of the Member's family (parents, spouse, brothers, sisters, children).
- J. Any prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage. Medications that can be self-administered or do not medically require administration by or under the direction of a physician are not covered even though they may be dispensed or administered in a physician office or provider facility. Benefits for prescription drugs may be available through a rider purchased by the Group and attached to the Evidence of Coverage.
- K. All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained and self-administered by the Member, except as stated in the Description of Covered Services. Over-the-Counter means any item or supply, as determined by CareFirst BlueChoice, that is available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions.
- L. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
- M. Services to reverse voluntary, surgically induced infertility, such as a reversal of a sterilization.
- N. All assisted reproductive technologies (except artificial insemination and intrauterine insemination), including in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same unless covered under a rider purchased by the Group and attached to the Evidence of Coverage.
- O. Fees or charges relating to fitness programs, weight loss or weight control programs; physical conditioning; pulmonary rehabilitation programs; exercise programs; and use of passive or patient-activated exercise equipment.
- P. Treatment for obesity except for the surgical treatment of Morbid Obesity.
- Q. Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications.
- R. Services furnished as a result of a referral prohibited by law.
- S. Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by CareFirst BlueChoice.
- T. Health education classes and self-help programs, other than birthing classes or for the treatment of diabetes.
- U. Acupuncture services except when approved or authorized by CareFirst BlueChoice when used for anesthesia.
- V. Any service related to recreational activities. This includes, but is not limited to sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst BlueChoice even though they may have therapeutic value or be provided by a health care provider.
- W. Coverage under this Description of Covered Services does not include the cost of services or payment for services for any illness, injury or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:
 - 1. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or
 - 2. From any federal, state, county or municipal facility or other government agency, including, in the case of service-connected disabilities, the Veterans Administration, to the extent that Benefits are payable by the federal, state, county or municipal facility or other government agency and provided at no charge to the Member, but excluding Medicare benefits and Medicaid benefits.Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for benefits.
- X. Private duty nursing.
- Y. Non-medical, health care provider services, including, but not limited to:
 - 1. Telephone consultations, failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the health care practitioner or the healthcare practitioner's staff.
 - 2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Description of Covered Services are available for Covered Services rendered to the Member by a health care provider.
- Z. Educational therapies intended to improve academic performance.
- AA. Vocational rehabilitation and employment counseling.
- BB. Routine eye examinations, frames and lenses or contact lenses. Benefits for routine eye examinations, frames and lenses or contact lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.
- CC. Custodial, personal, or domiciliary care that is provided to meet the activities of daily living, e.g., bathing, toileting and eating (care which may be provided by persons without professional medical skills or training).
- DD. Work hardening programs. Work hardening programs are highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

- EE. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.
- FF. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst BlueChoice, and CareFirst BlueChoice approved services listed in the Transplants section of this Description of Covered Services).
- GG. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
- HH. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

10.2 Infertility Services. Coverage for Artificial Insemination (and intrauterine insemination) does not include the following:

- A. Any costs associated with freezing, storage or thawing of sperm for future attempts or other use.
- B. Any charges associated with donor sperm.
- C. Infertility services that include the use of any surrogate or gestational carrier service.
- D. Infertility services when the infertility is a result of elective male or female surgical sterilization procedures, with or without reversal.
- E. All self-administered fertility drugs.

10.3 Organ and Tissue Transplants. Benefits will not be provided for the following:

- A. Non-human organs and their implantation.
- B. Any Hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.
- C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst BlueChoice.
- D. Services for a Member who is an organ donor when the recipient is not a Member.
- E. Benefits will not be provided for donor search services.
- F. Any service, supply or device related to a transplant that is not listed as a benefit in this Description of Covered Services.

10.4 Inpatient Hospital Services. Coverage is not provided for the following:

- A. Private room, unless Medically Necessary and authorized or approved by CareFirst BlueChoice. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.
- B. Non-medical items and convenience items, such as television, phone rentals, guest trays and laundry charges.
- C. Except for covered Emergency Services and Childbirth, a Hospital admission or any portion of a Hospital admission that had not been authorized or approved by CareFirst BlueChoice, whether or not services are Medically Necessary and/or meet all other conditions for coverage.
- D. Private duty nursing.

10.5 Home Health Services. Coverage is not provided for:

- A. Private duty nursing.
- B. Custodial Care.
- C. Services in the Member's home if it is outside the Service Area.

10.6 Hospice Benefits. Coverage is not provided for:

- A. Services, visits, medical equipment or supplies that are not included in the CareFirst BlueChoice-approved plan of treatment.
- B. Services in the Member's home if it is outside the Service Area.
- C. Financial and legal counseling.
- D. Any service for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.
- E. Chemotherapy or radiation therapy, unless used for symptom control.
- F. Services, visits, medical/surgical equipment or supplies; including equipment and medication not required to maintain the comfort and to manage the pain of the terminally ill Member.
- G. Reimbursement for volunteer services.
- H. Custodial Care, domestic or housekeeping services.
- I. Meals on Wheels or similar food service arrangements.
- J. Rental or purchase of renal dialysis equipment and supplies.
- K. Private duty nursing.

10.7 Outpatient Mental Health and Substance Abuse. Coverage is not provided for:

- A. Psychological testing, unless Medically Necessary, as determined by CareFirst BlueChoice, and appropriate within the scope of Covered Services.
- B. Services solely on court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.
- C. Mental retardation, after diagnosis.
- D. Psychoanalysis.

10.8 Inpatient Mental Health and Substance. The following services are excluded:

- A. Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.
- B. Custodial Care.
- C. Observation or isolation.

10.9 Emergency Services and Urgent Care. Benefits will not be provided for:

- A. Emergency care if the Member could have foreseen the need for the care before it became urgent (for example, periodic chemotherapy or dialysis treatment).
- B. Medical services rendered outside of the Service Area which could have been foreseen by the Member prior to departing the Service Area.
- C. Charges for emergency and Urgent Care services received from a Non-Contracting Provider after the Member could reasonably be expected to travel to the nearest Contracting Provider.
- D. Charges for services when the claims filing and notice procedures stated in Section 7 of this Description of Covered Services have not been followed by the Member.
- E. Except for Medically Necessary follow-up care after emergency surgery, charges for follow-up care received in the emergency or Urgent Care facility outside of the Service Area unless CareFirst BlueChoice determines that the Member could not reasonably be expected to return to the Service Area for such care.
- F. Except for covered ambulance services, travel, including travel required to return to the Service Area, whether or not recommended by a Contracting Provider.
- G. Treatment received in an emergency department to treat a health care problem that does not meet the definition of Emergency Services as defined in Section 7 of this Description of Covered Services.

10. 10 Medical Devices and Supplies. Coverage is not provided for:
- A. Convenience item. Any item that increases physical comfort or convenience without serving a Medically Necessary purpose, e.g. elevators, hoist/stair lifts, ramps, shower/bath bench.
 - B. Furniture items. Movable articles or accessories which serve as a place upon which to rest (people or things) or in which things are placed or stored, e.g. chair or dresser.
 - C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body, e.g. exercycle or other physical fitness equipment.
 - D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home, e.g. parallel bars.
 - E. Environmental control equipment. Any device such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.
 - F. Eyeglasses, contact lenses, dental prostheses or appliances, or hearing aids. Benefits for eyeglasses and contact lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.
 - G. Corrective shoes, unless they are an integral part of the lower body brace, shoe lifts or special shoe accessories.
 - H. Medical equipment/supplies of an expendable nature, except those specifically listed as a Covered Medical Supply in this Description of Covered Services. Non-covered supplies include incontinence pads or ace bandages.

Exclusions

Benefits will not be provided under this rider for:

- 1. Any devices, appliances, supplies, and equipment except as otherwise provided in Section B, above.
- 2. Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities.
- 3. Prescription Drugs for cosmetic use.
- 4. Prescription Drugs administered by a physician or dispensed in a physician's office.
- 5. Drugs, drug therapies or devices that are considered Experimental or Investigational by CareFirst BlueChoice.
- 6. Drugs or medications lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a prescription (Over-the-Counter medications).
- 7. Vitamins, except CareFirst BlueChoice will provide a benefit for Prescription Drug:
 - a. prenatal vitamins.
 - b. fluoride and fluoride containing vitamins.
 - c. single entity vitamins, such as Rocaltrol and DHT.
- 8. Infertility drugs and agents for use in connection with infertility services or treatments that are excluded from coverage under the Evidence of Coverage to which this rider is attached.
- 9. Any portion of a Prescription Drug that exceeds:
 - a. a thirty-four (34) day supply for Prescription Drugs; or,
 - b. a ninety (90) day supply for Maintenance Drugs unless authorized by CareFirst BlueChoice.
- 10. Prescription Drugs that are administered or dispensed by a health care facility for a Member who is a patient in the health care facility. This exclusion does not apply to Prescription Drugs that are dispensed by a Pharmacy on the health care facility's premises for a Member who is not a patient in the health care facility.
- 11. Prescription Drugs for weight loss.
- 12. Biologicals and allergy extracts.
- 13. Blood and blood products. (May be covered under the medical benefits in the Evidence of Coverage to which this rider is attached.)

Pharmacy Program

Integrated Deductible

See Annual Deductible on Medical Summary of Benefits
\$0/10/25/45 Retail Copays ■ 50% Injectables Coinsurance

Summary of Benefits

Plan Feature	Amount	Description
Deductible	See medical summary of benefit for annual deductible amount	If you meet your combined medical and drug deductible, you will pay a different copay or coinsurance depending on the drug tier. Drugs not subject to any medical or drug deductible are noted below.
Out-of-Pocket Maximum	See medical summary of benefit for annual out-of-pocket amount	If you reach your out-of-pocket maximum, CareFirst BlueChoice 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 (Affordable Care Act) (up to a 34-day supply)	\$0 (not subject to deductible)	A preventive drug is a prescribed medication or item on CareFirst's Preventive Drug List (ACA)* (examples: Folic Acid, Fluoride, and FDA approved contraceptives for women).
Oral Chemotherapy Drugs Diabetic Supplies (up to a 34-day supply)	\$0 (not subject to deductible except for HSA plans)	Diabetic supplies include needles, lancets, test strips and alcohol swabs.
Generic Drugs (Tier 1) (up to a 34-day supply)	\$10	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (up to a 34-day supply)	\$25	Preferred brand drugs are covered at this copay level.
Non-preferred Brand Drugs (Tier 3) (up to a 34-day supply)	\$45	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Discuss using alternatives with your physician or pharmacist.
Self-administered Injectable (excluding insulin) (Tier 4) (up to a 34-day supply)	50% coinsurance up to a maximum payment of \$75	All self-administered injectable drugs (excluding insulin) are covered at this payment level. Insulin is covered at appropriate copay level.
Maintenance Drugs (up to a 90-day supply)	Generic: \$20 Preferred Brand: \$50 Non-preferred Brand: \$90 Self-Administered Injectables: 50% coinsurance, up to a maximum payment of \$150	Maintenance drugs of up to a 90-day supply are available for twice the copay through Mail Service Pharmacy or a retail pharmacy. Injectables (excluding insulin) are covered at 50% coinsurance up to a maximum payment of \$150.
Restricted Generic Substitution	Yes	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. Also, if your prescription is written for a brand-name drug and DAW (dispense as written) is noted by your doctor, you will only pay the copay.



Visit www.carefirst.com/rx for the most up-to-date Preferred Drug List and Formulary (list of covered drugs), 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: VA/CFBC/RX3 (R. 8/12) • VA/CF/RX3 (R. 8/12)



CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., and CareFirst BlueChoice, Inc. are independent licensees of the Blue Cross and Blue Shield Association.
* Registered trademark of the Blue Cross and Blue Shield Association.

Below are limitations and exclusions contained in your CareFirst BlueChoice or CareFirst medical policy to which the prescription rider is attached.

Medical Limitations and Exclusions – CareFirst BlueChoice

10.1 Coverage is Not Provided For:

- A. Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst BlueChoice.
- B. Services that are Experimental/Investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time the service in question is rendered, as determined by CareFirst BlueChoice.
- C. The cost of services that:
 1. Are furnished without charge; or
 2. Are normally furnished without charge to persons without health insurance coverage; or
 3. Would have been furnished without charge if the Member was not covered under the Evidence of Coverage or under any health insurance.
- D. Services that are not described as covered in the Evidence of Coverage or that do not meet all other conditions and criteria for coverage, as determined by CareFirst BlueChoice. Referral by a Primary Care Physician and/or the provision of services by a Contracting Provider does not, by itself, entitle a Member to benefits if the services are not covered or do not otherwise meet the conditions and criteria for coverage.
- E. Except for Emergency Services, Urgent Care and follow-up care after emergency surgery, benefits will not be provided for any service(s) provided to a Member by Non-Contracting Physicians or Non-Contracting Providers, unless written prior authorization is specifically obtained from CareFirst BlueChoice.
- F. Routine, palliative or cosmetic foot care (except for conditions determined by CareFirst BlueChoice to be Medically Necessary) including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
- G. Except for treatment for Accidental Injury or benefits for Oral Surgery as described above, dental care including extractions; treatment of cavities; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia, except for the treatment of a cleft lip or cleft palate; false teeth; or any other dental services or supplies. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
- H. Benefits will not be provided for cosmetic surgery (except as specifically provided for reconstructive breast surgery and reconstructive surgery as listed above) or other services primarily intended to correct, change or improve appearances.
- I. Treatment rendered by a health care provider who is a member of the Member's family (parents, spouse, brothers, sisters, children).
- J. Any prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage. Medications that can be self-administered or do not medically require administration by or under the direction of a physician are not covered even though they may be dispensed or administered in a physician office or provider facility. Benefits for prescription drugs may be available through a rider purchased by the Group and attached to the Evidence of Coverage.
- K. All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained and self-administered by the Member, except as stated in the Description of Covered Services. Over-the-Counter means any item or supply, as determined by CareFirst BlueChoice, that is available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions.
- L. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
- M. Services to reverse voluntary, surgically induced infertility, such as a reversal of a sterilization.
- N. All assisted reproductive technologies (except artificial insemination and intrauterine insemination), including in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same unless covered under a rider purchased by the Group and attached to the Evidence of Coverage.
- O. Fees or charges relating to fitness programs, weight loss or weight control programs; physical conditioning; pulmonary rehabilitation programs; exercise programs; and use of passive or patient-activated exercise equipment.
- P. Treatment for obesity except for the surgical treatment of Morbid Obesity.
- Q. Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications.
- R. Services furnished as a result of a referral prohibited by law.
- S. Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by CareFirst BlueChoice.
- T. Health education classes and self-help programs, other than birthing classes or for the treatment of diabetes.
- U. Acupuncture services except when approved or authorized by CareFirst BlueChoice when used for anesthesia.
- V. Any service related to recreational activities. This includes, but is not limited to sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst BlueChoice even though they may have therapeutic value or be provided by a health care provider.
- W. Coverage under this Description of Covered Services does not include the cost of services or payment for services for any illness, injury or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:
 1. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or
 2. From any federal, state, county or municipal facility or other government agency, including, in the case of service-connected disabilities, the Veterans Administration, to the extent that Benefits are payable by the federal, state, county or municipal facility or other government agency and provided at no charge to the Member, but excluding Medicare benefits and Medicaid benefits. Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for benefits.
- X. Private duty nursing.
- Y. Non-medical, health care provider services, including, but not limited to:
 1. Telephone consultations, failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the health care practitioner or the healthcare practitioner's staff.
 2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Description of Covered Services are available for Covered Services rendered to the Member by a health care provider.
- Z. Educational therapies intended to improve academic performance.
- AA. Vocational rehabilitation and employment counseling.
- BB. Routine eye examinations, frames and lenses or contact lenses. Benefits for routine eye examinations, frames and lenses or contact

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lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.

- CC. Custodial, personal, or domiciliary care that is provided to meet the activities of daily living, e.g., bathing, toileting and eating (care which may be provided by persons without professional medical skills or training).
- DD. Work hardening programs. Work hardening programs are highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.
- EE. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.
- FF. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst BlueChoice, and CareFirst BlueChoice approved services listed in the Transplants section of this Description of Covered Services).
- GG. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
- HH. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

10.2 Infertility Services.

Coverage for Artificial Insemination (and intrauterine insemination) does not include the following:

- A. Any costs associated with freezing, storage or thawing of sperm for future attempts or other use.
- B. Any charges associated with donor sperm.
- C. Infertility services that include the use of any surrogate or gestational carrier service.
- D. Infertility services when the infertility is a result of elective male or female surgical sterilization procedures, with or without reversal.
- E. Infertility services for domestic partners or common law spouses, except in those states that recognize those unions.
- F. All self-administered fertility drugs.

10.3 Organ and Tissue Transplants.

Benefits will not be provided for the following:

- A. Non-human organs and their implantation.
- B. Any Hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.
- C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst BlueChoice.
- D. Services for a Member who is an organ donor when the recipient is not a Member.
- E. Benefits will not be provided for donor search services.
- F. Any service, supply or device related to a transplant that is not listed as a benefit in this Description of Covered Services.

10.4 Inpatient Hospital Services.

Coverage is not provided for the following:

- A. Private room, unless Medically Necessary and authorized or approved by CareFirst BlueChoice. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.
- B. Non-medical items and convenience items, such as television, phone rentals, guest trays and laundry charges.
- C. Except for covered Emergency Services and Childbirth, a Hospital admission or any portion of a Hospital admission that had not been authorized or approved by CareFirst BlueChoice, whether or not services are Medically Necessary and/or meet all other conditions for coverage.
- D. Private duty nursing.

10.5 Home Health Services.

Coverage is not provided for:

- A. Private duty nursing.
- B. Custodial Care.
- C. Services in the Member's home if it is outside the Service Area.

10.6 Hospice Benefits.

Coverage is not provided for:

- A. Services, visits, medical equipment or supplies that are not included in the CareFirst BlueChoice-approved plan of treatment.
- B. Services in the Member's home if it is outside the Service Area.
- C. Financial and legal counseling.
- D. Any service for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.
- E. Chemotherapy or radiation therapy, unless used for symptom control.
- F. Services, visits, medical/surgical equipment or supplies; including equipment and medication not required to maintain the comfort and to manage the pain of the terminally ill Member.
- G. Reimbursement for volunteer services.
- H. Custodial Care, domestic or housekeeping services.
- I. Meals on Wheels or similar food service arrangements.
- J. Rental or purchase of renal dialysis equipment and supplies.
- K. Private duty nursing.

10.7 Outpatient Mental Health and Substance Abuse.

Coverage is not provided for:

- A. Psychological testing, unless Medically Necessary, as determined by CareFirst BlueChoice, and appropriate within the scope of Covered Services.
- B. Services solely on court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.
- C. Mental retardation, after diagnosis.
- D. Psychoanalysis.

10.8 Inpatient Mental Health and Substance.

The following services are excluded:

- A. Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.
- B. Custodial Care.
- C. Observation or isolation.

10.9 Emergency Services and Urgent Care.

Benefits will not be provided for:

- A. Emergency care if the Member could have foreseen the need for the care before it became urgent (for example, periodic chemotherapy or dialysis treatment).
- B. Medical services rendered outside of the Service Area which could have been foreseen by the Member prior to departing the Service Area.
- C. Charges for emergency and Urgent Care services received from a Non-Contracting Provider after the Member could reasonably be expected to travel to the nearest Contracting Provider.
- D. Charges for services when the claims filing and notice procedures stated in Section 7 of this Description of Covered Services have not been followed by the Member.
- E. Except for Medically Necessary follow-up care after emergency surgery, charges for follow-up care received in the emergency or Urgent Care facility outside of the Service Area unless CareFirst BlueChoice determines that the Member could not reasonably be expected to return to the Service Area for such care.
- F. Except for covered ambulance services, travel, including travel required to return to the Service Area, whether or not recommended by a Contracting Provider.
- G. Treatment received in an emergency department to treat a health care problem that does not meet the definition of Emergency Services as defined in Section 7 of this Description of Covered Services.

10.10 Medical Devices and Supplies.

Coverage is not provided for:

- A. Convenience item. Any item that increases physical comfort or convenience without serving a Medically Necessary purpose, e.g. elevators, hoist/stair lifts, ramps, shower/bath bench.
- B. Furniture items. Movable articles or accessories which serve as a place upon which to rest (people or things) or in which things are placed or stored, e.g. chair or dresser.
- C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or

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condition all or part of the human body, e.g. exercycle or other physical fitness equipment.

- D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home, e.g. parallel bars.
- E. Environmental control equipment. Any device such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.
- F. Eyeglasses, contact lenses, dental prostheses or appliances, or hearing aids. Benefits for eyeglasses and contact lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.
- G. Corrective shoes, unless they are an integral part of the lower body brace, shoe lifts or special shoe accessories.
- H. Medical equipment/supplies of an expendable nature, except those specifically listed as a Covered Medical Supply in this Description of Covered Services. Non-covered supplies include incontinence pads or ace bandages.

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given in the benefit plan.

Prescription Drug Exclusions

Benefits will not be provided under this rider for:

- 1. Any devices, appliances, supplies, and equipment except as otherwise provided in the Evidence of Coverage.
- 2. Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities.
- 3. Prescription Drugs for cosmetic use.
- 4. Prescription Drugs administered by a physician or dispensed in a physician's office.
- 5. Drugs, drug therapies or devices that are considered Experimental/ Investigational by CareFirst BlueChoice.
- 6. Except for items included on the Preventive Drug List, Over-the-Counter medications or supplies lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a Prescription Drug.
- 7. Vitamins, except CareFirst BlueChoice will provide a benefit for Prescription Drug:
 - a. Prenatal vitamins.
 - b. Fluoride and fluoride containing vitamins.
 - c. Single entity vitamins, such as Rocaltrol and DHT.
 - d. Vitamins included on the Preventive Drug List.
- 8. Infertility drugs and agents for use in connection with infertility services or treatments that are excluded from coverage under the Evidence of Coverage to which this rider is attached.
- 9. Any portion of a Prescription Drug that exceeds:
 - a. a thirty-four (34) day supply for Prescription Drugs; or,
 - b. a ninety (90) day supply for Maintenance Drugs unless authorized by CareFirst BlueChoice.
- 10. Prescription Drugs that are administered or dispensed by a health care facility for a Member who is a patient in the health care facility. This exclusion does not apply to Prescription Drugs that are dispensed by a Pharmacy on the health care facility's premises for a Member who is not a patient in the health care facility.
- 11. Prescription Drugs for weight loss.
- 12. Biologicals and allergy extracts.
- 13. Blood and blood products. (May be covered under the medical benefits in the Evidence of Coverage to which this rider is attached.)

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Medical Limitations and Exclusions – CareFirst BlueCross BlueShield

10.1 General Exclusions

Coverage is not provided for the following:

- A. Any service, test, procedure, supply, or item which CareFirst determines not necessary for the prevention, diagnosis or treatment of the Member's illness, injury, or condition. Although a service may be listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in the Member's particular case.
- B. Any treatment, procedure, facility, equipment, drug, drug usage, device, or supply which, in the judgment of CareFirst, is Experimental/ Investigational, or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment, except for covered benefits for Clinical Trials.
- C. The cost of services that are furnished without charge or are normally furnished without charge if a Member was not covered under the Evidence of Coverage or under any health insurance, or any charge or any portion of a charge which by law the provider is not permitted to bill or collect from the Member directly.
- D. Any service, supply, or procedure that is not specifically listed in the Member's Evidence of Coverage as a covered benefit or that does not meet all other conditions and criteria for coverage as determined by CareFirst.
- E. Services that are beyond the scope of the license of the provider performing the service.
- F. Routine foot care, including services related to hygiene or any services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet, or partial removal of a nail without the removal of its matrix. However, benefits will be provided for these services if CareFirst determines that medical attention was needed because of a medical condition affecting the feet, such as diabetes and, that all other conditions for coverage have been met.
- G. Any type of dental care (except treatment of accidental injuries, oral surgery, and cleft lip, cleft palate, or ectodermal dysplasia, as described in this Description of Covered Services) including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess, removal of impacted teeth, orthodontia, false teeth, or any other dental services or supplies, unless provided in a separate rider or amendment to this Evidence of Coverage. Benefits for oral surgery are Section 2.21 in the Outpatient and Office Services Section of this Description of Covered Services. All other procedures involving the teeth or areas surrounding the teeth, including shortening of the mandible or maxillae for Cosmetic purposes or for correction of malocclusion unrelated to a functional impairment are excluded.
- H. Cosmetic surgery (except benefits for Reconstructive Breast Surgery or reconstructive surgery) or other services primarily intended to correct, change, or improve appearances. Cosmetic means a service or supply which is provided with the primary intent of improving appearances and not for the purpose of restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention as determined by CareFirst.
- I. Treatment rendered by a Health Care Provider who is the Member's Spouse, parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or resides in the Member's home.
- J. Any prescription drugs, unless administered to the Member in the course of covered outpatient or inpatient treatment or unless the prescription drug is specifically identified as covered. Take-home prescriptions or medications, including self-administered injections which can be administered by the patient or by an average individual who does not have medical training, or medications which do not medically require administration by or under the direction of a physician are not covered, even though they may be dispensed or administered in a physician or provider office or facility, unless the take-home prescription or medication is specifically identified as covered. Benefits for prescription drugs may be available through

Pharmacy Program

- a rider or amendment purchased by the Group and attached to the Evidence of Coverage.
- K. All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies routinely obtained and self-administered by the Member, except for the CareFirst benefits described in this Evidence of Coverage and diabetic supplies.
 - L. Food and formula consumed as a sole source or supplemental nutrition, except as listed as a Covered Service in this Description of Covered Services.
 - M. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
 - N. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.
 - O. Fees and charges relating to fitness programs, weight loss or weight control programs, physical, pulmonary conditioning programs or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education, except for diabetes outpatient self-management training and educational services. Cardiac rehabilitation programs are covered as described in this Evidence of Coverage.
 - P. Medical and surgical treatment for obesity and weight reduction, except in the instance of Morbid Obesity.
 - Q. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof. Benefits for vision may be available through a rider or amendment purchased by the Group and attached to the Evidence of Coverage.
 - R. Services solely based on a court order or as a condition of parole or probation, unless approved by CareFirst.
 - S. Health education classes and self-help programs, other than birthing classes or those for the treatment of diabetes.
 - T. Acupuncture services, except when approved or authorized by CareFirst when used for anesthesia.
 - U. Any service related to recreational activities. This includes, but is not limited to, sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst even though they may have therapeutic value or be provided by a Health Care Practitioner.
 - V. Any service received at no charge to the Member in any federal hospital or facility, or through any federal, state, or local governmental agency or department, not including Medicaid. (This exclusion does not apply to care received in a Veteran's hospital or facility unless that care is rendered for a condition that is a result of the Member's military service.)
 - W. Private Duty Nursing.
 - X. Non-medical, provider services, including but not limited to:
 1. Telephone consultations, failure to keep a scheduled visit, completion of forms, copying charges, or other administrative services provided by the Health Care Practitioner or the Health Care Practitioner's staff.
 2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Evidence of Coverage are available for Covered Services rendered to the Member by a Health Care Provider.
 - Y. Speech Therapy, Occupational Therapy, or Physical Therapy, unless CareFirst determines that the condition is subject to improvement. Coverage does not include non-medical Ancillary Services such as vocational rehabilitation, employment counseling, or educational therapy.
 - Z. Services or supplies for injuries or diseases related to a covered person's job to the extent the covered person is required to be covered by a workers' compensation law.
 - AA. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst, and services listed under the Section 2.14 Transplants Section of this Description of Covered Services), whether or not recommended by an Eligible Provider.
 - BB. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.
 - CC. Contraceptive drugs or devices, unless specifically identified as covered in this Evidence of Coverage, or in a rider or amendment to this Evidence of Coverage.
 - DD. Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.
 - EE. Services, drugs, or supplies the Member receives without charge while in active military service.
 - FF. Habilitative Services delivered through early intervention and school services.
 - GG. Custodial Care.
 - HH. Coverage does not include non-medical Ancillary Services, such as vocational rehabilitation, employment counseling, or educational therapy.
 - II. Services or supplies received before the effective date of the Member's coverage under this Evidence of Coverage.
 - JJ. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
 - KK. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.
 - LL. Work Hardening Programs. Work Hardening Program means a highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.
- ### 10.2 Infertility Services .
- Benefits will not be provided for any assisted reproductive technologies including artificial insemination, as well as in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same.
- ### 10.3 Transplants
- Benefits will not be provided for the following:
- A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary non-Experimental/Investigational skin grafts.
 - B. Any hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.
 - C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst.
 - D. Services for a Member who is an organ donor when the recipient is not a Member.
 - E. Benefits will not be provided for donor search services.
 - F. Any service, supply, or device related to a transplant that is not listed as a benefit in the Description of Covered Services.
- ### 10.4 Inpatient Hospital Services
- Coverage is not provided (or benefits are reduced, if applicable) for the following:
- A. Private room, unless Medically Necessary and authorized or approved by CareFirst. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.
 - B. Non-medical items and convenience items, such as television and phone rentals, guest trays, and laundry charges.
 - C. Except for covered Emergency Services and Maternity Care, a hospital admission or any portion of a hospital admission (other than Medically Necessary Ancillary Services) that had not been approved by CareFirst, whether or not services are Medically Necessary and/or meet all other conditions for coverage.
 - D. Private Duty Nursing.
- ### 10.5 Home Health Services
- Coverage is not provided for:
- A. Private Duty Nursing.
 - B. Custodial Care.

10.6 Hospice Services

Benefits will not be provided for the following:

- A. Services, visits, medical equipment, or supplies not authorized by CareFirst.
- B. Financial and legal counseling.
- C. Any services for which a Qualified Hospice Program does not customarily charge the patient or his or her family.
- D. Reimbursement for volunteer services.
- E. Chemotherapy or radiation therapy, unless used for symptom control.
- F. Services, visits, medical equipment, or supplies that are not required to maintain the comfort and manage the pain of the terminally ill Member.
- G. Custodial Care, domestic, or housekeeping services.

10.7 Medical Devices and Supplies

Benefits will not be provided for purchase, rental, or repair of the following:

- A. Convenience items. Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for a Member (e.g., an exercycle or other physical fitness equipment, elevators, hoist lifts, shower/bath bench).
- B. Furniture items, movable objects or accessories that serve as a place upon which to rest (people or things) or in which things are placed or stored (e.g., chair or dresser).
- C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body, (e.g., exercycle or other physical fitness equipment).
- D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home (e.g., parallel bars).
- E. Environmental control equipment. Equipment that can be used for non-medical purposes, such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.
- F. Eyeglasses or contact lenses (except when used as a prosthetic lens replacement for aphakic patients as in this Evidence of Coverage), dental prostheses or appliances (except for Medically Necessary treatment of Temporomandibular Joint Syndrome (TMJ)).
- G. Corrective shoes (unless required to be attached to a leg brace), shoe lifts, or special shoe accessories.
- H. Medical equipment/supplies of an expendable nature, except as specifically listed as a Covered Medical Supply in this Evidence of Coverage. Non-covered supplies include incontinence pads or ace bandages.

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given in the benefit plan.

Prescription Drug Exclusions

Benefits will not be provided under this rider for:

1. Any devices, appliances, supplies, and equipment except as otherwise provided in Evidence of Coverage.
2. Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities.
3. Prescription Drugs for cosmetic use.
4. Prescription Drugs administered by a physician or dispensed in a physician's office.
5. Drugs, drug therapies or devices that are considered Experimental/ Investigational by CareFirst.
6. Except for items included on the Preventive Drug List, Over-the-Counter medications or supplies lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a Prescription Drug.
7. Vitamins, except CareFirst will provide a benefit for Prescription Drug:
 - a. Prenatal vitamins.
 - b. Fluoride and fluoride containing vitamins.
 - c. Single entity vitamins, such as Rocaltrol and DHT.
 - d. Vitamins included on the Preventive Drug List.
8. Infertility drugs and agents for use in connection with infertility services or treatments that are excluded from coverage under the Evidence of Coverage to which this rider is attached.
9. Any portion of a Prescription Drug that exceeds:
 - a. a thirty-four (34) day supply for Prescription Drugs; or,
 - b. a ninety (90) day supply for Maintenance Drugs unless authorized by CareFirst.
10. Prescription Drugs that are administered or dispensed by a health care facility for a Member who is a patient in the health care facility. This exclusion does not apply to Prescription Drugs that are dispensed by a Pharmacy on the health care facility's premises for a Member who is not a patient in the health care facility.
11. Prescription Drugs for weight loss.
12. Biologicals and allergy extracts.
13. Blood and blood products. (May be covered under the medical benefits in the Evidence of Coverage to which this rider is attached.)

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.



Plan 2

BlueChoice Advantage

Offers You the Freedom to Choose

BlueChoice Advantage provides you with choices that offer control over your out-of-pocket costs. There's no need to select a primary care provider (PCP) or to obtain a referral to see a specialist with this plan. You have the freedom to visit any provider and your choice will determine your out-of-pocket costs.

Benefits of BlueChoice Advantage

- Choose from more than 37,000 CareFirst BlueChoice providers, specialists and hospitals in Maryland, Washington, D.C. and Northern Virginia.
- Access to more than 1 million professional providers nationally through the BlueCard® PPO network when receiving care outside the CareFirst BlueCross BlueShield (CareFirst) service area.
- No PCP selection required.
- No PCP referral required to see a specialist.
- Pay predictable copays when you receive care from an in-network provider.
- Preventive services, including well child visits, annual adult physicals and routine cancer screenings at no cost.
- Enroll in a BlueChoice Advantage HSA plan and pay for qualified medical expenses with tax-free dollars.



How your plan works

The BlueChoice Advantage Plan offers you the flexibility and freedom to choose from both in and out-of-network providers.

No need to select a PCP or obtain a referral.

Receiving care inside the CareFirst service area

When care is rendered in Maryland, Washington, D.C. or Northern Virginia, use the CareFirst BlueChoice Network



to receive the highest level of coverage and pay lower out-of-pocket costs.

Receiving care outside the CareFirst service area

Members seeking care outside the CareFirst service area will lower costs by using a national BlueCard® PPO provider. Members will still have the option to opt-out of this network but will pay a higher out-of-pocket expense.

If you receive services from a provider outside of the BlueCard network, you will have to:

- Pay the provider's actual charge at the time you receive care.
- File a claim for reimbursement.
- Satisfy a deductible and coinsurance.

The choice is entirely yours. That's the advantage of this plan.

Hospital authorization/Utilization management

If you are receiving care in Maryland, Washington, D.C. or Northern Virginia, your CareFirst BlueChoice or out-of-network participating provider in the service area will obtain any necessary admission authorizations for in-area covered services.

If you are receiving care outside of Maryland, Washington, D.C. or Northern Virginia, you'll be responsible for obtaining authorization for services. Call toll-free at (866) PREAUTH (773-2884) for authorization.

Your benefits

Step 1: Meet your deductible (if applicable)

If your plan requires you to meet a deductible, you will be responsible for the entire cost of your medical care up to the amount of your deductible. Once your deductible is satisfied, your full benefits will become available to you.

You will have a combined deductible amount for both in-network and out-of-network benefits.

If more than one person is covered under your plan, once the total deductible amount is satisfied, the plan will start to make payments for everyone covered. Deductible requirements vary based on your coverage level (e.g. individual, family) as well as the specific plan selected. Members should refer to their Evidence of Coverage for detailed deductible information.

Step 2: Your plan will start to pay for services

After you satisfy your deductible, your plan will start to pay for covered services. The level of those benefits will depend on whether you see in-network or out-of-network providers.

In-network refers to the use of providers who are in the health plan's provider network. Seeking care from in-network providers can reduce your out-of-pocket expenses.

Out-of-network refers to the use of health care providers who are either participating or have not contracted with the health plan to provide services (non-participating). Members can go out-of-network, but will pay higher out-of-pocket costs.

In general, non-participating providers don't have an agreement with CareFirst to accept the allowed benefit as payment in full for their services. Therefore, you may be balance billed based on the provider's actual charge. In addition, you may be required to pay the non-participating provider's total charges at the time of service and submit a claim for reimbursement.

Step 3: Your out-of-pocket maximum or out-of-pocket limit is the maximum amount you'll pay during your benefit period.

Should you ever reach your out-of-pocket limit, CareFirst will then pay 100% of the allowed benefit for all covered services for the remainder of the benefit period. Any amount you pay towards your deductible and most copays and/or coinsurance will count towards your out-of-pocket limit.

If more than one person is covered under your plan, once the out-of-pocket limit is satisfied, no copays or coinsurance amounts will be required for anyone covered under your plan. Out-of-pocket limit requirements vary based on your coverage level (e.g. individual, family) as well as the specific plan selected. Members should refer to their Evidence of Coverage for detailed out-of-pocket limit information.

Laboratory services

You must use a LabCorp® facility for any laboratory services in order to obtain coverage for those services. LabCorp has approximately 100 locations throughout Maryland, Washington, D.C. and Northern Virginia. To locate the LabCorp patient service center near you, call (888) LAB-CORP or visit www.labcorp.com.

Services performed at a facility in Maryland, Washington, D.C. or Northern Virginia that is not part of the LabCorp network may be considered out-of-network and may require members to pay higher out-of-pocket costs. Also, any lab work performed in an outpatient hospital setting will require a prior authorization.

If you are outside Maryland, Washington, D.C. and Northern Virginia and require laboratory services, you may use any participating BlueCard® PPO laboratory and you will receive in-network benefits.

Important terms

Allowed benefit is the dollar amount CareFirst BlueChoice, Inc. allows for the particular service in effect on the date that service is rendered.

Balance Billing is billing a member for the difference between the allowed charge and the actual cost.

Copay is a fixed dollar amount a member must pay for a covered service.

Coinsurance is a percentage of the doctor's charge or allowed benefit a member must pay for a covered service.

Deductible is the dollar amount of incurred covered expenses that the member must pay before CareFirst BlueChoice makes payment.

These benefits are issued under policy form numbers:

MD: MD/CFBC/PPN SOB (R. 6/10); MD/CFBC/HPN/EOC (R. 6/10); MD/CFBC/PPN/DOCS (R. 6/10); MD/CFBC/GC (R. 7/10); MD/CFBC/ELIG (R. 10/10); MD/CFBC/RX3 (R. 7/08)

DC: DC/CFBC/GC (R. 7/10); DC/CFBC/HPN/EOC (R. 6/10); DC/CFBC/PPN DOCS (R. 6/10); DC/CFBC/PPN SOB (R. 6/10); DC/CFBC/ATTC (R. 1/10); DC/CFBC/RX3 (R. 12/08)

VA: VA/CFBC/GC (R. 1/10); VA/CFBC/HPN/EOC (R. 6/10); VA/CFBC/PPN DOCS (R. 6/10); VA/CFBC/PPN SOB (R. 6/10); VA/CFBC/ATTC (R. 1/10); VA/CFBC/RX3 (R. 12/08)



HSA & HRA Compatible Plans

A Guide to How an HSA or HRA Compatible Plan Works

Your CareFirst BlueCross BlueShield (CareFirst) or CareFirst BlueChoice, Inc. (CareFirst BlueChoice) HSA/HRA compatible health plan is a high deductible health plan. The plan meets all of the requirements you need to establish your own Health Savings Account (HSA), or if your employer offers it, a Health Reimbursement Arrangement (HRA). This means it complies with IRS regulations, thus allowing you, your employer, or both to set up a medical funding arrangement or account to help fund your out-of-pocket costs.

These medical funding arrangements or accounts put you, the consumer, in the driver's seat. Your medical savings arrangement or account allows you to make the decision on where and how to spend your health care funds, while still benefiting from the Blue Cross and Blue Shield provider discounts.

Your employer may establish a Health Savings Account for you and your family, or you may be able to open one yourself from a local participating bank. With the Health Reimbursement Arrangement, your employer sets aside a specific amount of money for you each benefit year.

Here's how the HSA works:

- An HSA can be funded by you, your employer or both.
- You then use the money in your account to pay the full or discounted cost of covered services.
- The amount in your account is applied toward your health care expenses. If you use all of your account funds before meeting your deductible, you will then be responsible for any remaining balance of your deductible.
- Once you meet your deductible, your CareFirst or CareFirst BlueChoice health coverage begins. You will then pay a percentage of the cost of your care (called the coinsurance or copays) for medical covered services and a coinsurance or copay for prescription drugs.
- Funds in an HSA are completely portable, so if you change jobs or stop working, the funds stay with you (or you may set up your own HSA account if not offered by your employer).

- There are no "use it or lose it" rules like there are with Flexible Spending Accounts—unspent money stays in the HSA from year-to-year.
- Qualified HSA funds can be invested.

Amounts paid from an HSA are not taxed as long as they are used to pay for qualified health care expenses. You can decide how much to contribute, up to the difference between your health plan's annual deductible and the amount that your employer contributes towards the fund.

Here's how the HRA works:

- An HRA is funded by your employer.
- Each year, your employer makes a contribution toward your HRA.
- You then use the money to pay the cost of covered services.
- The amount is applied toward your health care expenses. If you use all of your funds before meeting your deductible, you will then be responsible for any remaining balance of your deductible.
- Once you meet your deductible, your CareFirst or CareFirst BlueChoice health coverage begins. You will then pay a percentage of the cost of your care (called the coinsurance or copays) for medical covered services, and depending on your plan, a copay for prescription drugs.
- Any remaining balance in your account at the end of the benefit year automatically (if employer allows) rolls over to the next year and is added to the annual contribution made by your employer.

HSA & HRA Compatible Plans

A Guide to How an HSA or HRA Compatible Plan Works

The greater the balance, the less you have to pay out-of-pocket.

- Dollars can be used to pay for any covered services received by any family member covered under the plan.
- If you choose another plan or leave the company without continuing your coverage, the balance returns to your employer.

How your deductible works

Your CareFirst or CareFirst BlueChoice health plan has an annual deductible that you must satisfy before your health coverage begins. While you need to meet a deductible each benefit year, the money spent from your HSA or HRA on certain eligible health care expenses will count toward meeting that deductible. Most plans cover routine preventive care at 100%, or for a predictable copay or coinsurance. This applies to such benefits as well-child visits, adult physicals and cancer screenings. Once your deductible is met, you may then pay a percentage of the cost of your care (called the copay or coinsurance) for all covered services, and depending on your plan, a copay for prescription drugs.

The more you know, the better you can manage your health care needs. With our HSA and HRA compatible

plans, you can tap into the power of the Internet to help manage your benefits.

We offer online tools which allow you to:

- Check the status of a claim
- Compare hospitals
- Request a member ID card
- Confirm or review eligibility
- Find a doctor
- Access health and wellness information
- Compare prescription drug costs

Our prescription drug web site provides you with specific details on prescription drug coverage along with the ability to conduct price inquiries and compare the cost of generic drugs versus brand name products. You can use the site to calculate daily and annual drug costs, search for pharmacies and compare the cost of retail and mail order options. Just visit www.carefirst.com/rx.

A toll-free help line and member education programs are also available.

NOTE: Since your plan may include a combined medical and prescription drug deductible, you will be required to pay the full discounted cost of your prescription drugs until you meet your deductible.

Disclaimer

The Health Savings Account is not an insurance program, but a financial savings account. CareFirst BlueCross BlueShield and CareFirst BlueChoice, through its vendors, provides administrative services only for the Account and is not liable for any account balances. The Account may be used for qualified medical expenses as defined in the employer's plan document. Account balances are unfunded liabilities of the employer. They are not vested benefits and may be reduced or withdrawn at any time, at the option of your employer. The employer's plan document terms prevail over any inconsistencies in any verbal, written, or electronic information provided by CareFirst BlueCross BlueShield and CareFirst BlueChoice.

How CareFirst and CareFirst BlueChoice handle discounts:

When a provider signs a contract to provide services to CareFirst and CareFirst BlueChoice members, he/she is also agreeing to accept reimbursement established by CareFirst and CareFirst BlueChoice as payment in full. The amount that CareFirst and CareFirst BlueChoice pays its providers for covered services is called the allowed benefit. The difference between the provider's actual charge for services and the allowed benefit by CareFirst and CareFirst BlueChoice is called the discount savings. Member deductibles and coinsurance are based on the lower of the allowed benefit and/or the provider's actual charge.

CareFirst and CareFirst BlueChoice may retain a portion of the discount savings as part of its fees. The discount

savings may take several forms, such as BlueCard® network access fees and other provider discounts that have been negotiated by CareFirst and CareFirst BlueChoice. The specific amount that we retain has been agreed upon by CareFirst and CareFirst BlueChoice and your employer. For more information, please refer to your member contract.

Not all services and procedures are covered by your benefits contract. This plan is for comparison purposes only and does not create rights not given through the benefit plan.

The CareFirst benefits are issued under policy form numbers:

MSGR: COC-NCA (MSGR) REV (7/14); MD/CF/MSGR/DOCS (7/14); MD/CF/MSGR/SOB/PPO/CORE (7/14); MD/CF/MSGR/SOB/PPO/ENHANCE (7/14);

MD/CF/MSGR/SOB/PPO/HSA/CORE (7/14); MD/CF/MSGR/SOB/PPO/HSA/ENHANCE (7/14); MD/CF/MSGR/SOB/PPO/HRA (7/14); MD/CFBC/MSGR/EOC (7/14); MD/CFBC/MSGR/DOCS (7/14); MD/CFBC/MSGR/SOB/CORE (7/14); MD/CFBC/MSGR/SOB/ENHANCE (7/14); MD/CFBC/MSGR/HSA/SOB/CORE (7/14); MD/CFBC/MSGR/HSA/ENHANCE (7/14); MD/CFBC/MSGR/HSA/OOP/OA (7/14)

MD (Non-MSGR): GC-M; GPS/M; COC/M; DOCS-PPO/M; ELIG-MD; MD/CF/SOB HDHP (7/14); MD/CF/CDH RX (7/14); MD/CF/MANDATES 10/00 HDHP (R. 12/04); MD/CFBC/GC (R. 7/03); MD/CFBC/EOC (R. 7/03); MD/CFBC/DOCS (R. 7/03); MD/BC-OOP/SOB HDHP (7/14); MD/CFBC/ELIG (R. 5/05); MD/CFBC/ADD SERV AMEND (7/14);

MD/CFBC HDHP/LL AMEND (7/14); MD/CFBC/HDHP RX (7/14); MD/CFBC/GC (R. 7/03); MD/CFBC EOC (R. 7/03); MD/CFBC/DOCS (R. 7/03); MD/BC-OOP/SOB HDHP (7/14); MD/CFBC/ELIG (R. 5/05); MD/CFBC/ADD SERV AMEND (7/14); MD/CFBC HDHP/LL AMEND (7/14); MD/CFBC/HDHP RX (7/14); CCH/NCA GC/M; CCH/NCA COC/M; DOCS/M; MD/CMM/SOB HDHP (7/14); MD/CF/ATTC (R. 5/05); MD/CFBC/ADD SERV AMEND (7/14); MD/CFBC/HDHP RX (7/14) and any amendments.

DC: GC-A/DC-6/94; GPS-DC-6/95; DC/CERT-9/96; DC/PPO-A-8/96; DC/NCA/ELIG-C 6/97; DC/CF/SOB HDHP (7/14); DC/CF/CDH RX (7/14); DC/CF/WIG HDHP (R. 12/04); DC/BC/GC 2/02; DC/BC/EOC 2/02; DC/BC/DOC 2/02; DC/CFBC/ATTC (R. 5/05); DC/BC-OOP/HDHP SOB (7/14); DC/CFBC/HDHP RX (7/14); DC/BC/GC 2/02; DC/BC/EOC 2/02; DC/BC/DOC 2/02; DC/CFBC/ATTC (R. 5/05); DC/BC-OOP/HDHP SOB (7/14); DC/CCH/NCA COC 8/96; DC/DOCS-8/96; DC/CF/ATTC (R. 5/05); DC/CCH/NCA GC 9/96; DC/CMM/SOB HDHP (7/14); DC/CF/CDH RX (R. 9/06) and any amendments.

VA: GC-A-4/95; GPS-F1-4/95; VA/CERT-5/96; PPP-A-5/95; VA/NCA/ELIG-C 5/97; VA/CF/SOB HDHP (7/14); VA/CF/CDH RX (7/14); VA/CF/WIG HDHP (R. 12/04); VA/CC/GC 5/01; VA/CFBC/EOC (R. 1/06); VA/CC/DOC 5/01; VA/BC-OOP/SOB HDHP (7/14); VA/CFBC/ATTC (R. 5/05); VA/CFBC/HDHP RX-9/06; VA/CC/GC 5/01; VA/CFBC/EOC (R. 1/06); VA/CC/DOC 5/01; VA/BC-OOP/SOB HDHP (7/14); VA/CFBC/ATTC (R. 5/05); CCH/NCA GC 5/95; CCH/NCA-CERT-5/95; CMM-A-4/95; VA/CMM/SOB HDHP-9/06; VA/CF/ATTC (R. 5/05); VA/CF/CDH RX (R. 9/06) and any amendments or riders.



The CareFirst BlueCross BlueShield family of health care plans

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are both independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.

HSA and HRA Compatible Plans

How your compatible plans work

Your employer has chosen to offer you a CareFirst “compatible” health plan. This means that it meets all the IRS regulations needed to allow you to establish a Health Savings Account (HSA) either on your own or through your employer. These plans can also be used with a Health Reimbursement Arrangement (HRA) if offered by your employer.

Compatible health plans allow you or your employer to set up a medical savings account, such as an HSA or an HRA, to help you pay for out-of-pocket medical costs on a tax-preferred basis. These plans were designed to put you, the consumer, in the driver’s seat, by empowering you to make decisions on where, when and how to spend your health care funds, while still enjoying the benefits of a CareFirst health plan.

Your annual deductible

Your CareFirst health plan has an annual deductible that you must satisfy before most of your health coverage begins. This deductible starts over at the beginning of each plan year. This means that if your plan includes a \$2,400 annual deductible, you will be required to meet the \$2,400 deductible each year before your health care benefits begin.

Because we want you to stay healthy, preventive care is not subject to the deductible. This includes routine physicals, routine GYN visits, well-child care and cancer screenings, as well as the lab tests associated with these preventive visits. These services are usually either covered in full or subject only to a predictable copay. Your summary of benefits will provide you with more details.

Paying for out-of-pocket costs

If you or your employer have set-up a medical savings account for your CareFirst compatible plan, you may use the money in your account to pay for the health care expenses that count toward meeting your deductible. For example, if you go to the doctor because of an illness, the cost of that visit will be applied to your annual deductible and you can use your HSA or HRA funds to pay for that service.



Compatible plans

A CareFirst “compatible” plan meets the requirements necessary to combine it with either a Health Savings Account or a Health Reimbursement Arrangement.

Services covered by your CareFirst health plan

If during the course of your plan year you reach your annual deductible, your CareFirst health plan will kick-in and you will receive the benefits for all covered services as outlined in your summary of benefits. You may still have some out-of-pocket expenses in the form of coinsurance or copays.

- A copay is a fixed amount you contribute toward a service.
- Coinsurance is a percentage of the cost of the service.

If funds remain in your HSA or HRA after meeting the deductible, you can use the funds to cover these out-of-pocket expenses.



Combined medical and Rx deductible

All HSA-compatible plans, and some HRA-compatible plans, include a combined medical and prescription drug deductible. For this type of plan, you will be required to pay the full cost of your prescription drugs until you meet your deductible. The amount you pay will reflect the discounted price negotiated by CareFirst.

If you are used to only paying a copayment for prescription drugs, the price of some drugs may surprise you as they can be very expensive. Before filling your prescription, try out CareFirst's Drug Pricing tool available on www.carefirst.com (go to *My Account*) to investigate potential alternatives that you can discuss with your doctor or pharmacist that may save you money.



BlueChoice Advantage

Integrated Deductible

Summary of Benefits

Services	In-Network You Pay ^{1,2}	Out-of-Network You Pay ^{1,3}
Visit www.carefirst.com/doctor to locate providers		
FIRSTHELP—24/7 NURSE ADVICE LINE		
Free advice from a registered nurse. Visit www.carefirst.com/needcare 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.	
BLUE REWARDS		
Visit www.carefirst.com/bluerewards for more information	Blue Rewards is an incentive program where you can earn up to \$600 for taking an active role in getting healthy and staying healthy.	
ANNUAL DEDUCTIBLE (Benefit period) ⁴		
Individual	\$2,000	\$4,000
Family	\$4,000	\$8,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period) ⁵		
Medical ⁶	\$3,000 Individual/\$6,550 Family	\$5,950 Individual/\$11,900 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*	40% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	No charge*	40% of Allowed Benefit
Breast Cancer Screening	No charge*	40% of Allowed Benefit
Pap Test	No charge*	40% of Allowed Benefit
Prostate Cancer Screening	No charge*	40% of Allowed Benefit
Colorectal Cancer Screening	No charge*	40% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	Deductible, then \$30 per visit	Deductible, then 40% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans) ⁷	Deductible, then 10% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Lab ⁷	Deductible, then 10% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
X-ray ⁷	Deductible, then 10% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Allergy Testing	Deductible, then \$30 per visit	Deductible, then 40% of Allowed Benefit
Allergy Shots	Deductible, then \$5 per visit	Deductible, then 40% of Allowed Benefit
Physical, Speech and Occupational Therapy ⁸ (limited to 30 visits/injury/benefit period)	Deductible, then \$30 per visit	Deductible, then 40% of Allowed Benefit
Chiropractic (limited to 20 visits/benefit period)	Deductible, then \$30 per visit	Deductible, then 40% of Allowed Benefit
Acupuncture	Not covered (except when approved or authorized by Plan when used for anesthesia)	Not covered (except when approved or authorized by Plan when used for anesthesia)
EMERGENCY SERVICES		
Urgent Care Center	Deductible, then \$75 per visit	In-network deductible, then \$75 per visit
Emergency Room—Facility Services	Deductible, then \$300 per visit (waived if admitted)	In-network deductible, then \$300 per visit (waived if admitted)
Emergency Room—Physician Services	No charge* after deductible	No charge* after in-network deductible
Ambulance (if medically necessary)	Deductible, then 10% of Allowed Benefit	Deductible, then 40% 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 \$300 per visit	Deductible, then 40% of Allowed Benefit
Outpatient Physician Services	Deductible, then 10% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Inpatient Facility Services	Deductible, then \$300 per admission	Deductible, then 40% of Allowed Benefit
Inpatient Physician Services	Deductible, then 10% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care	Deductible, then 10% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Hospice	Deductible, then 10% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Skilled Nursing Facility (limited to 100 days/ benefit period)	Deductible, then 10% 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 \$300 per admission	Deductible, then 40% of Allowed Benefit
Nursery Care of Newborn	Deductible, then 10% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Artificial and Intrauterine Insemination ⁹	Not covered	Not covered
In Vitro Fertilization Procedures ⁹	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE (Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	Deductible, then \$300 per admission	Deductible, then 40% of Allowed Benefit
Inpatient Physician Services	Deductible, then \$30 per visit	Deductible, then 40% of Allowed Benefit
Outpatient Facility Services	No charge* after deductible	Deductible, then 40% of Allowed Benefit
Outpatient Physician Services	No charge* after deductible	Deductible, then 40% of Allowed Benefit
Office Visits	No charge* after deductible	Deductible, then 40% of Allowed Benefit
Medication Management	No charge* after deductible	Deductible, then 40% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 40% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Hearing Aids	Not covered	Not covered
VISION		
Routine Exam (limited to 1 visit/benefit period)	\$10 per visit	Total charge minus \$33 Allowed Benefit
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.

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 in Maryland, Washington D.C. and/or Northern Virginia, collectively known as the CareFirst BlueChoice service area, by a provider in the CareFirst BlueChoice Provider network, care is reimbursed at the in-network level. In-network benefits are based on the CareFirst BlueChoice Allowed Benefit. The CareFirst BlueChoice Allowed Benefit is generally the contracted rates or fee schedules that CareFirst BlueChoice providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueChoice, Inc., however, in certain circumstances, an allowance may be established by law. Outside of the CareFirst BlueChoice service area, when covered services are rendered by a provider in the preferred provider network, care is also covered at the in-network level. These in-network benefits are based on the contracted rates or fee schedules that preferred providers have agreed to accept as payment for covered services that are established by the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.

³ Out-of-Network: When covered services are rendered by a provider that is not in the CareFirst BlueChoice network in Maryland, Washington D.C. or Northern Virginia, or is not in the preferred provider network outside of CareFirst BlueChoice service area, the care is reimbursed as out-of-network. Out-of-network benefits are based on the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that are established by CareFirst BlueChoice, or the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.

⁴ For family coverage only: The family deductible must be met before any member starts receiving benefits. The deductible may be met by one member or any combination of members.

⁵ For family coverage only: The family out-of-pocket maximum must be met before any member's services will be covered at 100% up to the Allowed Benefit. The out-of-pocket maximum may be met by one member or any combination of members.

⁶ Plan has an integrated medical and prescription drug out-of-pocket maximum.

⁷ If you receive laboratory services inside the CareFirst Service area (Maryland, D.C., Northern Virginia) members should use LabCorp to receive in-network benefits. Services performed by any other provider, while inside the CareFirst Service area will be considered out-of-network. If you receive laboratory services outside of Maryland, D.C. or Northern Virginia, you may use any participating BlueCard PPO laboratory and receive in-network benefits.

⁸ Visit Limitation does not apply to children ages 2-10 when Physical, Speech and Occupational Therapy is for treatment of Autism Spectrum Disorder.

⁹ 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.

These benefits are issued under policy form numbers: VA/CFBC/GC (R. 1/13) • VA/CFBC/HPN/EOC (R. 10/11) • VA/CFBC/PPN DOCS (R. 10/11) • VA/CFBC/PPN SOB (R. 10/11) • VA/CFBC/ATTC (R. 1/10) • VA/CFBC/DOL APPEAL (R. 7/12) • VA/CFBC/LG/ADV/INCENT (1/15) • VA/CFBC/RX3 (R. 1/15) and any amendments.



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Exclusions

11.1 Coverage is Not Provided For:

- A. Any services, tests, procedures, or supplies which CareFirst BlueChoice determines are not necessary for the prevention, diagnosis, or treatment of the Member's illness, injury, or condition. Although a service or supply may be listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in the Member's particular case.
- B. Any treatment, procedure, facility, equipment, drug, drug usage, device, or supply which, in CareFirst BlueChoice's judgment, is Experimental/ Investigational, or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment, except for covered benefits for Clinical Trials.
- C. The cost of services that are furnished without charge or are normally furnished without charge if a Member was not covered under this Evidence of Coverage or under any health insurance, or any charge or any portion of a charge which by law the provider is not permitted to bill or collect from the Member directly.
- D. Any service, supply, or procedure that is not specifically listed in the Member's Evidence of Coverage as a covered benefit or that do not meet all other conditions and criteria for coverage as determined by CareFirst BlueChoice.
- E. Routine, palliative, or Cosmetic foot care (except for conditions determined by CareFirst BlueChoice to be Medically Necessary), including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
- F. Except for treatment for Accidental Injury or benefits for Oral Surgery, dental care including extractions; treatment of cavities; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia, except for the treatment of a cleft lip or cleft palate; false teeth; or any other dental services or supplies. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
- G. Benefits will not be provided for Cosmetic surgery (except as specifically provided for Reconstructive Breast Surgery, Reconstructive Surgery and services for cleft lip or cleft palate or both, as listed above) or other services primarily intended to correct, change or improve appearances.
- H. Treatment rendered by a health care provider who is a member of the Member's family (e.g., parents, spouse, brothers, sisters, children).
- I. Any prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage. Medications that can be self-administered or do not medically require administration by or under the direction of a physician are not covered even though they may be dispensed or administered in a physician office or provider facility. Benefits for prescription drugs may be available through a rider purchased by the Group and attached to the Evidence of Coverage.
- J. All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained and self-administered by the Member, except as stated in the Description of Covered Services. Over-the-Counter means any item or supply, as determined by CareFirst BlueChoice, that is available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions.
- K. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
- L. Services to reverse voluntary, surgically induced infertility, such as a reversal of sterilization.
- M. All assisted reproductive technologies including artificial insemination and intrauterine insemination, in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same unless covered under a rider purchased by the Group and attached to the Evidence of Coverage.
- N. Fees or charges relating to fitness programs, weight loss or weight control programs; physical conditioning; exercise programs; and use of passive or patient-activated exercise equipment other than Medically Necessary and approved pulmonary rehabilitation programs.
- O. Treatment for weight reduction and obesity except for the surgical treatment of Morbid Obesity.
- P. Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications.
- Q. Services furnished as a result of a referral prohibited by law.
- R. Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by CareFirst BlueChoice.
- S. Health education classes and self-help programs, other than birthing classes or for the treatment of diabetes.
- T. Acupuncture services except when approved or authorized by CareFirst BlueChoice when used for anesthesia.
- U. Any service related to recreational activities. This includes, but is not limited to sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst BlueChoice even though they may have therapeutic value or be provided by a health care provider.
- V. Coverage under this Evidence of Coverage does not include the cost of services or payment for services for any illness, injury or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:
 - 1. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or
 - 2. From any federal, state, county or municipal facility or other government agency, including, in the case of service-connected disabilities, the Veterans Administration, to the extent that Benefits are payable by the federal, state, county or municipal facility or other government agency and provided at no charge to the Member, but excluding Medicare benefits and Medicaid benefits.Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for benefits.
- W. Private duty nursing.
- X. Non-medical, health care provider services, including, but not limited to:
 - 1. Telephone consultations, failure to keep a scheduled visit, completion of forms (except for forms that may be required by CareFirst BlueChoice), copying charges or other administrative services provided by the health care practitioner or the healthcare practitioner's staff.
 - 2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Evidence of Coverage are available for Covered Services rendered to the Member by a health care provider.
- Y. Educational therapies intended to improve academic performance.
- Z. Vocational rehabilitation and employment counseling.
- AA. Routine eye examinations, frames and lenses or contact lenses. Benefits for routine eye examinations, frames and lenses or contract lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.
- BB. Custodial, personal, or domiciliary care that is provided to meet the activities of daily living, e.g., bathing, toileting and eating (care which may be provided by persons without professional medical skills or training).
- CC. Work hardening programs. Work hardening programs are highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.
- DD. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, drug therapy, and psychiatric treatment.

- EE. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst BlueChoice and CareFirst BlueChoice approved services listed in Section 1.3, Organ and Tissue Transplants).
- FF. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
- GG. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

11.2 Organ and Tissue Transplants. Coverage is not provided for:

- A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary, non-experimental skin grafts that are covered under the Evidence of Coverage.
- B. Any hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.
- C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst BlueChoice.
- D. Services for a Member who is an organ donor when the recipient is not a Member.
- E. Benefits will not be provided for donor search services.
- F. Any service, supply or device related to a transplant that is not listed as a benefit in the Evidence of Coverage.

11.3 Inpatient Hospital Services. Coverage is not provided for:

- A. Private room, unless Medically Necessary and authorized or approved by CareFirst BlueChoice. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.
- B. Non-medical items and convenience items, such as television and phone rentals, guest trays and laundry charges.
- C. Except for covered Emergency Services and Maternity Care, a hospital admission or any portion of a hospital admission that had not been authorized or approved by CareFirst BlueChoice, whether or not services are Medically Necessary and/or meet all other conditions for coverage.
- D. Private duty nursing.
- E. Admissions to a facility that is a convalescent home, convalescent rest or nursing facilities, facilities primarily affording custodial, educational or rehabilitative care, or facilities for the aged, drug addicts or alcoholics.

11.4 Home Health Services. Coverage is not provided for:

- A. Private duty nursing.
- B. Custodial Care.

11.5 Hospice Benefits. Coverage is not provided for:

- A. Services, visits, medical equipment or supplies that are not included in CareFirst BlueChoice-approved plan of treatment.
- B. Financial and legal counseling.
- C. Any service for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.
- D. Chemotherapy or radiation therapy, unless used for symptom control.
- E. Services, visits, medical/surgical equipment or supplies; including equipment and medication not required to maintain the comfort and to manage the pain of the terminally ill Member.
- F. Reimbursement for volunteer services.
- G. Custodial Care, domestic or housekeeping services.
- H. Meals on Wheels or similar food service arrangements.
- I. Rental or purchase of renal dialysis equipment and supplies.
- J. Private duty nursing.

11.6 Outpatient Mental Health and Substance Abuse

Coverage is not provided for:

- A. Psychological testing, unless Medically Necessary, as determined by CareFirst BlueChoice, and appropriate within the scope of Covered Services.
- B. Services solely on court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.
- C. Intellectual disability, after diagnosis.
- D. Psychoanalysis.

11.7 Inpatient Mental Health and Substance Abuse

Coverage is not provided for:

- A. Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.
- B. Custodial Care.
- C. Observation or isolation.

11.8 Emergency Services and Urgent Care. Benefits for Emergency Services and Urgent Care will not be provided for:

- A. Emergency care, if the Member could have foreseen the need for the care before it became urgent (for example, periodic chemotherapy or dialysis treatment). Benefits may be available under the Out-of-Network provisions of the Evidence of Coverage.
- B. Medical services rendered outside of the Service Area that could have been foreseen by the Member prior to departing the Service Area. Benefits may be available under the Out-of-Network provisions of the Evidence of Coverage.
- C. Except for Medically Necessary follow-up care after emergency surgery, charges for Emergency Services and Urgent Care services received from an Out-of-Network Provider after the Member could reasonably be expected to travel to the nearest In-Network Provider. Benefits may be available under the Out-of-Network provisions of the Evidence of Coverage.
- D. Charges for services when the claims filing and notice procedures stated in Section 7 of the Description of Covered Services have not been followed by the Member.
- E. Except for Medically Necessary follow-up care after emergency surgery, charges for follow-up care received in the emergency or Urgent Care facility outside of the Service Area unless CareFirst BlueChoice determines that the Member could not reasonably be expected to return to the Service Area for such care. Benefits may be available under the Out-of-network provisions of the Evidence of Coverage.
- F. Except for covered ambulance services, travel, including travel required to return to the Service Area, whether or not recommended by the Member's treating physician.

11.9 Medical Devices and Supplies Coverage is not provided for:

- A. Convenience item. Any item that increases physical comfort or convenience without serving a Medically Necessary purpose, e.g. elevators, hooyer/stair lifts, ramps, shower/bath bench.
- B. Furniture items. Movable articles or accessories which serve as a place upon which to rest (people or things) or in which things are placed or stored, e.g. chair or dresser.

- C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body, e.g. exercycle or other physical fitness equipment.
- D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home, e.g. parallel bars.
- E. Environmental control equipment. Any device such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.
- F. Eyeglasses, contact lenses, dental prostheses or appliances, or hearing aids. Benefits for eyeglasses and contact lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.
- G. Corrective shoes, unless they are an integral part of the lower body brace, shoe lifts or special shoe accessories.
- H. Medical equipment/supplies of an expendable nature, except those specifically listed as a Covered Medical Supplies in this Description of Covered Services. Non-covered supplies include incontinence pads or ace bandages.
- I. Tinnitus maskers; purchase, examination, or fitting of hearing aids.

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Integrated Deductible

See Annual Deductible on Medical Summary of Benefits
\$0/10/25/45 Retail Copays ■ 50% Injectables Coinsurance

Summary of Benefits

Plan Feature	Amount	Description
Deductible	See medical summary of benefit for annual deductible amount	If you meet your combined medical and drug deductible, you will pay a different copay or coinsurance depending on the drug tier. Drugs not subject to any medical or drug deductible are noted below.
Out-of-Pocket Maximum	See medical summary of benefit for annual out-of-pocket amount	If you reach your out-of-pocket maximum, CareFirst BlueChoice 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 (Affordable Care Act) (up to a 34-day supply)	\$0 (not subject to deductible)	A preventive drug is a prescribed medication or item on CareFirst's Preventive Drug List (ACA)* (examples: Folic Acid, Fluoride, and FDA approved contraceptives for women).
Oral Chemotherapy Drugs Diabetic Supplies (up to a 34-day supply)	\$0 (not subject to deductible except for HSA plans)	Diabetic supplies include needles, lancets, test strips and alcohol swabs.
Generic Drugs (Tier 1) (up to a 34-day supply)	\$10	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (up to a 34-day supply)	\$25	Preferred brand drugs are covered at this copay level.
Non-preferred Brand Drugs (Tier 3) (up to a 34-day supply)	\$45	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Discuss using alternatives with your physician or pharmacist.
Self-administered Injectable (excluding insulin) (Tier 4) (up to a 34-day supply)	50% coinsurance up to a maximum payment of \$75	All self-administered injectable drugs (excluding insulin) are covered at this payment level. Insulin is covered at appropriate copay level.
Maintenance Drugs (up to a 90-day supply)	Generic: \$20 Preferred Brand: \$50 Non-preferred Brand: \$90 Self-Administered Injectables: 50% coinsurance, up to a maximum payment of \$150	Maintenance drugs of up to a 90-day supply are available for twice the copay through Mail Service Pharmacy or a retail pharmacy. Injectables (excluding insulin) are covered at 50% coinsurance up to a maximum payment of \$150.
Restricted Generic Substitution	Yes	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. Also, if your prescription is written for a brand-name drug and DAW (dispense as written) is noted by your doctor, you will only pay the copay.



Visit www.carefirst.com/rx for the most up-to-date Preferred Drug List and Formulary (list of covered drugs), 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: VA/CFBC/RX3 (R. 8/12) • VA/CF/RX3 (R. 8/12)



CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., and CareFirst BlueChoice, Inc. are independent licensees of the Blue Cross and Blue Shield Association.
* Registered trademark of the Blue Cross and Blue Shield Association.

Below are limitations and exclusions contained in your CareFirst BlueChoice or CareFirst medical policy to which the prescription rider is attached.

Medical Limitations and Exclusions – CareFirst BlueChoice

10.1 Coverage is Not Provided For:

- A. Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst BlueChoice.
- B. Services that are Experimental/Investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time the service in question is rendered, as determined by CareFirst BlueChoice.
- C. The cost of services that:
 1. Are furnished without charge; or
 2. Are normally furnished without charge to persons without health insurance coverage; or
 3. Would have been furnished without charge if the Member was not covered under the Evidence of Coverage or under any health insurance.
- D. Services that are not described as covered in the Evidence of Coverage or that do not meet all other conditions and criteria for coverage, as determined by CareFirst BlueChoice. Referral by a Primary Care Physician and/or the provision of services by a Contracting Provider does not, by itself, entitle a Member to benefits if the services are not covered or do not otherwise meet the conditions and criteria for coverage.
- E. Except for Emergency Services, Urgent Care and follow-up care after emergency surgery, benefits will not be provided for any service(s) provided to a Member by Non-Contracting Physicians or Non-Contracting Providers, unless written prior authorization is specifically obtained from CareFirst BlueChoice.
- F. Routine, palliative or cosmetic foot care (except for conditions determined by CareFirst BlueChoice to be Medically Necessary) including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
- G. Except for treatment for Accidental Injury or benefits for Oral Surgery as described above, dental care including extractions; treatment of cavities; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia, except for the treatment of a cleft lip or cleft palate; false teeth; or any other dental services or supplies. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
- H. Benefits will not be provided for cosmetic surgery (except as specifically provided for reconstructive breast surgery and reconstructive surgery as listed above) or other services primarily intended to correct, change or improve appearances.
- I. Treatment rendered by a health care provider who is a member of the Member's family (parents, spouse, brothers, sisters, children).
- J. Any prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage. Medications that can be self-administered or do not medically require administration by or under the direction of a physician are not covered even though they may be dispensed or administered in a physician office or provider facility. Benefits for prescription drugs may be available through a rider purchased by the Group and attached to the Evidence of Coverage.
- K. All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained and self-administered by the Member, except as stated in the Description of Covered Services. Over-the-Counter means any item or supply, as determined by CareFirst BlueChoice, that is available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions.
- L. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
- M. Services to reverse voluntary, surgically induced infertility, such as a reversal of a sterilization.
- N. All assisted reproductive technologies (except artificial insemination and intrauterine insemination), including in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same unless covered under a rider purchased by the Group and attached to the Evidence of Coverage.
- O. Fees or charges relating to fitness programs, weight loss or weight control programs; physical conditioning; pulmonary rehabilitation programs; exercise programs; and use of passive or patient-activated exercise equipment.
- P. Treatment for obesity except for the surgical treatment of Morbid Obesity.
- Q. Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications.
- R. Services furnished as a result of a referral prohibited by law.
- S. Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by CareFirst BlueChoice.
- T. Health education classes and self-help programs, other than birthing classes or for the treatment of diabetes.
- U. Acupuncture services except when approved or authorized by CareFirst BlueChoice when used for anesthesia.
- V. Any service related to recreational activities. This includes, but is not limited to sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst BlueChoice even though they may have therapeutic value or be provided by a health care provider.
- W. Coverage under this Description of Covered Services does not include the cost of services or payment for services for any illness, injury or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:
 1. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or
 2. From any federal, state, county or municipal facility or other government agency, including, in the case of service-connected disabilities, the Veterans Administration, to the extent that Benefits are payable by the federal, state, county or municipal facility or other government agency and provided at no charge to the Member, but excluding Medicare benefits and Medicaid benefits. Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for benefits.
- X. Private duty nursing.
- Y. Non-medical, health care provider services, including, but not limited to:
 1. Telephone consultations, failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the health care practitioner or the healthcare practitioner's staff.
 2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Description of Covered Services are available for Covered Services rendered to the Member by a health care provider.
- Z. Educational therapies intended to improve academic performance.
- AA. Vocational rehabilitation and employment counseling.
- BB. Routine eye examinations, frames and lenses or contact lenses. Benefits for routine eye examinations, frames and lenses or contact

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lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.

- CC. Custodial, personal, or domiciliary care that is provided to meet the activities of daily living, e.g., bathing, toileting and eating (care which may be provided by persons without professional medical skills or training).
- DD. Work hardening programs. Work hardening programs are highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.
- EE. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.
- FF. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst BlueChoice, and CareFirst BlueChoice approved services listed in the Transplants section of this Description of Covered Services).
- GG. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
- HH. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

10.2 Infertility Services.

Coverage for Artificial Insemination (and intrauterine insemination) does not include the following:

- A. Any costs associated with freezing, storage or thawing of sperm for future attempts or other use.
- B. Any charges associated with donor sperm.
- C. Infertility services that include the use of any surrogate or gestational carrier service.
- D. Infertility services when the infertility is a result of elective male or female surgical sterilization procedures, with or without reversal.
- E. Infertility services for domestic partners or common law spouses, except in those states that recognize those unions.
- F. All self-administered fertility drugs.

10.3 Organ and Tissue Transplants.

Benefits will not be provided for the following:

- A. Non-human organs and their implantation.
- B. Any Hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.
- C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst BlueChoice.
- D. Services for a Member who is an organ donor when the recipient is not a Member.
- E. Benefits will not be provided for donor search services.
- F. Any service, supply or device related to a transplant that is not listed as a benefit in this Description of Covered Services.

10.4 Inpatient Hospital Services.

Coverage is not provided for the following:

- A. Private room, unless Medically Necessary and authorized or approved by CareFirst BlueChoice. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.
- B. Non-medical items and convenience items, such as television, phone rentals, guest trays and laundry charges.
- C. Except for covered Emergency Services and Childbirth, a Hospital admission or any portion of a Hospital admission that had not been authorized or approved by CareFirst BlueChoice, whether or not services are Medically Necessary and/or meet all other conditions for coverage.
- D. Private duty nursing.

10.5 Home Health Services.

Coverage is not provided for:

- A. Private duty nursing.
- B. Custodial Care.
- C. Services in the Member's home if it is outside the Service Area.

10.6 Hospice Benefits.

Coverage is not provided for:

- A. Services, visits, medical equipment or supplies that are not included in the CareFirst BlueChoice-approved plan of treatment.
- B. Services in the Member's home if it is outside the Service Area.
- C. Financial and legal counseling.
- D. Any service for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.
- E. Chemotherapy or radiation therapy, unless used for symptom control.
- F. Services, visits, medical/surgical equipment or supplies; including equipment and medication not required to maintain the comfort and to manage the pain of the terminally ill Member.
- G. Reimbursement for volunteer services.
- H. Custodial Care, domestic or housekeeping services.
- I. Meals on Wheels or similar food service arrangements.
- J. Rental or purchase of renal dialysis equipment and supplies.
- K. Private duty nursing.

10.7 Outpatient Mental Health and Substance Abuse.

Coverage is not provided for:

- A. Psychological testing, unless Medically Necessary, as determined by CareFirst BlueChoice, and appropriate within the scope of Covered Services.
- B. Services solely on court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.
- C. Mental retardation, after diagnosis.
- D. Psychoanalysis.

10.8 Inpatient Mental Health and Substance.

The following services are excluded:

- A. Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.
- B. Custodial Care.
- C. Observation or isolation.

10.9 Emergency Services and Urgent Care.

Benefits will not be provided for:

- A. Emergency care if the Member could have foreseen the need for the care before it became urgent (for example, periodic chemotherapy or dialysis treatment).
- B. Medical services rendered outside of the Service Area which could have been foreseen by the Member prior to departing the Service Area.
- C. Charges for emergency and Urgent Care services received from a Non-Contracting Provider after the Member could reasonably be expected to travel to the nearest Contracting Provider.
- D. Charges for services when the claims filing and notice procedures stated in Section 7 of this Description of Covered Services have not been followed by the Member.
- E. Except for Medically Necessary follow-up care after emergency surgery, charges for follow-up care received in the emergency or Urgent Care facility outside of the Service Area unless CareFirst BlueChoice determines that the Member could not reasonably be expected to return to the Service Area for such care.
- F. Except for covered ambulance services, travel, including travel required to return to the Service Area, whether or not recommended by a Contracting Provider.
- G. Treatment received in an emergency department to treat a health care problem that does not meet the definition of Emergency Services as defined in Section 7 of this Description of Covered Services.

10.10 Medical Devices and Supplies.

Coverage is not provided for:

- A. Convenience item. Any item that increases physical comfort or convenience without serving a Medically Necessary purpose, e.g. elevators, hoist/stair lifts, ramps, shower/bath bench.
- B. Furniture items. Movable articles or accessories which serve as a place upon which to rest (people or things) or in which things are placed or stored, e.g. chair or dresser.
- C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or

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condition all or part of the human body, e.g. exercycle or other physical fitness equipment.

- D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home, e.g. parallel bars.
- E. Environmental control equipment. Any device such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.
- F. Eyeglasses, contact lenses, dental prostheses or appliances, or hearing aids. Benefits for eyeglasses and contact lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.
- G. Corrective shoes, unless they are an integral part of the lower body brace, shoe lifts or special shoe accessories.
- H. Medical equipment/supplies of an expendable nature, except those specifically listed as a Covered Medical Supply in this Description of Covered Services. Non-covered supplies include incontinence pads or ace bandages.

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given in the benefit plan.

Prescription Drug Exclusions

Benefits will not be provided under this rider for:

- 1. Any devices, appliances, supplies, and equipment except as otherwise provided in the Evidence of Coverage.
- 2. Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities.
- 3. Prescription Drugs for cosmetic use.
- 4. Prescription Drugs administered by a physician or dispensed in a physician's office.
- 5. Drugs, drug therapies or devices that are considered Experimental/ Investigational by CareFirst BlueChoice.
- 6. Except for items included on the Preventive Drug List, Over-the-Counter medications or supplies lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a Prescription Drug.
- 7. Vitamins, except CareFirst BlueChoice will provide a benefit for Prescription Drug:
 - a. Prenatal vitamins.
 - b. Fluoride and fluoride containing vitamins.
 - c. Single entity vitamins, such as Rocaltrol and DHT.
 - d. Vitamins included on the Preventive Drug List.
- 8. Infertility drugs and agents for use in connection with infertility services or treatments that are excluded from coverage under the Evidence of Coverage to which this rider is attached.
- 9. Any portion of a Prescription Drug that exceeds:
 - a. a thirty-four (34) day supply for Prescription Drugs; or,
 - b. a ninety (90) day supply for Maintenance Drugs unless authorized by CareFirst BlueChoice.
- 10. Prescription Drugs that are administered or dispensed by a health care facility for a Member who is a patient in the health care facility. This exclusion does not apply to Prescription Drugs that are dispensed by a Pharmacy on the health care facility's premises for a Member who is not a patient in the health care facility.
- 11. Prescription Drugs for weight loss.
- 12. Biologicals and allergy extracts.
- 13. Blood and blood products. (May be covered under the medical benefits in the Evidence of Coverage to which this rider is attached.)

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Medical Limitations and Exclusions – CareFirst BlueCross BlueShield

10.1 General Exclusions

Coverage is not provided for the following:

- A. Any service, test, procedure, supply, or item which CareFirst determines not necessary for the prevention, diagnosis or treatment of the Member's illness, injury, or condition. Although a service may be listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in the Member's particular case.
- B. Any treatment, procedure, facility, equipment, drug, drug usage, device, or supply which, in the judgment of CareFirst, is Experimental/ Investigational, or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment, except for covered benefits for Clinical Trials.
- C. The cost of services that are furnished without charge or are normally furnished without charge if a Member was not covered under the Evidence of Coverage or under any health insurance, or any charge or any portion of a charge which by law the provider is not permitted to bill or collect from the Member directly.
- D. Any service, supply, or procedure that is not specifically listed in the Member's Evidence of Coverage as a covered benefit or that does not meet all other conditions and criteria for coverage as determined by CareFirst.
- E. Services that are beyond the scope of the license of the provider performing the service.
- F. Routine foot care, including services related to hygiene or any services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet, or partial removal of a nail without the removal of its matrix. However, benefits will be provided for these services if CareFirst determines that medical attention was needed because of a medical condition affecting the feet, such as diabetes and, that all other conditions for coverage have been met.
- G. Any type of dental care (except treatment of accidental injuries, oral surgery, and cleft lip, cleft palate, or ectodermal dysplasia, as described in this Description of Covered Services) including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess, removal of impacted teeth, orthodontia, false teeth, or any other dental services or supplies, unless provided in a separate rider or amendment to this Evidence of Coverage. Benefits for oral surgery are Section 2.21 in the Outpatient and Office Services Section of this Description of Covered Services. All other procedures involving the teeth or areas surrounding the teeth, including shortening of the mandible or maxillae for Cosmetic purposes or for correction of malocclusion unrelated to a functional impairment are excluded.
- H. Cosmetic surgery (except benefits for Reconstructive Breast Surgery or reconstructive surgery) or other services primarily intended to correct, change, or improve appearances. Cosmetic means a service or supply which is provided with the primary intent of improving appearances and not for the purpose of restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention as determined by CareFirst.
- I. Treatment rendered by a Health Care Provider who is the Member's Spouse, parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or resides in the Member's home.
- J. Any prescription drugs, unless administered to the Member in the course of covered outpatient or inpatient treatment or unless the prescription drug is specifically identified as covered. Take-home prescriptions or medications, including self-administered injections which can be administered by the patient or by an average individual who does not have medical training, or medications which do not medically require administration by or under the direction of a physician are not covered, even though they may be dispensed or administered in a physician or provider office or facility, unless the take-home prescription or medication is specifically identified as covered. Benefits for prescription drugs may be available through

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- a rider or amendment purchased by the Group and attached to the Evidence of Coverage.
- K. All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies routinely obtained and self-administered by the Member, except for the CareFirst benefits described in this Evidence of Coverage and diabetic supplies.
 - L. Food and formula consumed as a sole source or supplemental nutrition, except as listed as a Covered Service in this Description of Covered Services.
 - M. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
 - N. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.
 - O. Fees and charges relating to fitness programs, weight loss or weight control programs, physical, pulmonary conditioning programs or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education, except for diabetes outpatient self-management training and educational services. Cardiac rehabilitation programs are covered as described in this Evidence of Coverage.
 - P. Medical and surgical treatment for obesity and weight reduction, except in the instance of Morbid Obesity.
 - Q. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof. Benefits for vision may be available through a rider or amendment purchased by the Group and attached to the Evidence of Coverage.
 - R. Services solely based on a court order or as a condition of parole or probation, unless approved by CareFirst.
 - S. Health education classes and self-help programs, other than birthing classes or those for the treatment of diabetes.
 - T. Acupuncture services, except when approved or authorized by CareFirst when used for anesthesia.
 - U. Any service related to recreational activities. This includes, but is not limited to, sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst even though they may have therapeutic value or be provided by a Health Care Practitioner.
 - V. Any service received at no charge to the Member in any federal hospital or facility, or through any federal, state, or local governmental agency or department, not including Medicaid. (This exclusion does not apply to care received in a Veteran's hospital or facility unless that care is rendered for a condition that is a result of the Member's military service.)
 - W. Private Duty Nursing.
 - X. Non-medical, provider services, including but not limited to:
 - 1. Telephone consultations, failure to keep a scheduled visit, completion of forms, copying charges, or other administrative services provided by the Health Care Practitioner or the Health Care Practitioner's staff.
 - 2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Evidence of Coverage are available for Covered Services rendered to the Member by a Health Care Provider.
 - Y. Speech Therapy, Occupational Therapy, or Physical Therapy, unless CareFirst determines that the condition is subject to improvement. Coverage does not include non-medical Ancillary Services such as vocational rehabilitation, employment counseling, or educational therapy.
 - Z. Services or supplies for injuries or diseases related to a covered person's job to the extent the covered person is required to be covered by a workers' compensation law.
 - AA. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst, and services listed under the Section 2.14 Transplants Section of this Description of Covered Services), whether or not recommended by an Eligible Provider.
 - BB. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.
 - CC. Contraceptive drugs or devices, unless specifically identified as covered in this Evidence of Coverage, or in a rider or amendment to this Evidence of Coverage.
 - DD. Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.
 - EE. Services, drugs, or supplies the Member receives without charge while in active military service.
 - FF. Habilitative Services delivered through early intervention and school services.
 - GG. Custodial Care.
 - HH. Coverage does not include non-medical Ancillary Services, such as vocational rehabilitation, employment counseling, or educational therapy.
 - II. Services or supplies received before the effective date of the Member's coverage under this Evidence of Coverage.
 - JJ. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
 - KK. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.
 - LL. Work Hardening Programs. Work Hardening Program means a highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.
- ### 10.2 Infertility Services .
- Benefits will not be provided for any assisted reproductive technologies including artificial insemination, as well as in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same.
- ### 10.3 Transplants
- Benefits will not be provided for the following:
- A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary non-Experimental/Investigational skin grafts.
 - B. Any hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.
 - C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst.
 - D. Services for a Member who is an organ donor when the recipient is not a Member.
 - E. Benefits will not be provided for donor search services.
 - F. Any service, supply, or device related to a transplant that is not listed as a benefit in the Description of Covered Services.
- ### 10.4 Inpatient Hospital Services
- Coverage is not provided (or benefits are reduced, if applicable) for the following:
- A. Private room, unless Medically Necessary and authorized or approved by CareFirst. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.
 - B. Non-medical items and convenience items, such as television and phone rentals, guest trays, and laundry charges.
 - C. Except for covered Emergency Services and Maternity Care, a hospital admission or any portion of a hospital admission (other than Medically Necessary Ancillary Services) that had not been approved by CareFirst, whether or not services are Medically Necessary and/or meet all other conditions for coverage.
 - D. Private Duty Nursing.
- ### 10.5 Home Health Services
- Coverage is not provided for:
- A. Private Duty Nursing.
 - B. Custodial Care.

10.6 Hospice Services

Benefits will not be provided for the following:

- A. Services, visits, medical equipment, or supplies not authorized by CareFirst.
- B. Financial and legal counseling.
- C. Any services for which a Qualified Hospice Program does not customarily charge the patient or his or her family.
- D. Reimbursement for volunteer services.
- E. Chemotherapy or radiation therapy, unless used for symptom control.
- F. Services, visits, medical equipment, or supplies that are not required to maintain the comfort and manage the pain of the terminally ill Member.
- G. Custodial Care, domestic, or housekeeping services.

10.7 Medical Devices and Supplies

Benefits will not be provided for purchase, rental, or repair of the following:

- A. Convenience items. Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for a Member (e.g., an exercycle or other physical fitness equipment, elevators, hoist lifts, shower/bath bench).
- B. Furniture items, movable objects or accessories that serve as a place upon which to rest (people or things) or in which things are placed or stored (e.g., chair or dresser).
- C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body, (e.g., exercycle or other physical fitness equipment).
- D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home (e.g., parallel bars).
- E. Environmental control equipment. Equipment that can be used for non-medical purposes, such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.
- F. Eyeglasses or contact lenses (except when used as a prosthetic lens replacement for aphakic patients as in this Evidence of Coverage), dental prostheses or appliances (except for Medically Necessary treatment of Temporomandibular Joint Syndrome (TMJ)).
- G. Corrective shoes (unless required to be attached to a leg brace), shoe lifts, or special shoe accessories.
- H. Medical equipment/supplies of an expendable nature, except as specifically listed as a Covered Medical Supply in this Evidence of Coverage. Non-covered supplies include incontinence pads or ace bandages.

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given in the benefit plan.

Prescription Drug Exclusions

Benefits will not be provided under this rider for:

1. Any devices, appliances, supplies, and equipment except as otherwise provided in Evidence of Coverage.
2. Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities.
3. Prescription Drugs for cosmetic use.
4. Prescription Drugs administered by a physician or dispensed in a physician's office.
5. Drugs, drug therapies or devices that are considered Experimental/ Investigational by CareFirst.
6. Except for items included on the Preventive Drug List, Over-the-Counter medications or supplies lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a Prescription Drug.
7. Vitamins, except CareFirst will provide a benefit for Prescription Drug:
 - a. Prenatal vitamins.
 - b. Fluoride and fluoride containing vitamins.
 - c. Single entity vitamins, such as Rocaltrol and DHT.
 - d. Vitamins included on the Preventive Drug List.
8. Infertility drugs and agents for use in connection with infertility services or treatments that are excluded from coverage under the Evidence of Coverage to which this rider is attached.
9. Any portion of a Prescription Drug that exceeds:
 - a. a thirty-four (34) day supply for Prescription Drugs; or,
 - b. a ninety (90) day supply for Maintenance Drugs unless authorized by CareFirst.
10. Prescription Drugs that are administered or dispensed by a health care facility for a Member who is a patient in the health care facility. This exclusion does not apply to Prescription Drugs that are dispensed by a Pharmacy on the health care facility's premises for a Member who is not a patient in the health care facility.
11. Prescription Drugs for weight loss.
12. Biologicals and allergy extracts.
13. Blood and blood products. (May be covered under the medical benefits in the Evidence of Coverage to which this rider is attached.)

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.



Plan 3

BluePreferred PPO

A Referral-Free Go Anywhere Health Plan

Designed for today's health conscious and busy families, the BluePreferred PPO plan offers one less thing to worry about during your busy day. Your plan gives you the freedom to visit any provider you wish—any time you wish. This means you can receive care from the provider of your choice without ever needing to select a primary care provider (PCP) or obtaining a PCP referral for specialist care.

Benefits of BluePreferred PPO

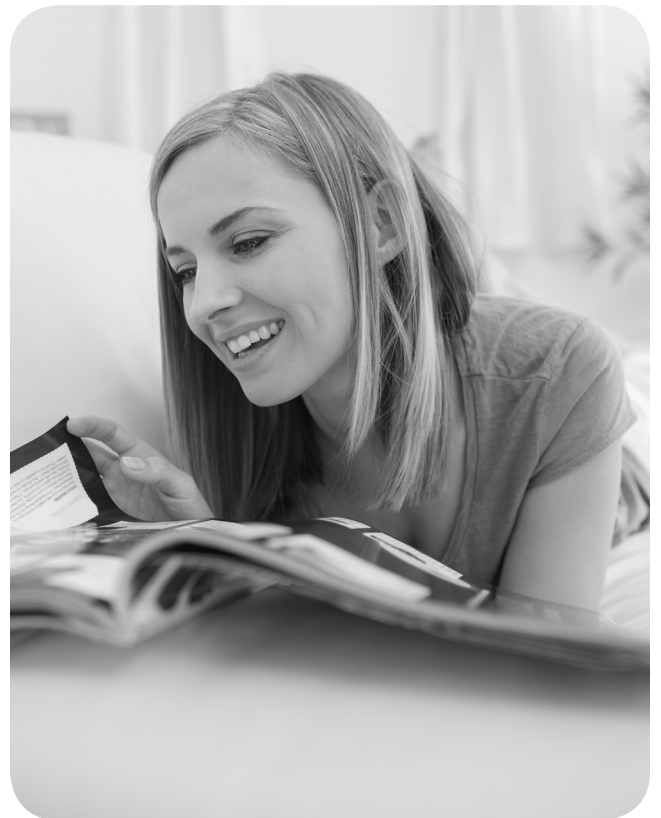
- Access to our network of more than 43,000 doctors, specialists and hospitals in Maryland, Washington, D.C. and Northern Virginia.
- No primary care provider required and no referrals to see a specialist.
- Receive coverage for preventive health care services at no cost.
- Save time—you don't have to file a claim when you receive care from a preferred provider.
- Avoid balance billing when you receive care from a preferred provider.
- Take your health care benefits with you—across the country and around the world.
- Enjoy the freedom to visit providers outside of the BluePreferred network and still be covered but with a higher out-of-pocket cost.

How your plan works

In-network vs. out-of-network coverage

The amount of coverage your BluePreferred PPO plan offers depends on whether you see a provider in the BluePreferred network (preferred provider). You'll always receive a higher level of benefits when you visit a preferred provider. However, the choice is entirely yours. That's the advantage of a BluePreferred PPO plan.

In-network benefits provide a higher level of coverage. This means you have lower out-of-pocket costs when you choose a preferred provider. If you're out of the CareFirst BlueCross BlueShield (CareFirst) service area, you have



*No referrals,
no PCPs,
coverage anywhere.*



BluePreferred PPO

A Referral-Free Go Anywhere Health Plan

the freedom to select any provider that participates with a Blue Cross and Blue Shield PPO plan across the country and receive benefits at the in-network level.

Out-of-network benefits provide a lower level of coverage in exchange for the freedom to seek care from any provider you choose. If you receive services from a provider outside of the BluePreferred network (non-preferred provider), you may have to:

- Pay the provider's actual charge at the time you receive care.
- File a claim for reimbursement.
- Satisfy a higher deductible and/or coinsurance amount.

Hospital authorization/Utilization management

Preferred providers will obtain any necessary admission authorizations for in-area covered services. You'll be responsible for obtaining authorization for services provided by non-preferred providers and out-of-area admissions. Call toll-free at (866)—PREAUTH.

Your benefits

Step 1: Meet your deductible (if applicable)

If your plan requires you to meet a deductible, you'll be responsible for the entire cost of your medical care up to the amount of your deductible. Once your deductible is satisfied, your coverage will become available to you.

You'll have a different deductible amount for in-network vs. out-of-network benefits. However, any amount applied to your in-network deductible will also count toward your out-of-network deductible and vice versa.

If more than one person is covered under your plan, once the total deductible amount is satisfied, the plan will start to make payments for everyone covered. Deductible requirements vary based on your coverage level (e.g. individual, family) as well as the specific plan selected. Members should refer to their Certificate or Evidence of Coverage for detailed deductible information.

Step 2: Your BluePreferred PPO plan will start to pay for services

After you satisfy your deductible, your plan will start to pay for covered services. The level of those benefits will depend on whether you see preferred or non-preferred providers.

In general, non-preferred providers don't have an agreement with CareFirst to accept the allowed benefit as payment in full for their services. Therefore, if you receive services from a non-preferred provider, you may be balance billed based on the provider's actual charge. In addition, you may be required to pay the non-preferred provider's total charges at the time of service and submit a claim to CareFirst for reimbursement.

Depending on your particular plan, you may have to pay a copay or coinsurance when you receive care.

Step 3: Your out-of-pocket maximum

Your out-of-pocket maximum is the maximum amount you will pay during your benefit period. Should you reach your out-of-pocket maximum, CareFirst will then pay 100% of the allowed benefit for most covered services for the remainder of the benefit period. Any amount you pay toward your deductible and most copays and/or coinsurance will count toward your out-of-pocket maximum.

You'll have a different out-of-pocket maximum for in-network vs. out-of-network benefits. However, deductible amounts applied to your in-network out-of-pocket maximum will also count toward your out-of-network out-of-pocket maximum limit and vice versa.

If more than one person is covered under your plan, once the total out-of-pocket maximum is satisfied, no copays or coinsurance amounts will be required for anyone covered under your plan. Out-of-pocket maximum requirements vary based on your coverage level (e.g. individual, family) as well as the specific plan selected. Members should refer to their Certificate or Evidence of Coverage for detailed out-of-pocket maximum information.

Out-of-area coverage

You have the freedom to take your health care benefits with you—across the country and around the world. BlueCard® PPO, a program from the Blue Cross and Blue Shield Association, allows you to receive the same health care benefits while living or traveling outside of the CareFirst service area (Maryland, Washington, D.C. and Northern Virginia). The BlueCard® program includes more than 6,000 hospitals and 1 million other professional health care providers nationally.

Important terms

Allowed benefit is the dollar amount CareFirst BlueChoice, Inc. allows for the particular service in effect on the date that service is rendered.

Balance billing is billing a member for the difference between the allowed charge and the actual charge.

Copay is a fixed dollar amount a member must pay for a covered service.

Coinsurance is a percentage of the doctor's charge or allowed benefit a member must pay for a covered service.

These benefits are issued under policy form numbers:

DC: BluePreferred - DC/CF/GC (R. 10/07); DC/CF/BP/EOC (7/14); DC/GHMSI/DOL APPEAL (7/14); DC/CF/BP/DOCS (7/14); DC/CF/BP/SOB (7/14); DC/CF/ATTC (R. 1/08) and any amendments or riders.

MD: BluePreferred - MD/CF/GC (R. 10/07); MD/BP/EOC (7/14); MD/GHMSI/DOL APPEAL (R.6/06); MD/BP/DOCS (7/14); MD/CF/PPO/SOB (7/14); MD/CF/ATTC (R. 1/08); and any amendments or riders.

MD: BluePreferred MSGR - MD/CF/MSGR/GC (7/14); GS-NCA (MSGR) (7/14); MD/CF/MSGR/COC (R. 7/08); MD/GHMSI/DOL APPEAL (R.6/06); MD/CF/MSGR/DOCS (R. 7/07); MD/CF/MSGR/DOCS/RPN (7/14); PPO-HSA DOCS AMEND (MSGR) 9/04; MD/CF/MSGR/SOB/PPO/CORE (R. 7/07); MD/CF/MSGR/SOB/PPO/HSA/ENHANCE (R. 7/07); MD/CF/MSGR/SOB/PPO/HSA/CORE (R. 7/07) and any amendments.

VA: BluePreferred - VA/CF/GC (R. 1/09); VA/CF/BP/EOC (7/14); VA/GHMSI/DOL APPEAL (R. 8/06); VA/CF/BP/DOCS (7/14); VA/CF/BP/SOB (7/14); VA/CF/SOB-CDH (7/14)VA/CF/ATTC (R. 1/08) and any amendments or riders.



HSA & HRA Compatible Plans

A Guide to How an HSA or HRA Compatible Plan Works

Your CareFirst BlueCross BlueShield (CareFirst) or CareFirst BlueChoice, Inc. (CareFirst BlueChoice) HSA/HRA compatible health plan is a high deductible health plan. The plan meets all of the requirements you need to establish your own Health Savings Account (HSA), or if your employer offers it, a Health Reimbursement Arrangement (HRA). This means it complies with IRS regulations, thus allowing you, your employer, or both to set up a medical funding arrangement or account to help fund your out-of-pocket costs.

These medical funding arrangements or accounts put you, the consumer, in the driver's seat. Your medical savings arrangement or account allows you to make the decision on where and how to spend your health care funds, while still benefiting from the Blue Cross and Blue Shield provider discounts.

Your employer may establish a Health Savings Account for you and your family, or you may be able to open one yourself from a local participating bank. With the Health Reimbursement Arrangement, your employer sets aside a specific amount of money for you each benefit year.

Here's how the HSA works:

- An HSA can be funded by you, your employer or both.
- You then use the money in your account to pay the full or discounted cost of covered services.
- The amount in your account is applied toward your health care expenses. If you use all of your account funds before meeting your deductible, you will then be responsible for any remaining balance of your deductible.
- Once you meet your deductible, your CareFirst or CareFirst BlueChoice health coverage begins. You will then pay a percentage of the cost of your care (called the coinsurance or copays) for medical covered services and a coinsurance or copay for prescription drugs.
- Funds in an HSA are completely portable, so if you change jobs or stop working, the funds stay with you (or you may set up your own HSA account if not offered by your employer).

- There are no "use it or lose it" rules like there are with Flexible Spending Accounts—unspent money stays in the HSA from year-to-year.
- Qualified HSA funds can be invested.

Amounts paid from an HSA are not taxed as long as they are used to pay for qualified health care expenses. You can decide how much to contribute, up to the difference between your health plan's annual deductible and the amount that your employer contributes towards the fund.

Here's how the HRA works:

- An HRA is funded by your employer.
- Each year, your employer makes a contribution toward your HRA.
- You then use the money to pay the cost of covered services.
- The amount is applied toward your health care expenses. If you use all of your funds before meeting your deductible, you will then be responsible for any remaining balance of your deductible.
- Once you meet your deductible, your CareFirst or CareFirst BlueChoice health coverage begins. You will then pay a percentage of the cost of your care (called the coinsurance or copays) for medical covered services, and depending on your plan, a copay for prescription drugs.
- Any remaining balance in your account at the end of the benefit year automatically (if employer allows) rolls over to the next year and is added to the annual contribution made by your employer.

HSA & HRA Compatible Plans

A Guide to How an HSA or HRA Compatible Plan Works

The greater the balance, the less you have to pay out-of-pocket.

- Dollars can be used to pay for any covered services received by any family member covered under the plan.
- If you choose another plan or leave the company without continuing your coverage, the balance returns to your employer.

How your deductible works

Your CareFirst or CareFirst BlueChoice health plan has an annual deductible that you must satisfy before your health coverage begins. While you need to meet a deductible each benefit year, the money spent from your HSA or HRA on certain eligible health care expenses will count toward meeting that deductible. Most plans cover routine preventive care at 100%, or for a predictable copay or coinsurance. This applies to such benefits as well-child visits, adult physicals and cancer screenings. Once your deductible is met, you may then pay a percentage of the cost of your care (called the copay or coinsurance) for all covered services, and depending on your plan, a copay for prescription drugs.

The more you know, the better you can manage your health care needs. With our HSA and HRA compatible

plans, you can tap into the power of the Internet to help manage your benefits.

We offer online tools which allow you to:

- Check the status of a claim
- Compare hospitals
- Request a member ID card
- Confirm or review eligibility
- Find a doctor
- Access health and wellness information
- Compare prescription drug costs

Our prescription drug web site provides you with specific details on prescription drug coverage along with the ability to conduct price inquiries and compare the cost of generic drugs versus brand name products. You can use the site to calculate daily and annual drug costs, search for pharmacies and compare the cost of retail and mail order options. Just visit www.carefirst.com/rx.

A toll-free help line and member education programs are also available.

NOTE: Since your plan may include a combined medical and prescription drug deductible, you will be required to pay the full discounted cost of your prescription drugs until you meet your deductible.

Disclaimer

The Health Savings Account is not an insurance program, but a financial savings account. CareFirst BlueCross BlueShield and CareFirst BlueChoice, through its vendors, provides administrative services only for the Account and is not liable for any account balances. The Account may be used for qualified medical expenses as defined in the employer's plan document. Account balances are unfunded liabilities of the employer. They are not vested benefits and may be reduced or withdrawn at any time, at the option of your employer. The employer's plan document terms prevail over any inconsistencies in any verbal, written, or electronic information provided by CareFirst BlueCross BlueShield and CareFirst BlueChoice.

How CareFirst and CareFirst BlueChoice handle discounts:

When a provider signs a contract to provide services to CareFirst and CareFirst BlueChoice members, he/she is also agreeing to accept reimbursement established by CareFirst and CareFirst BlueChoice as payment in full. The amount that CareFirst and CareFirst BlueChoice pays its providers for covered services is called the allowed benefit. The difference between the provider's actual charge for services and the allowed benefit by CareFirst and CareFirst BlueChoice is called the discount savings. Member deductibles and coinsurance are based on the lower of the allowed benefit and/or the provider's actual charge.

CareFirst and CareFirst BlueChoice may retain a portion of the discount savings as part of its fees. The discount

savings may take several forms, such as BlueCard® network access fees and other provider discounts that have been negotiated by CareFirst and CareFirst BlueChoice. The specific amount that we retain has been agreed upon by CareFirst and CareFirst BlueChoice and your employer. For more information, please refer to your member contract.

Not all services and procedures are covered by your benefits contract. This plan is for comparison purposes only and does not create rights not given through the benefit plan.

The CareFirst benefits are issued under policy form numbers:

MSGR: COC-NCA (MSGR) REV (7/14); MD/CF/MSGR/DOCS (7/14); MD/CF/MSGR/SOB/PPO/CORE (7/14); MD/CF/MSGR/SOB/PPO/ENHANCE (7/14);

MD/CF/MSGR/SOB/PPO/HSA/CORE (7/14); MD/CF/MSGR/SOB/PPO/HSA/ENHANCE (7/14); MD/CF/MSGR/SOB/PPO/HRA (7/14); MD/CFBC/MSGR/EOC (7/14); MD/CFBC/MSGR/DOCS (7/14); MD/CFBC/MSGR/SOB/CORE (7/14); MD/CFBC/MSGR/SOB/ENHANCE (7/14); MD/CFBC/MSGR/HSA/SOB/CORE (7/14); MD/CFBC/MSGR/HSA/ENHANCE (7/14); MD/CFBC/MSGR/HSA/OOP/OA (7/14)

MD (Non-MSGR): GC-M; GPS/M; COC/M; DOCS-PPO/M; ELIG-MD; MD/CF/SOB HDHP (7/14); MD/CF/CDH RX (7/14); MD/CF/MANDATES 10/00 HDHP (R. 12/04); MD/CFBC/GC (R. 7/03); MD/CFBC/EOC (R. 7/03); MD/CFBC/DOCS (R. 7/03); MD/BC-OOP/SOB HDHP (7/14); MD/CFBC/ELIG (R. 5/05); MD/CFBC/ADD SERV AMEND (7/14);

MD/CFBC HDHP/LL AMEND (7/14); MD/CFBC/HDHP RX (7/14); MD/CFBC/GC (R. 7/03); MD/CFBC EOC (R. 7/03); MD/CFBC/DOCS (R. 7/03); MD/BC-OOP/SOB HDHP (7/14); MD/CFBC/ELIG (R. 5/05); MD/CFBC/ADD SERV AMEND (7/14); MD/CFBC HDHP/LL AMEND (7/14); MD/CFBC/HDHP RX (7/14); CCH/NCA GC/MO; CCH/NCA COC/MO; DOCS/M; MD/CMM/SOB HDHP (7/14); MD/CF/ATTC (R. 5/05); MD/CFBC/ADD SERV AMEND (7/14); MD/CFBC/HDHP RX (7/14) and any amendments.

DC: GC-A/DC-6/94; GPS-DC-6/95; DC/CERT-9/96; DC/PPO-A-8/96; DC/NCA/ELIG-C 6/97; DC/CF/SOB HDHP (7/14); DC/CF/CDH RX (7/14); DC/CF/WIG HDHP (R. 12/04); DC/BC/GC 2/02; DC/BC/EOC 2/02; DC/BC/DOC 2/02; DC/CFBC/ATTC (R. 5/05); DC/BC-OOP/HDHP SOB (7/14); DC/CFBC/HDHP RX (7/14); DC/BC/GC 2/02; DC/BC/EOC 2/02; DC/BC/DOC 2/02; DC/CFBC/ATTC (R. 5/05); DC/BC-OOP/HDHP SOB (7/14); DC/CCH/NCA COC 8/96; DC/DOCS-8/96; DC/CF/ATTC (R. 5/05); DC/CCH/NCA GC 9/96; DC/CMM/SOB HDHP (7/14); DC/CF/CDH RX (R. 9/06) and any amendments.

VA: GC-A-4/95; GPS-F1-4/95; VA/CERT-5/96; PPP-A-5/95; VA/NCA/ELIG-C 5/97; VA/CF/SOB HDHP (7/14); VA/CF/CDH RX (7/14); VA/CF/WIG HDHP (R. 12/04); VA/CC/GC 5/01; VA/CFBC/EOC (R. 1/06); VA/CC/DOC 5/01; VA/BC-OOP/SOB HDHP (7/14); VA/CFBC/ATTC (R. 5/05); VA/CFBC/HDHP RX-9/06; VA/CC/GC 5/01; VA/CFBC/EOC (R. 1/06); VA/CC/DOC 5/01; VA/BC-OOP/SOB HDHP (7/14); VA/CFBC/ATTC (R. 5/05); CCH/NCA GC 5/95; CCH/NCA-CERT-5/95; CMM-A-4/95; VA/CMM/SOB HDHP-9/06; VA/CF/ATTC (R. 5/05); VA/CF/CDH RX (R. 9/06) and any amendments or riders.



The CareFirst BlueCross BlueShield
family of health care plans

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are both independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.

HSA and HRA Compatible Plans

How your compatible plans work

Your employer has chosen to offer you a CareFirst “compatible” health plan. This means that it meets all the IRS regulations needed to allow you to establish a Health Savings Account (HSA) either on your own or through your employer. These plans can also be used with a Health Reimbursement Arrangement (HRA) if offered by your employer.

Compatible health plans allow you or your employer to set up a medical savings account, such as an HSA or an HRA, to help you pay for out-of-pocket medical costs on a tax-preferred basis. These plans were designed to put you, the consumer, in the driver’s seat, by empowering you to make decisions on where, when and how to spend your health care funds, while still enjoying the benefits of a CareFirst health plan.

Your annual deductible

Your CareFirst health plan has an annual deductible that you must satisfy before most of your health coverage begins. This deductible starts over at the beginning of each plan year. This means that if your plan includes a \$2,400 annual deductible, you will be required to meet the \$2,400 deductible each year before your health care benefits begin.

Because we want you to stay healthy, preventive care is not subject to the deductible. This includes routine physicals, routine GYN visits, well-child care and cancer screenings, as well as the lab tests associated with these preventive visits. These services are usually either covered in full or subject only to a predictable copay. Your summary of benefits will provide you with more details.

Paying for out-of-pocket costs

If you or your employer have set-up a medical savings account for your CareFirst compatible plan, you may use the money in your account to pay for the health care expenses that count toward meeting your deductible. For example, if you go to the doctor because of an illness, the cost of that visit will be applied to your annual deductible and you can use your HSA or HRA funds to pay for that service.



Compatible plans

A CareFirst “compatible” plan meets the requirements necessary to combine it with either a Health Savings Account or a Health Reimbursement Arrangement.

Services covered by your CareFirst health plan

If during the course of your plan year you reach your annual deductible, your CareFirst health plan will kick-in and you will receive the benefits for all covered services as outlined in your summary of benefits. You may still have some out-of-pocket expenses in the form of coinsurance or copays.

- A copay is a fixed amount you contribute toward a service.
- Coinsurance is a percentage of the cost of the service.

If funds remain in your HSA or HRA after meeting the deductible, you can use the funds to cover these out-of-pocket expenses.



Combined medical and Rx deductible

All HSA-compatible plans, and some HRA-compatible plans, include a combined medical and prescription drug deductible. For this type of plan, you will be required to pay the full cost of your prescription drugs until you meet your deductible. The amount you pay will reflect the discounted price negotiated by CareFirst.

If you are used to only paying a copayment for prescription drugs, the price of some drugs may surprise you as they can be very expensive. Before filling your prescription, try out CareFirst's Drug Pricing tool available on www.carefirst.com (go to *My Account*) to investigate potential alternatives that you can discuss with your doctor or pharmacist that may save you money.



BluePreferred HSA

Integrated Deductible

Summary of Benefits

Services	In-Network You Pay ^{1,2}	Out-of-Network You Pay ^{1,3}
Visit www.carefirst.com/doctor to locate providers		
FIRSTHELP—24/7 NURSE ADVICE LINE		
Free advice from a registered nurse. Visit www.carefirst.com/needcare 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.	
BLUE REWARDS		
Visit www.carefirst.com/bluerewards for more information	Blue Rewards is an incentive program where you can earn up to \$600 for taking an active role in getting healthy and staying healthy.	
ANNUAL DEDUCTIBLE (Benefit period) ⁴		
Individual	\$1,500	\$3,000
Family	\$3,000	\$6,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period) ⁵		
Medical ⁶	\$3,000 Individual/\$6,550 Family	\$6,000 Individual/\$12,000 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*	CareFirst pays 100% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	No charge*	20% of Allowed Benefit
Breast Cancer Screening	No charge*	CareFirst pays 100% of Allowed Benefit
Pap Test	No charge*	CareFirst pays 100% of Allowed Benefit
Prostate Cancer Screening	No charge*	CareFirst pays 100% of Allowed Benefit
Colorectal Cancer Screening	No charge*	CareFirst pays 100% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans)	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Lab	No charge* after deductible	Deductible, then 20% of Allowed Benefit
X-ray	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Allergy Testing	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Allergy Shots	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Physical, Speech and Occupational Therapy	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Chiropractic	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Acupuncture	Not covered (except when approved or authorized by Plan when used for anesthesia)	Not covered (except when approved or authorized by Plan when used for anesthesia)
EMERGENCY SERVICES		
Urgent Care Center	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Emergency Room—Facility Services	Deductible, then \$100 per visit (waived if admitted)	In-network deductible, then \$100 per visit (waived if admitted)
Emergency Room—Physician Services	No charge* after deductible	No charge* after in-network deductible
Ambulance (if medically necessary)	No charge* after deductible	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	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Inpatient Facility Services	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	No charge* after deductible	Deductible, then 20% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 90 visits per episode of care)	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Hospice (limited for a maximum 180 day Hospice eligibility period)	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Skilled Nursing Facility (limited to 60 days/benefit period)	No charge* after deductible	Deductible, then 20% of Allowed Benefit
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then 20% of Allowed Benefit
Delivery and Facility Services	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Nursery Care of Newborn	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Artificial and Intrauterine Insemination ⁷	Not covered	Not covered
In Vitro Fertilization Procedures ⁷	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE (Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Outpatient Facility Services	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Office Visits	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Medication Management	No charge* after deductible	Deductible, then 20% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	No charge* after deductible	Deductible, then 20% 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	Plan pays \$33, you pay balance
Eyeglasses and Contact Lenses	Discounts at 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.

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: The family deductible must be met before any member starts receiving benefits. The deductible may be met by one member or any combination of members.

⁵ For family coverage only: The family out-of-pocket maximum must be met before any member's services will be covered at 100% up to the Allowed Benefit. The out-of-pocket maximum may be met by one member or any combination of members.

⁶ Plan has an integrated medical and prescription drug out-of-pocket maximum.

⁷ 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.

These benefits are issued under policy form numbers: VA/CF/GC (R. 1/13), VA/CF/BP/EOC (7/08), VA/GHMSI/DOL APPEAL (R. 7/12), VA/CF/BP/DOCS (7/08), VA/CF/BP/SOB HDHP (7/08), VA/CF/ATTC (R. 1/10), VA/CF/RX3 (R. 1/15), and any amendments.



CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. which is an independent licensee of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association.

Exclusions & Limitations

10.1 General Exclusions

Coverage is not provided for the following:

- A. Any service, test, procedure, supply, or item which CareFirst determines not necessary for the prevention, diagnosis or treatment of the Member's illness, injury, or condition. Although a service may be listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in the Member's particular case.
- B. Any treatment, procedure, facility, equipment, drug, drug usage, device, or supply which, in the judgment of CareFirst, is Experimental/ Investigational, or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment, except for covered benefits for Clinical Trials.
- C. The cost of services that are furnished without charge or are normally furnished without charge if a Member was not covered under the Evidence of Coverage or under any health insurance, or any charge or any portion of a charge which by law the provider is not permitted to bill or collect from the Member directly.
- D. Any service, supply, or procedure that is not specifically listed in the Member's Evidence of Coverage as a covered benefit or that does not meet all other conditions and criteria for coverage as determined by CareFirst.
- E. Services that are beyond the scope of the license of the provider performing the service.
- F. Routine foot care, including services related to hygiene or any services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet, or partial removal of a nail without the removal of its matrix. However, benefits will be provided for these services if CareFirst determines that medical attention was needed because of a medical condition affecting the feet, such as diabetes and, that all other conditions for coverage have been met.
- G. Any type of dental care (except treatment of accidental injuries, oral surgery, and cleft lip, cleft palate, or ectodermal dysplasia, as described in this Description of Covered Services) including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess, removal of impacted teeth, orthodontia, false teeth, or any other dental services or supplies, unless provided in a separate rider or amendment to this Evidence of Coverage. Benefits for oral surgery are Section 2.21 in the Outpatient and Office Services Section of this Description of Covered Services. All other procedures involving the teeth or areas surrounding the teeth, including shortening of the mandible or maxillae for Cosmetic purposes or for correction of malocclusion unrelated to a functional impairment are excluded.
- H. Cosmetic surgery (except benefits for Reconstructive Breast Surgery or reconstructive surgery) or other services primarily intended to correct, change, or improve appearances. Cosmetic means a service or supply which is provided with the primary intent of improving appearances and not for the purpose of restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention as determined by CareFirst.
- I. Treatment rendered by a Health Care Provider who is the Member's Spouse, parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or resides in the Member's home.
- J. Any prescription drugs, unless administered to the Member in the course of covered outpatient or inpatient treatment or unless the prescription drug is specifically identified as covered. Take-home prescriptions or medications, including self-administered injections which can be administered by the patient or by an average individual who does not have medical training, or medications which do not medically require administration by or under the direction of a physician are not covered, even though they may be dispensed or administered in a physician or provider office or facility, unless the take-home prescription or medication is specifically identified as covered. Benefits for prescription drugs may be available through a rider or amendment purchased by the Group and attached to the Evidence of Coverage.
- K. All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies routinely obtained and self-administered by the Member, except for the CareFirst benefits described in this Evidence of Coverage and diabetic supplies.
- L. Food and formula consumed as a sole source or supplemental nutrition, except as listed as a Covered Service in this Description of Covered Services.
- M. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
- N. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.
- O. Fees and charges relating to fitness programs, weight loss or weight control programs, physical, pulmonary conditioning programs or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education, except for diabetes outpatient self-management training and educational services. Cardiac rehabilitation programs are covered as described in this Evidence of Coverage.
- P. Medical and surgical treatment for obesity and weight reduction, except in the instance of Morbid Obesity.
- Q. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof. Benefits for vision may be available through a rider or amendment purchased by the Group and attached to the Evidence of Coverage.
- R. Services solely based on a court order or as a condition of parole or probation, unless approved by CareFirst.
- S. Health education classes and self-help programs, other than birthing classes or those for the treatment of diabetes.
- T. Acupuncture services, except when approved or authorized by CareFirst when used for anesthesia.
- U. Any service related to recreational activities. This includes, but is not limited to, sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst even though they may have therapeutic value or be provided by a Health Care Practitioner.
- V. Any service received at no charge to the Member in any federal hospital or facility, or through any federal, state, or local governmental agency or department, not including Medicaid. (This exclusion does not apply to care received in a Veteran's hospital or facility unless that care is rendered for a condition that is a result of the Member's military service.)
- W. Private Duty Nursing.
- X. Non-medical, provider services, including but not limited to:
 - 1. Telephone consultations, failure to keep a scheduled visit, completion of forms, copying charges, or other administrative services provided by the Health Care Practitioner or the Health Care Practitioner's staff.
 - 2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees.Benefits under this Evidence of Coverage are available for Covered Services rendered to the Member by a Health Care Provider.
- Y. Speech Therapy, Occupational Therapy, or Physical Therapy, unless CareFirst determines that the condition is subject to improvement. Coverage does not include non-medical Ancillary Services such as vocational rehabilitation, employment counseling, or educational therapy.
- Z. Services or supplies for injuries or diseases related to a covered person's job to the extent the covered person is required to be covered by a workers' compensation law.
- AA. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst, and services listed under the Section 2.14 Transplants Section of this Description of Covered Services), whether or not recommended by an Eligible Provider.
- BB. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.
- CC. Contraceptive drugs or devices, unless specifically identified as covered in this Evidence of Coverage, or in a rider or amendment to this Evidence of Coverage.

- DD. Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.
- EE. Services, drugs, or supplies the Member receives without charge while in active military service.
- FF. Habilitative Services delivered through early intervention and school services.
- GG. Custodial Care.
- HH. Coverage does not include non-medical Ancillary Services, such as vocational rehabilitation, employment counseling, or educational therapy.
- II. Services or supplies received before the effective date of the Member's coverage under this Evidence of Coverage.
- JJ. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
- KK. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.
- LL. Work Hardening Programs. Work Hardening Program means a highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

10.2 Infertility Services

Benefits will not be provided for any assisted reproductive technologies including artificial insemination, as well as in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same.

10.3 Transplants

Benefits will not be provided for the following:

- A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary non-Experimental/Investigational skin grafts.
- B. Any hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.
- C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst.
- D. Services for a Member who is an organ donor when the recipient is not a Member.
- E. Benefits will not be provided for donor search services.
- F. Any service, supply, or device related to a transplant that is not listed as a benefit in the Description of Covered Services.

10.4 Inpatient Hospital Services

Coverage is not provided (or benefits are reduced, if applicable) for the following:

- A. Private room, unless Medically Necessary and authorized or approved by CareFirst. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.
- B. Non-medical items and convenience items, such as television and phone rentals, guest trays, and laundry charges.
- C. Except for covered Emergency Services and Maternity Care, a hospital admission or any portion of a hospital admission (other than Medically Necessary Ancillary Services) that had not been approved by CareFirst, whether or not services are Medically Necessary and/or meet all other conditions for coverage.
- D. Private Duty Nursing.

10.5 Home Health Services

Coverage is not provided for:

- A. Private Duty Nursing.
- B. Custodial Care.

10.6 Hospice Services

Benefits will not be provided for the following:

- A. Services, visits, medical equipment, or supplies not authorized by CareFirst.
- B. Financial and legal counseling.
- C. Any services for which a Qualified Hospice Program does not customarily charge the patient or his or her family.
- D. Reimbursement for volunteer services.
- E. Chemotherapy or radiation therapy, unless used for symptom control.
- F. Services, visits, medical equipment, or supplies that are not required to maintain the comfort and manage the pain of the terminally ill Member.
- G. Custodial Care, domestic, or housekeeping services.

10.7 Medical Devices and Supplies

Benefits will not be provided for purchase, rental, or repair of the following:

- A. Convenience items. Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for a Member (e.g., an exercycle or other physical fitness equipment, elevators, hoist lifts, shower/bath bench).
- B. Furniture items, movable objects or accessories that serve as a place upon which to rest (people or things) or in which things are placed or stored (e.g., chair or dresser).
- C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body, (e.g., exercycle or other physical fitness equipment).
- D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home (e.g., parallel bars).
- E. Environmental control equipment. Equipment that can be used for non-medical purposes, such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.
- F. Eyeglasses or contact lenses (except when used as a prosthetic lens replacement for aphakic patients as in this Evidence of Coverage), dental prostheses or appliances (except for Medically Necessary treatment of Temporomandibular Joint Syndrome (TMJ)).
- G. Corrective shoes (unless required to be attached to a leg brace), shoe lifts, or special shoe accessories.
- H. Medical equipment/supplies of an expendable nature, except as specifically listed as a Covered Medical Supply in this Evidence of Coverage. Non-covered supplies include incontinence pads or ace bandages.

Prescription Drug Rider Exclusions

Benefits will not be provided under this rider for:

1. Any devices, appliances, supplies, and equipment except as otherwise provided in Section B, above.
2. Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities.
3. Prescription Drugs for cosmetic use.
4. Prescription Drugs administered by a physician or dispensed in a physician's office.
5. Drugs, drug therapies or devices that are considered experimental or investigational by CareFirst.

6. Drugs or medications lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a prescription (Over-the-Counter medications).
7. Vitamins, except CareFirst will provide a benefit for Prescription Drug:
 - a. prenatal vitamins
 - b. fluoride and fluoride containing vitamins.
 - c. single entity vitamins, such as Rocaltrol and DHT.
8. Infertility drugs and agents for use in connection with infertility services or treatments that are excluded from coverage under the Evidence of Coverage to which this rider is attached.
9. Any portion of a Prescription Drug that exceeds:
 - a. a thirty-four (34) day supply for Prescription Drugs; or,
 - b. a ninety (90) day supply for Maintenance Drugs unless authorized by CareFirst.
10. Prescription Drugs that are administered or dispensed by a health care facility for a Member who is a patient in the health care facility. This exclusion does not apply to Prescription Drugs that are dispensed by a Pharmacy on the health care facility's premises for a Member who is not a patient in the health care facility.
11. Prescription Drugs for weight loss.
12. Biologicals and allergy extracts.
13. Blood and blood products. (May be covered under the medical benefits in the Evidence of Coverage to which this rider is attached.)

Pharmacy Program

Integrated Deductible

See Annual Deductible on Medical Summary of Benefits
\$0/10/25/45 Retail Copays ■ 50% Injectables Coinsurance

Summary of Benefits

Plan Feature	Amount	Description
Deductible	See medical summary of benefit for annual deductible amount	If you meet your combined medical and drug deductible, you will pay a different copay or coinsurance depending on the drug tier. Drugs not subject to any medical or drug deductible are noted below.
Out-of-Pocket Maximum	See medical summary of benefit for annual out-of-pocket amount	If you reach your out-of-pocket maximum, CareFirst BlueChoice 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 (Affordable Care Act) (up to a 34-day supply)	\$0 (not subject to deductible)	A preventive drug is a prescribed medication or item on CareFirst's Preventive Drug List (ACA)* (examples: Folic Acid, Fluoride, and FDA approved contraceptives for women).
Oral Chemotherapy Drugs Diabetic Supplies (up to a 34-day supply)	\$0 (not subject to deductible except for HSA plans)	Diabetic supplies include needles, lancets, test strips and alcohol swabs.
Generic Drugs (Tier 1) (up to a 34-day supply)	\$10	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (up to a 34-day supply)	\$25	Preferred brand drugs are covered at this copay level.
Non-preferred Brand Drugs (Tier 3) (up to a 34-day supply)	\$45	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Discuss using alternatives with your physician or pharmacist.
Self-administered Injectable (excluding insulin) (Tier 4) (up to a 34-day supply)	50% coinsurance up to a maximum payment of \$75	All self-administered injectable drugs (excluding insulin) are covered at this payment level. Insulin is covered at appropriate copay level.
Maintenance Drugs (up to a 90-day supply)	Generic: \$20 Preferred Brand: \$50 Non-preferred Brand: \$90 Self-Administered Injectables: 50% coinsurance, up to a maximum payment of \$150	Maintenance drugs of up to a 90-day supply are available for twice the copay through Mail Service Pharmacy or a retail pharmacy. Injectables (excluding insulin) are covered at 50% coinsurance up to a maximum payment of \$150.
Restricted Generic Substitution	Yes	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. Also, if your prescription is written for a brand-name drug and DAW (dispense as written) is noted by your doctor, you will only pay the copay.



Visit www.carefirst.com/rx for the most up-to-date Preferred Drug List and Formulary (list of covered drugs), 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: VA/CFBC/RX3 (R. 8/12) • VA/CF/RX3 (R. 8/12)



CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., and CareFirst BlueChoice, Inc. are independent licensees of the Blue Cross and Blue Shield Association.
* Registered trademark of the Blue Cross and Blue Shield Association.

Below are limitations and exclusions contained in your CareFirst BlueChoice or CareFirst medical policy to which the prescription rider is attached.

Medical Limitations and Exclusions – CareFirst BlueChoice

10.1 Coverage is Not Provided For:

- A. Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst BlueChoice.
- B. Services that are Experimental/Investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time the service in question is rendered, as determined by CareFirst BlueChoice.
- C. The cost of services that:
 1. Are furnished without charge; or
 2. Are normally furnished without charge to persons without health insurance coverage; or
 3. Would have been furnished without charge if the Member was not covered under the Evidence of Coverage or under any health insurance.
- D. Services that are not described as covered in the Evidence of Coverage or that do not meet all other conditions and criteria for coverage, as determined by CareFirst BlueChoice. Referral by a Primary Care Physician and/or the provision of services by a Contracting Provider does not, by itself, entitle a Member to benefits if the services are not covered or do not otherwise meet the conditions and criteria for coverage.
- E. Except for Emergency Services, Urgent Care and follow-up care after emergency surgery, benefits will not be provided for any service(s) provided to a Member by Non-Contracting Physicians or Non-Contracting Providers, unless written prior authorization is specifically obtained from CareFirst BlueChoice.
- F. Routine, palliative or cosmetic foot care (except for conditions determined by CareFirst BlueChoice to be Medically Necessary) including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
- G. Except for treatment for Accidental Injury or benefits for Oral Surgery as described above, dental care including extractions; treatment of cavities; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia, except for the treatment of a cleft lip or cleft palate; false teeth; or any other dental services or supplies. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
- H. Benefits will not be provided for cosmetic surgery (except as specifically provided for reconstructive breast surgery and reconstructive surgery as listed above) or other services primarily intended to correct, change or improve appearances.
- I. Treatment rendered by a health care provider who is a member of the Member's family (parents, spouse, brothers, sisters, children).
- J. Any prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage. Medications that can be self-administered or do not medically require administration by or under the direction of a physician are not covered even though they may be dispensed or administered in a physician office or provider facility. Benefits for prescription drugs may be available through a rider purchased by the Group and attached to the Evidence of Coverage.
- K. All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained and self-administered by the Member, except as stated in the Description of Covered Services. Over-the-Counter means any item or supply, as determined by CareFirst BlueChoice, that is available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions.
- L. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
- M. Services to reverse voluntary, surgically induced infertility, such as a reversal of a sterilization.
- N. All assisted reproductive technologies (except artificial insemination and intrauterine insemination), including in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same unless covered under a rider purchased by the Group and attached to the Evidence of Coverage.
- O. Fees or charges relating to fitness programs, weight loss or weight control programs; physical conditioning; pulmonary rehabilitation programs; exercise programs; and use of passive or patient-activated exercise equipment.
- P. Treatment for obesity except for the surgical treatment of Morbid Obesity.
- Q. Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications.
- R. Services furnished as a result of a referral prohibited by law.
- S. Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by CareFirst BlueChoice.
- T. Health education classes and self-help programs, other than birthing classes or for the treatment of diabetes.
- U. Acupuncture services except when approved or authorized by CareFirst BlueChoice when used for anesthesia.
- V. Any service related to recreational activities. This includes, but is not limited to sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst BlueChoice even though they may have therapeutic value or be provided by a health care provider.
- W. Coverage under this Description of Covered Services does not include the cost of services or payment for services for any illness, injury or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:
 1. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or
 2. From any federal, state, county or municipal facility or other government agency, including, in the case of service-connected disabilities, the Veterans Administration, to the extent that Benefits are payable by the federal, state, county or municipal facility or other government agency and provided at no charge to the Member, but excluding Medicare benefits and Medicaid benefits. Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for benefits.
- X. Private duty nursing.
- Y. Non-medical, health care provider services, including, but not limited to:
 1. Telephone consultations, failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the health care practitioner or the healthcare practitioner's staff.
 2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Description of Covered Services are available for Covered Services rendered to the Member by a health care provider.
- Z. Educational therapies intended to improve academic performance.
- AA. Vocational rehabilitation and employment counseling.
- BB. Routine eye examinations, frames and lenses or contact lenses. Benefits for routine eye examinations, frames and lenses or contact

Pharmacy Program

lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.

- CC. Custodial, personal, or domiciliary care that is provided to meet the activities of daily living, e.g., bathing, toileting and eating (care which may be provided by persons without professional medical skills or training).
- DD. Work hardening programs. Work hardening programs are highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.
- EE. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.
- FF. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst BlueChoice, and CareFirst BlueChoice approved services listed in the Transplants section of this Description of Covered Services).
- GG. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
- HH. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

10.2 Infertility Services.

Coverage for Artificial Insemination (and intrauterine insemination) does not include the following:

- A. Any costs associated with freezing, storage or thawing of sperm for future attempts or other use.
- B. Any charges associated with donor sperm.
- C. Infertility services that include the use of any surrogate or gestational carrier service.
- D. Infertility services when the infertility is a result of elective male or female surgical sterilization procedures, with or without reversal.
- E. Infertility services for domestic partners or common law spouses, except in those states that recognize those unions.
- F. All self-administered fertility drugs.

10.3 Organ and Tissue Transplants.

Benefits will not be provided for the following:

- A. Non-human organs and their implantation.
- B. Any Hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.
- C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst BlueChoice.
- D. Services for a Member who is an organ donor when the recipient is not a Member.
- E. Benefits will not be provided for donor search services.
- F. Any service, supply or device related to a transplant that is not listed as a benefit in this Description of Covered Services.

10.4 Inpatient Hospital Services.

Coverage is not provided for the following:

- A. Private room, unless Medically Necessary and authorized or approved by CareFirst BlueChoice. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.
- B. Non-medical items and convenience items, such as television, phone rentals, guest trays and laundry charges.
- C. Except for covered Emergency Services and Childbirth, a Hospital admission or any portion of a Hospital admission that had not been authorized or approved by CareFirst BlueChoice, whether or not services are Medically Necessary and/or meet all other conditions for coverage.
- D. Private duty nursing.

10.5 Home Health Services.

Coverage is not provided for:

- A. Private duty nursing.
- B. Custodial Care.
- C. Services in the Member's home if it is outside the Service Area.

10.6 Hospice Benefits.

Coverage is not provided for:

- A. Services, visits, medical equipment or supplies that are not included in the CareFirst BlueChoice-approved plan of treatment.
- B. Services in the Member's home if it is outside the Service Area.
- C. Financial and legal counseling.
- D. Any service for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.
- E. Chemotherapy or radiation therapy, unless used for symptom control.
- F. Services, visits, medical/surgical equipment or supplies; including equipment and medication not required to maintain the comfort and to manage the pain of the terminally ill Member.
- G. Reimbursement for volunteer services.
- H. Custodial Care, domestic or housekeeping services.
- I. Meals on Wheels or similar food service arrangements.
- J. Rental or purchase of renal dialysis equipment and supplies.
- K. Private duty nursing.

10.7 Outpatient Mental Health and Substance Abuse.

Coverage is not provided for:

- A. Psychological testing, unless Medically Necessary, as determined by CareFirst BlueChoice, and appropriate within the scope of Covered Services.
- B. Services solely on court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.
- C. Mental retardation, after diagnosis.
- D. Psychoanalysis.

10.8 Inpatient Mental Health and Substance.

The following services are excluded:

- A. Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.
- B. Custodial Care.
- C. Observation or isolation.

10.9 Emergency Services and Urgent Care.

Benefits will not be provided for:

- A. Emergency care if the Member could have foreseen the need for the care before it became urgent (for example, periodic chemotherapy or dialysis treatment).
- B. Medical services rendered outside of the Service Area which could have been foreseen by the Member prior to departing the Service Area.
- C. Charges for emergency and Urgent Care services received from a Non-Contracting Provider after the Member could reasonably be expected to travel to the nearest Contracting Provider.
- D. Charges for services when the claims filing and notice procedures stated in Section 7 of this Description of Covered Services have not been followed by the Member.
- E. Except for Medically Necessary follow-up care after emergency surgery, charges for follow-up care received in the emergency or Urgent Care facility outside of the Service Area unless CareFirst BlueChoice determines that the Member could not reasonably be expected to return to the Service Area for such care.
- F. Except for covered ambulance services, travel, including travel required to return to the Service Area, whether or not recommended by a Contracting Provider.
- G. Treatment received in an emergency department to treat a health care problem that does not meet the definition of Emergency Services as defined in Section 7 of this Description of Covered Services.

10.10 Medical Devices and Supplies.

Coverage is not provided for:

- A. Convenience item. Any item that increases physical comfort or convenience without serving a Medically Necessary purpose, e.g. elevators, hoist/stair lifts, ramps, shower/bath bench.
- B. Furniture items. Movable articles or accessories which serve as a place upon which to rest (people or things) or in which things are placed or stored, e.g. chair or dresser.
- C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or

Pharmacy Program

condition all or part of the human body, e.g. exercycle or other physical fitness equipment.

- D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home, e.g. parallel bars.
- E. Environmental control equipment. Any device such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.
- F. Eyeglasses, contact lenses, dental prostheses or appliances, or hearing aids. Benefits for eyeglasses and contact lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.
- G. Corrective shoes, unless they are an integral part of the lower body brace, shoe lifts or special shoe accessories.
- H. Medical equipment/supplies of an expendable nature, except those specifically listed as a Covered Medical Supply in this Description of Covered Services. Non-covered supplies include incontinence pads or ace bandages.

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given in the benefit plan.

Prescription Drug Exclusions

Benefits will not be provided under this rider for:

- 1. Any devices, appliances, supplies, and equipment except as otherwise provided in the Evidence of Coverage.
- 2. Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities.
- 3. Prescription Drugs for cosmetic use.
- 4. Prescription Drugs administered by a physician or dispensed in a physician's office.
- 5. Drugs, drug therapies or devices that are considered Experimental/ Investigational by CareFirst BlueChoice.
- 6. Except for items included on the Preventive Drug List, Over-the-Counter medications or supplies lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a Prescription Drug.
- 7. Vitamins, except CareFirst BlueChoice will provide a benefit for Prescription Drug:
 - a. Prenatal vitamins.
 - b. Fluoride and fluoride containing vitamins.
 - c. Single entity vitamins, such as Rocaltrol and DHT.
 - d. Vitamins included on the Preventive Drug List.
- 8. Infertility drugs and agents for use in connection with infertility services or treatments that are excluded from coverage under the Evidence of Coverage to which this rider is attached.
- 9. Any portion of a Prescription Drug that exceeds:
 - a. a thirty-four (34) day supply for Prescription Drugs; or,
 - b. a ninety (90) day supply for Maintenance Drugs unless authorized by CareFirst BlueChoice.
- 10. Prescription Drugs that are administered or dispensed by a health care facility for a Member who is a patient in the health care facility. This exclusion does not apply to Prescription Drugs that are dispensed by a Pharmacy on the health care facility's premises for a Member who is not a patient in the health care facility.
- 11. Prescription Drugs for weight loss.
- 12. Biologicals and allergy extracts.
- 13. Blood and blood products. (May be covered under the medical benefits in the Evidence of Coverage to which this rider is attached.)

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Medical Limitations and Exclusions – CareFirst BlueCross BlueShield

10.1 General Exclusions

Coverage is not provided for the following:

- A. Any service, test, procedure, supply, or item which CareFirst determines not necessary for the prevention, diagnosis or treatment of the Member's illness, injury, or condition. Although a service may be listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in the Member's particular case.
- B. Any treatment, procedure, facility, equipment, drug, drug usage, device, or supply which, in the judgment of CareFirst, is Experimental/ Investigational, or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment, except for covered benefits for Clinical Trials.
- C. The cost of services that are furnished without charge or are normally furnished without charge if a Member was not covered under the Evidence of Coverage or under any health insurance, or any charge or any portion of a charge which by law the provider is not permitted to bill or collect from the Member directly.
- D. Any service, supply, or procedure that is not specifically listed in the Member's Evidence of Coverage as a covered benefit or that does not meet all other conditions and criteria for coverage as determined by CareFirst.
- E. Services that are beyond the scope of the license of the provider performing the service.
- F. Routine foot care, including services related to hygiene or any services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet, or partial removal of a nail without the removal of its matrix. However, benefits will be provided for these services if CareFirst determines that medical attention was needed because of a medical condition affecting the feet, such as diabetes and, that all other conditions for coverage have been met.
- G. Any type of dental care (except treatment of accidental injuries, oral surgery, and cleft lip, cleft palate, or ectodermal dysplasia, as described in this Description of Covered Services) including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess, removal of impacted teeth, orthodontia, false teeth, or any other dental services or supplies, unless provided in a separate rider or amendment to this Evidence of Coverage. Benefits for oral surgery are Section 2.21 in the Outpatient and Office Services Section of this Description of Covered Services. All other procedures involving the teeth or areas surrounding the teeth, including shortening of the mandible or maxillae for Cosmetic purposes or for correction of malocclusion unrelated to a functional impairment are excluded.
- H. Cosmetic surgery (except benefits for Reconstructive Breast Surgery or reconstructive surgery) or other services primarily intended to correct, change, or improve appearances. Cosmetic means a service or supply which is provided with the primary intent of improving appearances and not for the purpose of restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention as determined by CareFirst.
- I. Treatment rendered by a Health Care Provider who is the Member's Spouse, parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or resides in the Member's home.
- J. Any prescription drugs, unless administered to the Member in the course of covered outpatient or inpatient treatment or unless the prescription drug is specifically identified as covered. Take-home prescriptions or medications, including self-administered injections which can be administered by the patient or by an average individual who does not have medical training, or medications which do not medically require administration by or under the direction of a physician are not covered, even though they may be dispensed or administered in a physician or provider office or facility, unless the take-home prescription or medication is specifically identified as covered. Benefits for prescription drugs may be available through

Pharmacy Program

- a rider or amendment purchased by the Group and attached to the Evidence of Coverage.
- K. All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies routinely obtained and self-administered by the Member, except for the CareFirst benefits described in this Evidence of Coverage and diabetic supplies.
 - L. Food and formula consumed as a sole source or supplemental nutrition, except as listed as a Covered Service in this Description of Covered Services.
 - M. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
 - N. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.
 - O. Fees and charges relating to fitness programs, weight loss or weight control programs, physical, pulmonary conditioning programs or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education, except for diabetes outpatient self-management training and educational services. Cardiac rehabilitation programs are covered as described in this Evidence of Coverage.
 - P. Medical and surgical treatment for obesity and weight reduction, except in the instance of Morbid Obesity.
 - Q. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof. Benefits for vision may be available through a rider or amendment purchased by the Group and attached to the Evidence of Coverage.
 - R. Services solely based on a court order or as a condition of parole or probation, unless approved by CareFirst.
 - S. Health education classes and self-help programs, other than birthing classes or those for the treatment of diabetes.
 - T. Acupuncture services, except when approved or authorized by CareFirst when used for anesthesia.
 - U. Any service related to recreational activities. This includes, but is not limited to, sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst even though they may have therapeutic value or be provided by a Health Care Practitioner.
 - V. Any service received at no charge to the Member in any federal hospital or facility, or through any federal, state, or local governmental agency or department, not including Medicaid. (This exclusion does not apply to care received in a Veteran's hospital or facility unless that care is rendered for a condition that is a result of the Member's military service.)
 - W. Private Duty Nursing.
 - X. Non-medical, provider services, including but not limited to:
 1. Telephone consultations, failure to keep a scheduled visit, completion of forms, copying charges, or other administrative services provided by the Health Care Practitioner or the Health Care Practitioner's staff.
 2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Evidence of Coverage are available for Covered Services rendered to the Member by a Health Care Provider.
 - Y. Speech Therapy, Occupational Therapy, or Physical Therapy, unless CareFirst determines that the condition is subject to improvement. Coverage does not include non-medical Ancillary Services such as vocational rehabilitation, employment counseling, or educational therapy.
 - Z. Services or supplies for injuries or diseases related to a covered person's job to the extent the covered person is required to be covered by a workers' compensation law.
 - AA. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst, and services listed under the Section 2.14 Transplants Section of this Description of Covered Services), whether or not recommended by an Eligible Provider.
 - BB. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.
 - CC. Contraceptive drugs or devices, unless specifically identified as covered in this Evidence of Coverage, or in a rider or amendment to this Evidence of Coverage.
 - DD. Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.
 - EE. Services, drugs, or supplies the Member receives without charge while in active military service.
 - FF. Habilitative Services delivered through early intervention and school services.
 - GG. Custodial Care.
 - HH. Coverage does not include non-medical Ancillary Services, such as vocational rehabilitation, employment counseling, or educational therapy.
 - II. Services or supplies received before the effective date of the Member's coverage under this Evidence of Coverage.
 - JJ. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
 - KK. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.
 - LL. Work Hardening Programs. Work Hardening Program means a highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.
- ### 10.2 Infertility Services .
- Benefits will not be provided for any assisted reproductive technologies including artificial insemination, as well as in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same.
- ### 10.3 Transplants
- Benefits will not be provided for the following:
- A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary non-Experimental/Investigational skin grafts.
 - B. Any hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.
 - C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst.
 - D. Services for a Member who is an organ donor when the recipient is not a Member.
 - E. Benefits will not be provided for donor search services.
 - F. Any service, supply, or device related to a transplant that is not listed as a benefit in the Description of Covered Services.
- ### 10.4 Inpatient Hospital Services
- Coverage is not provided (or benefits are reduced, if applicable) for the following:
- A. Private room, unless Medically Necessary and authorized or approved by CareFirst. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.
 - B. Non-medical items and convenience items, such as television and phone rentals, guest trays, and laundry charges.
 - C. Except for covered Emergency Services and Maternity Care, a hospital admission or any portion of a hospital admission (other than Medically Necessary Ancillary Services) that had not been approved by CareFirst, whether or not services are Medically Necessary and/or meet all other conditions for coverage.
 - D. Private Duty Nursing.
- ### 10.5 Home Health Services
- Coverage is not provided for:
- A. Private Duty Nursing.
 - B. Custodial Care.

10.6 Hospice Services

Benefits will not be provided for the following:

- A. Services, visits, medical equipment, or supplies not authorized by CareFirst.
- B. Financial and legal counseling.
- C. Any services for which a Qualified Hospice Program does not customarily charge the patient or his or her family.
- D. Reimbursement for volunteer services.
- E. Chemotherapy or radiation therapy, unless used for symptom control.
- F. Services, visits, medical equipment, or supplies that are not required to maintain the comfort and manage the pain of the terminally ill Member.
- G. Custodial Care, domestic, or housekeeping services.

10.7 Medical Devices and Supplies

Benefits will not be provided for purchase, rental, or repair of the following:

- A. Convenience items. Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for a Member (e.g., an exercycle or other physical fitness equipment, elevators, hoist lifts, shower/bath bench).
- B. Furniture items, movable objects or accessories that serve as a place upon which to rest (people or things) or in which things are placed or stored (e.g., chair or dresser).
- C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body, (e.g., exercycle or other physical fitness equipment).
- D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home (e.g., parallel bars).
- E. Environmental control equipment. Equipment that can be used for non-medical purposes, such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.
- F. Eyeglasses or contact lenses (except when used as a prosthetic lens replacement for aphakic patients as in this Evidence of Coverage), dental prostheses or appliances (except for Medically Necessary treatment of Temporomandibular Joint Syndrome (TMJ)).
- G. Corrective shoes (unless required to be attached to a leg brace), shoe lifts, or special shoe accessories.
- H. Medical equipment/supplies of an expendable nature, except as specifically listed as a Covered Medical Supply in this Evidence of Coverage. Non-covered supplies include incontinence pads or ace bandages.

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given in the benefit plan.

Prescription Drug Exclusions

Benefits will not be provided under this rider for:

1. Any devices, appliances, supplies, and equipment except as otherwise provided in Evidence of Coverage.
2. Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities.
3. Prescription Drugs for cosmetic use.
4. Prescription Drugs administered by a physician or dispensed in a physician's office.
5. Drugs, drug therapies or devices that are considered Experimental/ Investigational by CareFirst.
6. Except for items included on the Preventive Drug List, Over-the-Counter medications or supplies lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a Prescription Drug.
7. Vitamins, except CareFirst will provide a benefit for Prescription Drug:
 - a. Prenatal vitamins.
 - b. Fluoride and fluoride containing vitamins.
 - c. Single entity vitamins, such as Rocaltrol and DHT.
 - d. Vitamins included on the Preventive Drug List.
8. Infertility drugs and agents for use in connection with infertility services or treatments that are excluded from coverage under the Evidence of Coverage to which this rider is attached.
9. Any portion of a Prescription Drug that exceeds:
 - a. a thirty-four (34) day supply for Prescription Drugs; or,
 - b. a ninety (90) day supply for Maintenance Drugs unless authorized by CareFirst.
10. Prescription Drugs that are administered or dispensed by a health care facility for a Member who is a patient in the health care facility. This exclusion does not apply to Prescription Drugs that are dispensed by a Pharmacy on the health care facility's premises for a Member who is not a patient in the health care facility.
11. Prescription Drugs for weight loss.
12. Biologicals and allergy extracts.
13. Blood and blood products. (May be covered under the medical benefits in the Evidence of Coverage to which this rider is attached.)

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.



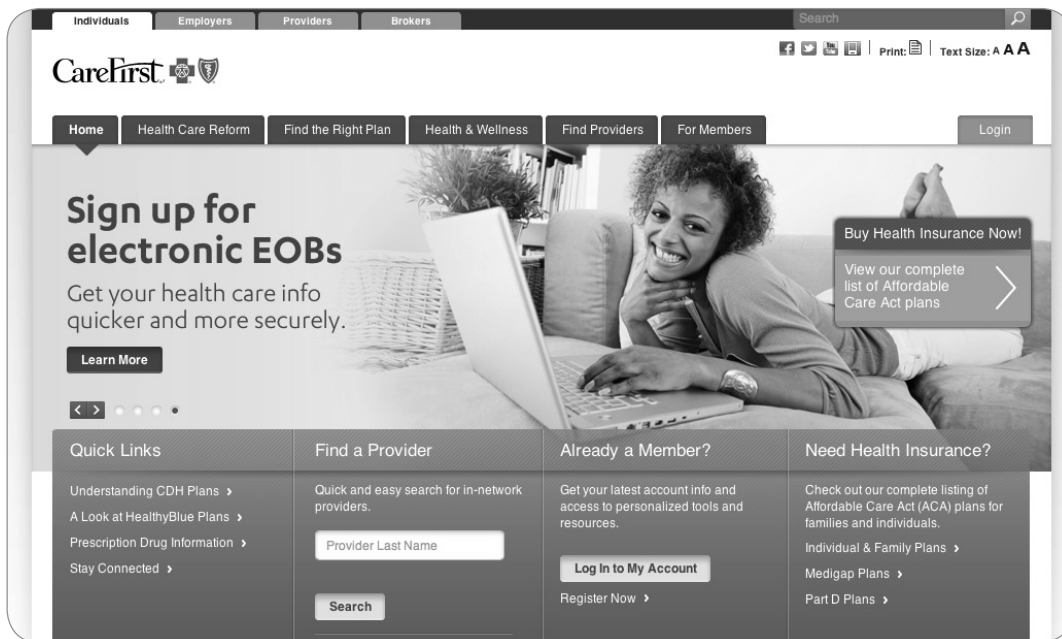
Getting the most
from your plan

Getting the Most from Your Plan

There's More to Your Health Plan Than You Might Think

Whether you need to find a doctor or hospital, plan your health care expenses, manage your claims and benefits or search for information to help maintain your health, CareFirst offers the services and resources you need...right at your fingertips.

This section outlines the added features you receive as a CareFirst member. Feel free to visit us at **www.carefirst.com** to learn more about the following member benefits.



Find a doctor

Quickly search for the type of doctor you need in your area.

Check claims and benefits

Manage many aspects of your CareFirst plan online, day or night.

Compare plans

Make an informed decision if you have more than one health plan to choose from with our Coverage Advisor tool.

Get discounts

Access wellness discounts on fitness gear, gym memberships, healthy eating options, and more.

Read up about your health

Find a variety of health education articles, nutritious recipes, interactive health tools and more on the *Health and Wellness* section of our website. Or, download the latest issue of our *Vitality* magazine to learn more about your plan and staying healthy.

Blue Rewards

and your Health Savings Account

Members who have a health plan with a health savings account (HSA) option must follow certain rules to meet Internal Revenue Service (IRS) regulations. Because there are tax advantages with an HSA account, there are specific rules for when and how the CareFirst Blue Rewards Visa® Incentive Card can be used.

How quickly will I receive my incentive card after completing the Blue Rewards steps?

When you receive your incentive card depends on whether you, or your employer, fund your HSA during the plan year. To get a better idea of the timing:

- Log in to *My Account* at www.carefirst.com/myaccount and click on *Blue Rewards* under *Quick Links*. You will notice a message at the top of the screen prompting you to “check eligibility.”
- Answer a few questions to determine whether you are eligible to receive your incentive card prior to meeting the IRS minimum deductible of \$1,300 individual/\$2,600 family.
- Review the chart below to learn more.



Do you have an HSA that will be funded this plan year by either you or your employer?			
If the answer is no, then...			You will receive your card 10-14 days after completing the Blue Rewards steps
If the answer is yes and:	You have dental or vision coverage through CareFirst and you certify to use the incentive card only for dental/vision expenses prior to meeting the IRS minimum deductible, then		You will receive your card 10-14 days after completing the Blue Rewards steps
	You do not have dental or vision through CareFirst, then		You will receive your card after meeting the minimum deductible
	You have dental or vision coverage through CareFirst and do not certify to use the incentive card only for dental/vision expenses prior to meeting the IRS minimum deductible.		You will receive your card after meeting the minimum deductible

Where can I use the card?

- You can use your incentive card to pay for services that are covered by your health plan, also known as qualified health care expenses.
- If you have dental or vision coverage through CareFirst and have not yet met your IRS minimum deductible, you can use your card for out-of-pocket dental and vision expenses such as your deductible, copays or coinsurance.
- Once you meet the IRS minimum deductible, you can also use your card toward medical and prescription expenses such as your deductible or out-of-pocket costs like copays at doctors' offices, pharmacies, urgent care centers and more.
- You have until the end of your benefit period to use the funds on your incentive card.
- Always make sure to save your receipts as proof of your expense.



Is there anything else I need to know?

You will receive your incentive card with reward funds preloaded. Only one card is issued to the policyholder but it can be used by everyone covered under your policy. If you or your covered spouse/domestic partner earned a reward last year, that incentive card will be reloaded with your latest earned reward. Additional amounts earned during your benefit period will be automatically added to your card. As long as you remain a CareFirst member you have the opportunity to earn rewards each plan year, so make sure to keep your incentive card.

You can start earning your reward as soon as your health care coverage begins. Simply log in to *My Account* at www.carefirst.com/myaccount.



Know Before You Go

Your money, your health, your decision

Choosing the right setting for your care—from allergies to X-rays—is key to getting the best treatment with the lowest out-of-pocket costs. It's important to understand your options so you can make the best decision when you or your family members need care.*

Primary care provider (PCP)

Establishing a relationship with a primary care provider is the best way to receive consistent, quality care. Except for emergencies, your PCP should be your first call when you require medical attention. Your PCP may be able to provide advice over the phone or fit you in for a visit right away.

FirstHelp—free 24-hour nurse advice line

Call 800-535-9700 anytime to speak with a registered nurse. Nurses can provide you with medical advice and recommend the most appropriate care.

CareFirst Video Visit

See a doctor 24/7 without an appointment! You can consult with a board-certified doctor on your smartphone, tablet or computer. Doctors can treat a number of common health issues like flu and pinkeye. Visit www.carefirst.com/needcare for more information.

Convenience care centers (retail health clinics)

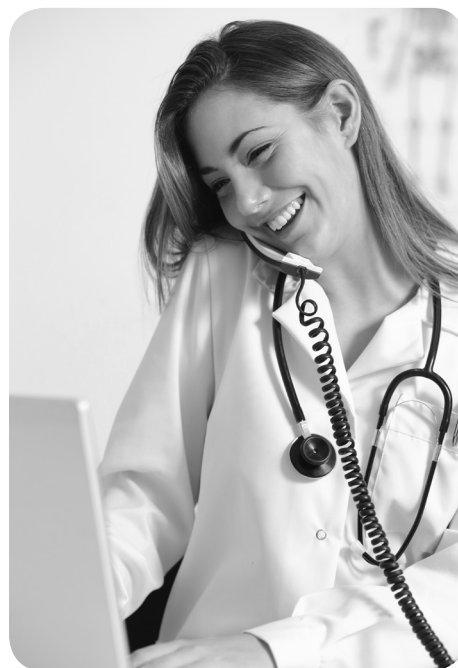
These are typically located inside a pharmacy or retail store (like CVS MinuteClinic or Walgreens Healthcare Clinic) and offer accessible care with extended hours. Visit a convenience care center for help with minor concerns like cold symptoms and ear infections.

Urgent care centers

Urgent care centers (such as Patient First or ExpressCare) have a doctor on staff and are another option when you need care on weekends or after hours.

Emergency room (ER)

An emergency room provides treatment for acute illnesses and trauma. You should call 911 or go straight to the ER if you have a life-threatening injury, illness or emergency. Prior authorization is not needed for emergency room services.



For more information, visit
www.carefirst.com/needcare.

*The medical providers mentioned in this document are independent providers making their own medical determinations and are not employed by CareFirst. CareFirst does not direct the action of participating providers or provide medical advice.

When you need care

When your PCP isn't available, being familiar with your options will help you locate the most appropriate and cost-effective medical care. The chart below shows how costs* may vary for a sample health plan depending on where you choose to get care.

	Sample cost	Sample symptoms	Available 24/7	Prescriptions?
Video Visit	\$20	<ul style="list-style-type: none">■ Cough, cold and flu■ Pink eye■ Ear infection	✓	✓
Convenience Care (e.g., CVS MinuteClinic or Walgreens Healthcare Clinic)	\$20	<ul style="list-style-type: none">■ Cough, cold and flu■ Pink eye■ Ear infection	X	✓
Urgent Care (e.g., Patient First or ExpressCare)	\$60	<ul style="list-style-type: none">■ Sprains■ Cut requiring stitches■ Minor burns	X	✓
Emergency Room	\$200	<ul style="list-style-type: none">■ Chest pain■ Difficulty breathing■ Abdominal pain	✓	✓

* The costs in this chart are for illustrative purposes only and may not represent your specific benefits or costs.



*Did you know that
where you choose
to get lab work,*

*X-rays and surgical procedures
can have a big impact on your
wallet? Typically, services
performed in a hospital cost
more than non-hospital
settings like LabCorp,
Advanced Radiology or
ambulatory surgery centers.*

To determine your specific benefits and associated costs:

- Log in to *My Account* at www.carefirst.com/myaccount
- Check your Evidence of Coverage or benefit summary
- Ask your benefit administrator, or
- Call Member Services at the telephone number on the back of your member ID card

For more information and frequently asked questions,
visit www.carefirst.com/needcare.

PLEASE READ: The information provided in this document regarding various care options is meant to be helpful when you are seeking care and is not intended as medical advice. Only a medical provider can offer medical advice. The choice of provider or place to seek medical treatment belongs entirely to you.



BlueCard® & Global Core

Wherever you go, your health care coverage goes with you

With your Blue Cross and Blue Shield member ID card, you have access to doctors and hospitals almost anywhere. BlueCard gives you the peace of mind that you'll always have the care you need when you're away from home, from coast to coast. And with Blue Cross Blue Shield Global Core (Global Core) you have access to care outside of the U.S.



As always, go directly to the nearest hospital in an emergency.

Your membership gives you a world of choices. More than 93% of all doctors and hospitals throughout the U.S. contract with Blue Cross and Blue Shield plans. Whether you need care here in the United States or abroad, you'll have access to health care in more than 190 countries.

When you're outside of the CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. service area (Maryland, Washington, D.C., and Northern Virginia), you'll have access to the local Blue Cross Blue Shield Plan and their negotiated rates with doctors and hospitals in that area. You shouldn't have to pay any amount above these negotiated rates. Also, you shouldn't have to complete a claim form or pay up front for your health care services, except for those out-of-pocket expenses (like non-covered services, deductibles, copayments, and coinsurance) that you'd pay anyway.

Within the U.S.

1. Always carry your current member ID card for easy reference and access to service.
2. To find names and addresses of nearby doctors and hospitals, visit www.carefirst.com/doctor, or call BlueCard Access at 800-810-2583.
3. Call Member Services for pre-certification or prior authorization, if necessary. Refer to the phone number on your ID card because it's different from the BlueCard Access number listed in Step 2.
4. When you arrive at the participating doctor's office or hospital, simply present your ID card.
5. After you receive care, you shouldn't have to complete any claim forms or have to pay up front for medical services other than the usual out-of-pocket expenses. CareFirst will send you a complete explanation of benefits.

Around the world

Like your passport, you should always carry your ID card when you travel or live outside the U.S. The Global Core program provides medical assistance services and access to doctors, hospitals and other health care professionals around the world. Follow the same process as if you were in the U.S. with the following exceptions:

- At hospitals in the Global Core network, you shouldn't have to pay up front for inpatient care, in most cases. You're responsible for the usual out-of-pocket expenses. And, the hospital should submit your claim.
- At hospitals outside the Global Core network, you pay the doctor or hospital for inpatient care, outpatient hospital care, and other medical services. Then, complete an international claim form and send it to the Global Core Service Center. The claim form is available online at **www.bcbsglobalcore.com**.
- To find a provider outside of the U.S. visit **www.bcbs.com** and select *Find a Doctor*.

Members of Maryland Small Group Reform (MSGSR) groups have access to emergency coverage only outside of the U.S.

Medical assistance when outside the U.S.

Call 800-810-2583 24 hours a day, 7 days a week for information on doctors, hospitals, other health care professionals or to receive medical assistance services. A medical assistance coordinator, in conjunction with a medical professional, will make an appointment with a doctor or arrange hospitalization if necessary.



CareFirst 
Family of health care plans

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., and CareFirst BlueChoice, Inc. are independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association.

Away From Home Care®

Your HMO Coverage Goes With You

We've got you covered when you're away from home for 90 consecutive days or more. Whether you're out-of-town on extended business, traveling, or going to school out-of-state, you have access to routine and urgent care with our Away From Home Care program.

Coverage while you're away

You're covered when you see a provider of an affiliated Blue Cross Blue Shield HMO (Host HMO) outside of the CareFirst BlueChoice, Inc. service area (Maryland, Washington, D.C. and Northern Virginia). If you receive care, then you're considered a member of that Host HMO receiving the benefits under that plan. So your copays may be different than when you're in the CareFirst BlueChoice service area. You'll be responsible for any copays under that plan.

Enrolling in Away From Home Care

To make sure you and your covered dependents have ongoing access to care:

- Call the Member Service phone number on your ID card and ask for the Away From Home Care Coordinator.
- The coordinator will let you know the name of the Host HMO in the area. **If there are no participating affiliated HMOs in the area, the program will not be available to you.**
- The coordinator will help you choose a primary care physician (PCP) and complete the application. Once completed, the coordinator will send you the application to sign and date.
- Once the application is returned, we will send it to your Host HMO.



Always remember to carry your ID card to access Away From Home Care.

- The Host HMO will send you a new, temporary ID card which will identify your PCP and information on how to access your benefits while using Away From Home Care.
- Simply call your Host HMO primary care physician for an appointment when you need care.

No paperwork or upfront costs

Once you are enrolled in the program and receive care, you don't have to complete claim forms, so there is no paperwork. And you're only responsible for out-of-pocket expenses such as copays, deductibles, coinsurance and the cost of non-covered services.



CareFirst BlueChoice, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.
® Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.

Health & Wellness

Take charge

Whether you're looking for health and wellness tips, discounts on health-related services, or support to manage a health condition, we have the resources to help you get on the path to better well-being.

With our Health & Wellness program you can

- Become aware of unhealthy habits.
- Improve your health with programs that target your specific health or lifestyle issues.
- Access online tools to help you get and stay healthy.
- Manage chronic conditions and deal with unexpected health issues.

15 minutes can help improve your well-being

When it comes to your health, it's important to know where you stand. You can get an accurate picture of your health status with our confidential, online assessment. 24 hours after you complete the survey, you'll receive your personalized well-being score, along with a link to create your own personal well-being plan.

Take your well-being assessment today—these may be the most important questions you'll ever answer! Get started by logging in to *My Account* at **www.carefirst.com/myaccount**. Next, click on *Health Assessment and Online Coaching* under *Quick Links*.

Getting healthy

Based on your results after completing the well-being assessment, a health coach may contact you to discuss your results. The health coach will refer you to the appropriate resources, tools and programs that can guide you toward better health.

Health Coaching

Participate in confidential lifestyle and health coaching programs to help improve your health. Your coach will monitor your progress and provide support with programs like tobacco cessation, weight loss and disease management for conditions like diabetes or chronic obstructive pulmonary disease.



Don't forget to take your well-being assessment to get an immediate picture of your health.



Online health and wellness tools

Looking for tools and resources that empower you to take action, stay connected and get inspired? Log in to *My Account* at www.carefirst.com/myaccount to take advantage of

Well-Being Connect™, our wellness portal:

- **Well-Being Plan**—A personalized, easy-to-navigate interactive plan including recommendations and focus areas to help keep you on track.
- **Resource Center**—Find a library of articles, videos and other resources specific to your interests and focus areas.
- **Trackers**—Record daily behaviors and check your progress for weight, exercise, medication, tobacco use, healthy eating and more. Share within your community group or on Facebook.
- **Social Networking**—Join chat sessions, update group activities and share information, personal stories, tips and successes even on Facebook.
- **Recipe Center**—Search thousands of healthy meal ideas, including cuisine-specific recipes and menus that map out calories and nutrition.
- **Message Center**—Receive health tips, activity tracker reminders and encouraging emails.

Vitality magazine

Vitality provides information about your health plan and includes articles on health and wellness topics, including nutrition, physical fitness and preventive health.

Wellness discount program

Blue365 delivers great discounts from top national and local retailers on fitness gear, gym memberships, family activities, healthy eating options and more.

Coordinating your care

Whether you're trying to get healthy or stay healthy, you need the best care. CareFirst has programs to help you take an active role in your health, address any health care issues and enjoy a healthier future.

Patient-Centered Medical Home (PCMH)

PCMH was designed to provide your primary care provider (PCP) with a more complete view of your health needs, as well as the care you receive from other providers. When you participate in this program, you are the focus of an entire health care team whose goal is to keep you in better health and manage any current or potential health risks.

If you have a chronic condition, or are at risk for one, your PCP may:

- Create a care plan based on your health needs with specific follow-up activities to help you manage your health.
- Provide access to a care coordinator, who is a registered nurse, so you have the support you need, answers to your questions and information about your care.

Find a participating PCMH provider in our provider directory at www.carefirst.com/findadoc.

Case Management

If you have a serious illness or injury, our Case Management program can help you navigate the health care system and provide support along the way. Our case managers are registered nurses who will:

- Work closely with you and your doctors to develop a personalized treatment plan.
- Coordinate necessary services.
- Answer any of your questions.

Our Case Management program is voluntary and confidential. For more information, or to enroll, call 888-264-8648.



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This wellness program is administered by Healthways, an independent company that provides health improvement services to CareFirst and BlueChoice members.

Rx Drug Program—4 Tiers

A total prescription for health

Prescription drugs are an integral part of high-quality health care. The prescription benefits your employer is offering give you an affordable and convenient way to make the best decisions when it comes to your prescriptions.

Your Rx benefits

As a CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc. (CareFirst) member, you have access to:

- A nationwide network with more than 60,000 participating pharmacies
- Nearly 5,000 drugs
- Mail Service Pharmacy, our convenient, fast and accurate mail order drug program
- Coordinated medical and pharmacy programs to help improve your overall health and reduce costs
- Personalized notices detailing cost savings opportunities, safety alerts and other important drug information

How your plan works

A formulary is a list of covered prescription drugs. Our drug list is reviewed and approved by an independent national committee comprised of physicians, pharmacists and other health care professionals who make sure the drugs on the formulary are safe and clinically effective.



Talk to your doctor to make sure you are using drugs on CareFirst's Preferred Drug List. Remember, you'll save the most money when using drugs on the Preferred Drug List.

The prescription drugs found on the CareFirst Formulary (drug list) are divided into tiers. These tiers include no cost drugs, generics, preferred brand and non-preferred brand drugs and the price you pay is determined by the tier the drug falls into.

Drug tier (Cost-share)	Definition	More information
No cost drugs (preventive drugs, oral chemotherapy and diabetic supplies)	The Affordable Care Act (ACA) classifies certain drug therapies as “preventive” if they reduce the risk of some serious health conditions. Oral chemotherapy drugs and diabetic supplies (needles, lancets, test strips, alcohol swabs) covered under the pharmacy benefit are included in this tier.	Preventive drugs (aspirin, folic acid, fluoride, iron supplements, smoking cessation products and FDA-approved contraceptives for women) are available at no cost if prescribed under certain medical criteria by your doctor. Oral chemotherapy drugs and diabetic supplies covered under the pharmacy benefit are also available at no cost for non-Health Savings Account (HSA) plans. If you have an HSA, you must first meet your deductible.
Tier 1 You pay: lowest copay (\$)	Generic drugs	Generic drugs will be in Tier 1.
Tier 2 You pay: higher copay (\$\$)	Preferred brand drugs	If a generic version of a Tier 2 drug is released then: <ul style="list-style-type: none"> ■ The generic drug is added to Tier 1. ■ The brand drug moves to Tier 3 and becomes a non-preferred brand drug.
Tier 3 You pay: highest copay (\$\$\$)	Non-preferred brand drugs	Some plans require members who choose a Tier 3 drug over the generic version to: <ul style="list-style-type: none"> ■ Pay the highest copay, and ■ Pay the cost difference between the preferred brand drug and its generic up to the cost of the prescription. ■ If your prescription is written for a brand-name drug and DAW (dispense as written) is noted by your doctor, you will only pay the copay.
Tier 4 You pay: cost share (50%)	Self-injectable drugs (excluding insulin)	Some Tier 4 designs require a coinsurance payment (up to a maximum limit) for certain self-administered injectable drugs.

Note: If the cost of your medication is less than your copay or coinsurance, you only pay the cost of the medication. Once you meet your deductible (if applicable to your plan), you may pay a different copay or coinsurance amount for drugs depending on if you use generic, preferred brand, non-preferred brand or self-injectable (excluding insulin) drugs. Check your benefit summary or enrollment materials for specific plan information. Once you are a member, you can view specific cost-share information in *My Account*.

Preferred Drug List

CareFirst has identified a Preferred Drug List that may save you money. The list includes generic and preferred brand drugs selected for their quality, effectiveness, safety and cost by an independent CVS/caremark¹ national Pharmacy and Therapeutics (P&T) committee.

- By using the CareFirst Preferred Drug List, you can work with your doctor or pharmacists to make safe and cost-effective decisions to better manage your health care and costs.
- Even though non-preferred drugs aren't part of the Preferred Drug List, they're still covered, but at the highest cost-share. Go to www.carefirst.com/rx and refer to the Drug Search section to view the entire formulary.

Two ways to fill

Retail pharmacies

With access to more than 60,000 pharmacies across the country, you can visit www.carefirst.com/rx and use our *Find a Pharmacy* tool to locate a convenient participating pharmacy. Be sure to take your prescription and member ID card with you when filling prescriptions.

Mail Service Pharmacy

Mail Service Pharmacy is a convenient way to fill your prescriptions, especially for refilling medications taken frequently, with fast, accurate home delivery. Plus, it's an easy way to save on your maintenance medications. You can register three ways—online through *My Account*,

¹ CVS/caremark is an independent company that provides pharmacy benefit management services.

by phone or by mail. Once you register for Mail Service Pharmacy you'll be able to:

- Refill prescriptions online, by phone or by email
- Choose your delivery location
- Consult with pharmacists by phone 24 hours a day, seven days a week
- Schedule automatic refills
- Receive email notification of order status
- Choose from multiple payment options

Prescription guidelines

In addition, some medications are only intended to be used in limited quantities; others require that your doctor obtain prior authorization through CareFirst before they can be filled. These drug provisions are indicated on the formulary found in the Drug Search section on www.carefirst.com/rx.

- **Quantity limits** have been placed on the use of selected drugs for quality, safety or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.
- **Prior authorization** is required before you fill prescriptions for certain drugs. Your doctor must obtain prior authorization from CareFirst before these drugs are covered.
- **Step therapy** asks that you try lower-cost, equally effective drugs that treat the same medical condition before trying a higher-cost alternative. Your physician can speak to your experience with these alternatives prior to dispensing a more expensive drug.

Care management

Take advantage of the following programs and resources available at no cost to you with your CareFirst prescription drug plan.

Specialty Pharmacy Coordination Program

The specialty pharmacy program provides personalized care for our members with certain chronic conditions requiring specialty medications. Working together, we can help you achieve the best possible results from your specialty medication therapy.

Personal Attention

The more you know about your health condition, the better you can successfully manage it. Our specialty customer care team works together with your doctors and case managers to provide you with in-depth support and service for your particular condition. We offer:

- One-on-one therapy support with a registered nurse for certain chronic conditions like multiple sclerosis, hepatitis C, hemophilia, and selected autoimmune diseases
- Injection training coordination
- Medications mailed to your home or office, or available for pick up at any CVS retail pharmacy
- 24-hour pharmacist assistance
- Educational materials for your specific condition
- Drug interaction monitoring and review
- Refill reminders

To take full advantage of these program benefits, your specialty medications must be filled through the CVS/caremark Specialty Pharmacy².

Comprehensive Medication Review (CMR)

Medication complications cause 10% of hospital admissions³. The Comprehensive Medication Review program seeks to reduce prescription drug-related complications, and related hospitalizations, and ensure the best possible outcomes for members with high potential for medication-related issues. If you are identified for the program, a dedicated team of pharmacists will collaborate with you and your doctor(s) to review and evaluate:

- Possibilities for drug interactions
- Opportunities to support medication adherence
- Cost effective therapy
- Gaps in care
- Duplications in drug therapy

The program's one-on-one support ensures you are not only taking the most favorable drug therapy to manage your conditions, but you are also able to take your medications as prescribed.

² May not apply in VA or for MD PPO plans. Check your plan for more information.

³ Osterberg, L., Blaschke, T. (2005). Adherence to medication. *N Engl J Med*, 353(5), 487-497. and Berg JS, Dischler J, Wagner DJ, Raia JJ, Palmer-Shevin N. Medication compliance: a healthcare problem. *Ann Pharmacother*. 1993 Sep;27(9 Suppl):S1-24. Review



Medication Therapy Management (MTM) program

Taking medications as prescribed not only helps improve your health but can also reduce health care costs. Working together with CVS/caremark, CareFirst's MTM program is designed to help you get the best results from your medication therapy.

We review pharmacy claims for opportunities to:

- Save you money;
- Support compliance with medications;
- Improve your care; and
- Ensure safe use of high risk medications.

When opportunities are identified, "Drug Advisories" are mailed to you and/or your providers outlining potential for savings for any medication-related issues. You may also have the opportunity to speak one-to-one with pharmacist, through the Pharmacy Advisor program, who can answer questions and help you manage your prescription medications.

Online tools and resources

To get the most from your prescription drug plan, you need to stay informed. Our easy-to-use, interactive tools and resources are available 24 hours a day, seven days a week. Visit www.carefirst.com/rx and select *Drug Tools* to see if a drug is covered, find a pharmacy, learn how drugs interact with each other and get more information about medications. You can access even more tools and resources once you're a member through *My Account*.

Keeping you informed

Our pharmacy benefit manager, CVS/caremark, keeps you informed about your prescription drug coverage and provides you with periodic updates about your plan through targeted mailings. You could get notices about lower cost drug alternatives, alerts about possible safety concerns, drug tier changes and more.

Ways to save

Here are some ways to help you save on your prescription drug costs.

- **Use generic drugs**—generic drugs can cost up to 80 percent less than their brand-name counterparts. Made with the same active ingredients as their brand-name counterparts, generics are also equivalent in dosage, safety, strength, quality, performance and intended use.
- **Use drugs on the Preferred Drug List**—the Preferred Drug List identifies generic and preferred brand drugs that may save you money.
- **Use maintenance medications**—maintenance medications are drugs you take regularly for ongoing conditions such as diabetes, high blood pressure or asthma. You can get up to a three-month supply of your maintenance medications for the cost of two copays through any pharmacy in the network, including through mail order.
- **Use mail order**—by using our Mail Service Pharmacy you get the added convenience of having your prescriptions delivered right to your home. Plus, if you pay a coinsurance for your maintenance drugs, the overall cost of the drug may be less expensive through mail order, reducing your out-of-pocket costs.

Should you have any questions about your prescription benefits, please call CareFirst Pharmacy Services at 800-241-3371.



Ways to Save with Generic Drugs

Take control & save on your drug costs

You can save money on prescription drugs by switching to generics. Generic drugs are proven to be just as safe and effective as their brand-name counterparts. The difference? Name and price.

What are generics?

- Generics work the same as brand-name drugs, but cost much less.
- A generic drug is essentially a copy of a brand-name drug. It contains the same active ingredients and is identical in dosage, safety, strength, how it's taken, quality, performance and intended use.
- Generic drugs are approved by the U.S. Food and Drug Administration (FDA).
- Generic drugs are manufactured in facilities that are required to meet the same FDA standards of good manufacturing practices as brandname products.¹

Save by using generic drugs

- Generic drugs are less expensive than brandname medications.
- On average a member can potentially save around \$200 to \$360 per year by using generic drugs.²
- A study by the FDA concluded that consumers who are able to replace all their branded prescriptions with generics can save up to 52 percent on their daily drug costs.¹

Here's an example of how much you could save by switching to a generic alternative.

Brand name	Generic name	Average monthly cost* of brand	Average monthly cost* of generic	Monthly savings if using generic
Ambien (10mg)	Zolpidem Tartrate	\$398	\$2	\$396
Coumadin (2mg)	Warfarin Sodium	\$55	\$6	\$49
Lipitor (20mg)	Atorvastatin Calcium	\$237	\$5	\$268
Singulair (10mg)	Montelukast Sodium	\$204	\$7	\$197

**Costs based on June 2015 prices at CVS pharmacies and rounded to the nearest dollar.*

¹ FDA, *Savings from Generic Drugs Purchased at Retail Pharmacies*, June 26, 2009.

² Annual savings estimate based on 2009 data from CVS Caremark Industry Analytics and Finance.

How do I switch to a generic drug?

You can ask your doctor if any of the prescription medications you are currently taking can be filled with a generic alternative. To find out if there are lower cost drugs available, including generics, which can be used to treat your condition:

- Visit the Drug Search section of www.carefirst.com/rx to view the CareFirst Preferred Drug List.
- Print the list and take it with you to your doctor.
- Ask your doctor if a generic drug could work for you.

How we help you save

To help you get the most savings, our pharmacy benefit manager, CVS/caremark* notifies members by mail about opportunities to save with generic drugs.

- If you fill a prescription for a non-preferred brand drug you will receive a personalized letter from CVS/caremark with available lower-cost generic alternative options plus steps for changing to a generic alternative.
- Plus, a letter will be enclosed that you can take to your doctor on your next visit.

*CVS/caremark is an independent company that provides pharmacy benefit management services.



Generic drugs are a great alternative. Take control of your prescriptions and save money by talking to your doctor today about switching to a generic drug.



Mail Service Pharmacy

Reliable. Fast. Convenient.

Take advantage of Mail Service Pharmacy, a fast and accurate home delivery service that offers a way for you to save both time and money on your long-term (maintenance) prescriptions.*

As a CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc. (CareFirst) member, once you register for Mail Service Pharmacy you'll be able to:

- Refill prescriptions online, by phone or by email
- Schedule automatic refills for certain maintenance medications through ReadyFill at Mail®
- Choose from home or office delivery service
- Consult with pharmacies by phone 24/7
- Use our automated phone system to check account balances and make payments 24/7
- Receive email notifications of order status
- Choose from multiple payment options

It's easy to register for mail service

Choose one of the following three ways:



Online

Go to **www.carefirst.com** and log in to *My Account*. Under the *My Coverage* tab, select *Drug and Pharmacy Resources*, click on *My Drug Home* and select *Order Prescriptions* to set up an account.



By phone

Call the toll-free phone number on the back of your member ID card. Our Customer Care representatives can walk you through the process.



By mail

If you already have your prescription, you can send it to us with a completed *Mail Service Pharmacy Order Form*. You can download the form by selecting *My Drug Forms* in the *Drug and Pharmacy Resources* section in *My Account*.

* Long-term or maintenance medications are prescription drugs anticipated to be required for 6 months or more to treat a chronic or ongoing condition such as diabetes, high blood pressure or asthma.

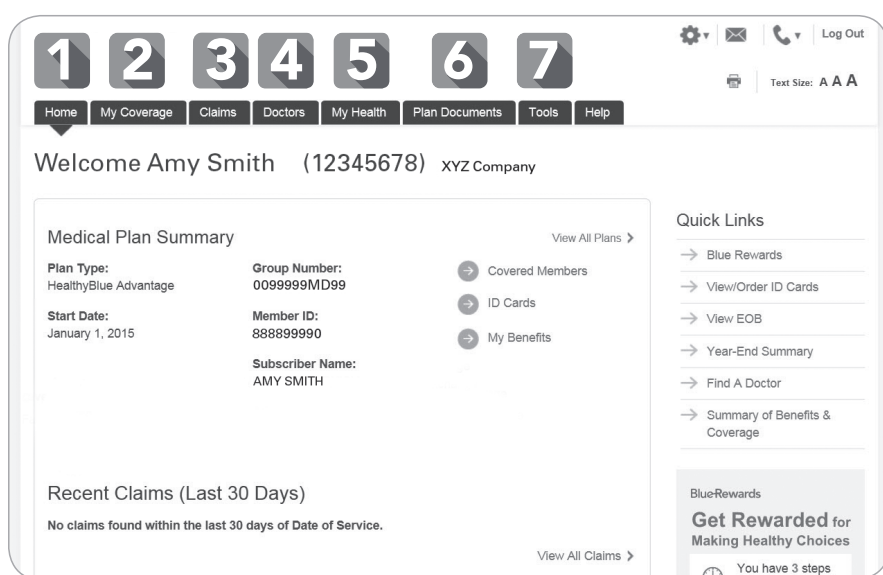


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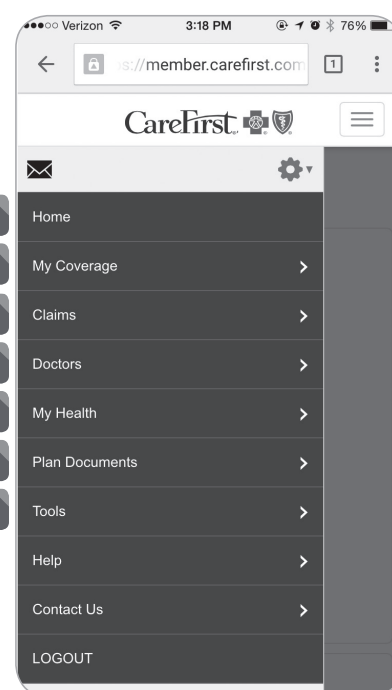
My Account

Online access to your health care information

View your personalized health insurance information online with *My Account*. Simply log on to **www.carefirst.com** from your computer, tablet or smartphone for real-time information about your plan.



As viewed on a computer.



As viewed on a smartphone.

My Account at a glance

1. Home

- Quickly view your coverage, deductible, copays, claims and out-of-pocket costs
- Use *Settings* ⚙️ to manage your password and communications preferences
- Access the Message Center ✉️

2. My Coverage

- Access your plan information, including who is covered
- Update your other health insurance info
- View/order ID cards
- Order and refill prescriptions^{1,2}
- View prescription drug claims^{1,2}
- Find a pharmacy¹
- Oversee your BlueFund account

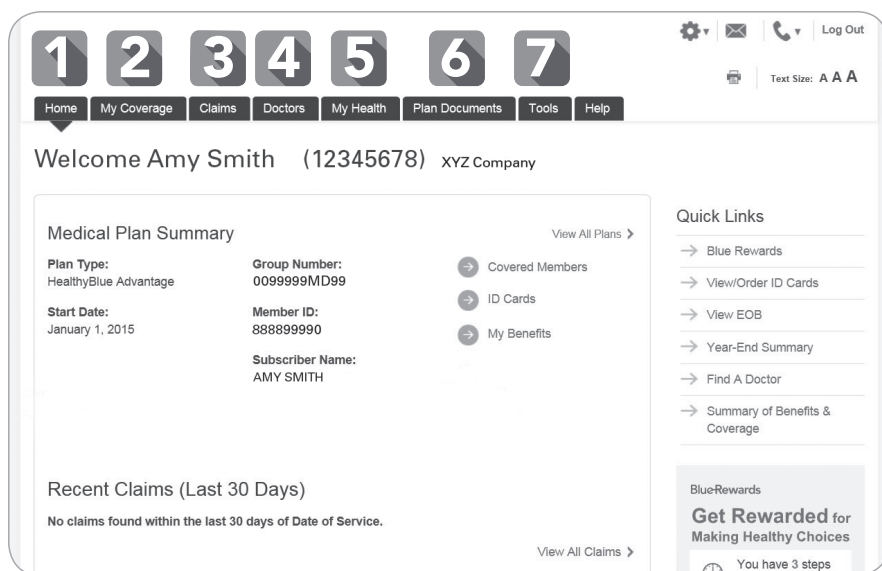
Signing up is easy

Information included on your member ID card will be needed to set up your account.

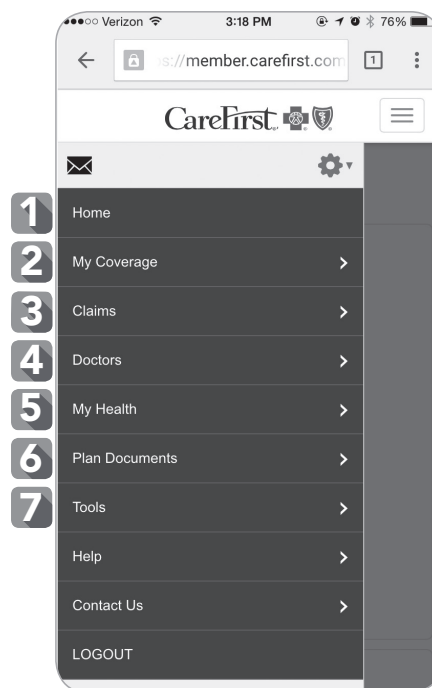
- Visit **www.carefirst.com**
- Select *Register Now*
- Create your User ID and Password

My Account

Online access to your health care information



As viewed on a computer.



As viewed on a smartphone.

3. Claims

- Check your paid claims, deductible and out-of-pocket totals
- Research your Explanation of Benefits (EOBs) history
- Review your year-end claims summary

4. Doctors

- Select or change your primary care provider (PCP)
- Search for a specialist

5. My Health

- Learn about your wellness program options²
- Locate an online wellness coach²
- Track your Blue Rewards progress

6. Plan Documents

- Look up your forms and other plan documentation²
- Review your member handbook²

7. Tools

- Treatment Cost Estimator
- Drug pricing tool^{1,2}
- Hospital comparison tool²

¹ These features are available only if your drug benefits are provided by CareFirst.

² These features are available only when using a computer at this time.



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Find a Doctor, Hospital or Urgent Care

www.carefirst.com/doctor

It's easy to find the most up-to-date information on health care providers and facilities who participate with CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively CareFirst).

Whether you need a doctor, nurse practitioner or health care facility, **www.carefirst.com/doctor** can help you find what you're looking for based on your specific needs.

You can search and filter results by:

- Provider name
- Provider specialty
- Distance
- Zip code
- City and state
- Accepting new patients
- Language
- Group affiliations
- Gender

To view personalized information on which doctors are in your network, log in to *My Account* on your computer, tablet or smartphone and click *Find a Doctor* from the Doctors tab or the Quick Links.

Find a Doctor

What type of care are you looking for?



Medical

Search for a doctor or facility by name or provider type



Mental Health

Search for a behavioral health/substance abuse provider or facility



Dental

Search for a dentist or facility for dental care



Vision

Search for a provider or facility for vision care



Pharmacy

Locate a pharmacy near you home or office



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Coordination of Benefits

If You're Covered by More Than One Health Plan

As a valued CareFirst member, we want to help you maximize your benefits and lower your out-of-pocket costs. If you're insured by more than one health insurance plan, our Coordination of Benefits program can help manage your benefit payments for you, so that you get the maximum benefits.

What is Coordination of Benefits (COB)?

It's a way of organizing or managing benefits when you're covered by more than one health insurance plan. For example:

- You and your spouse have coverage under your employer's plan.
- Your spouse also has coverage with another health insurance plan through his or her employer.

When you're covered by more than one plan, we coordinate benefit payments with the other health care plan to make sure you receive the maximum benefits entitled to you under both plans.

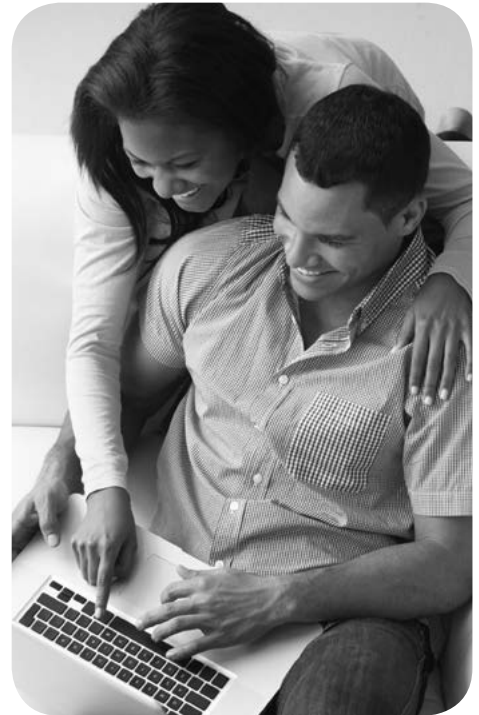
How does COB work?

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively, CareFirst) and most commercial insurance carriers follow the primary-secondary rule. This rule states when a person has double coverage, one carrier is determined to be the primary plan and the other plan becomes the secondary plan.

The **primary plan** has the initial responsibility to consider benefits for payment of covered services and pays the same amount of benefits it would normally pay, as if you didn't have another plan.

The **secondary plan** then considers the balances after the primary plan has made their payment. This additional payment may be subject to applicable deductibles, copay amounts, and contractual limitations of the secondary plan.

With the COB between your primary and secondary plans, your out-of-pocket costs may be lower than they would've been if you only had one insurance carrier.



Covered by more than
one health plan?
Contact Member Services
at the number listed on
your ID card.

What if I have other coverage?

Contact Member Services at the number listed on your ID card, so we can update your records and pay your claims as quickly and accurately as possible. Let us know when:

- You're covered under another plan.
- Your other coverage cancels.
- Your other coverage is changing to another company.

We may send you a routine questionnaire asking if you have double coverage and requesting information regarding that coverage, if applicable. Complete and return the form promptly, so we can continue to process your claims.

How do I submit claims?

When CareFirst is the primary plan

You or your doctor should submit your claims first to CareFirst, as if you had no other coverage. The remaining balance, if any, should be submitted to your secondary plan. Contact your secondary plan for more information on how to submit the claims for the remaining balance.

When CareFirst is the secondary plan

Submit your claim to the primary plan first. Once the claim has been processed and you receive an Explanation of Benefits detailing the amount paid or denial reasons, the claim can be submitted to CareFirst for consideration of the balances. Mail a copy of the Explanation of Benefits from the primary carrier and a copy of the original claim to the address on the back of your CareFirst ID card.

When CareFirst is the primary and secondary plan

You don't need to submit two claims. When a claim form is submitted, write the CareFirst ID number of the primary plan in the subscriber ID number space. Then complete the form by indicating the CareFirst secondary plan ID number under *Other Health Insurance*. In most cases, we'll automatically process a second claim to consider any balances.

Which health plan is primary?

There are standard rules throughout the insurance industry to determine which plan is primary and secondary. It's important to know these rules because your claims will be paid more quickly and accurately if you submit them in the right order. Keep in mind that the primary-secondary rule may be different for different family members.

Here are the rules we use to determine which plan is primary:

- If a health plan doesn't have a COB provision, that plan is primary.
- If one person holds more than one health insurance policy in their name, the plan that has been in effect the longest is primary.
- If you're the subscriber under one plan and a covered dependent under another, the plan that covers you as the subscriber is primary for you.
- If your child(ren) are covered under your plan and your spouse's plan, the Birthday Rule applies. This rule states the health plan of the parent whose birthday occurs earlier in the year is the primary plan for the children.
 - For example, if your birthday is May 3 and your spouse's is October 15, your plan is primary for your children. But, if the other insurer does not follow the Birthday Rule, then its rules will be followed.
 - When parents are separated or divorced, the family plan in the name of the parent with custody is primary unless this is contrary to a court determination.
 - For dependent coverage only, if none of the above rules apply, the plan that's covered the dependent longer is primary.





Legal Notices

Notice of Nondiscrimination and Availability of Language Assistance Services

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
 - ☐ Qualified sign language interpreters
 - ☐ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - ☐ Qualified interpreters
 - ☐ Information written in other languages

If you need these services, please call 855-258-6518.

If you believe CareFirst has failed to provide these services, or discriminated in another way, on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues, or other documentation to this office.

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address P.O. Box 8894
Baltimore, Maryland 21224

Email Address civilrightscoordinator@carefirst.com

Telephone Number 410-528-7820

Fax Number 410-505-2011

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



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Notice of Nondiscrimination and Availability of Language Assistance Services

Foreign Language Assistance

Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their member identification card. All others may call 855-258-6518 and wait through the dialogue until prompted to push 0. When an agent answers, state the language you need and you will be connected to an interpreter.

አማርኛ (Amharic) ማሳሰቢያ፡- ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀን-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኸን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ እገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

Èdè Yorùbá (Yoruba) Ìtẹ̀tílẹ̀kọ: Àkíyèsí yìí ní iwífún nípa isẹ̀ adójú tòfò rẹ̀. Ó le ní àwọn déètì pàtó o sì le ní láti gbé igbésẹ̀ ní àwọn ojò gbèdẹ̀kẹ kan. O ni ètò láti gba iwífún yí àti ìrànlowò ní èdè rẹ̀ lófẹ́. Àwọn ọ̀mọ-ẹ̀gbẹ̀ gbòdò pe nọmbà fòònu tò wà lẹ́yìn kààdì idánimọ̀ wọn. Àwọn mírán le pe 855-258-6518 kí o sì dúró nípasẹ̀ ijiròrò tíítí a ó fí sọ fún ọ̀ láti tẹ̀ 0. Nígbatí aṣojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì sọ ọ̀ pọ̀ mó ògbufò kan.

Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.

Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawang iyong insurance. Maaari itong maglaman ng mga pinakamahahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyologo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.

Español (Spanish) Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.

Русский (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.



Notice of Nondiscrimination and Availability of Language Assistance Services

हिन्दी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

Bàsɔ̀-wùdù (Bassa) Tò Dùù Cáo! Bǝ̀ nǝ̀ kɛ bá nyo bǝ̀ ké m̃ gbo kpá bó nǝ̀ fùà-fùá-tǝ̀n nyɛɛ jè dyí. Bǝ̀ nǝ̀ kɛ bédé wé jéé bǝ̀ bǝ̀ m̃ kɛ dɛ wa mó m̃ kɛ nyuɛɛ nyu hwé bǝ̀ wé bǝ̀ kɛ zi. ɔ̀ m̃ nǝ̀ kpé bǝ̀ m̃ kɛ bǝ̀ nǝ̀ kɛ kɛ gbo-kpá-kpá m̃ móɛ dyé dɛ nǝ̀ bídí-wùdù mú bǝ̀ m̃ kɛ se wídí dɛ pɛ́ɛ. Kpooɔ̀ nyo bǝ̀ m̃ dǝ̀ fùùn-nòbà nǝ̀ dɛ waà I.D. káàò dɛín nyɛ. Nyo tòò sɛín m̃ dǝ̀ nòbà nǝ̀ kɛ: 855-258-6518, kɛ m̃ m̃ fò tee bǝ̀ wa kɛ m̃ gbo cǝ̀ bǝ̀ m̃ kɛ nòbà m̃òà 0 kɛ dyi pàdàin hwé. ɔ̀ jǝ̀ kɛ nyo dɛ dyi m̃ gǝ̀ jǝ̀in, po wuɔ̀ m̃ mó poe dyie, kɛ nyo dɛ mu bó nǝ̀in bǝ̀ ɔ̀ kɛ nǝ̀ wuɔ̀dù mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

اردو (Urdu) توجہ: یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہ کیے اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ ممبران کو اپنے شناختی کارڈ کی پشت پر موجود فون نمبر پر کال کرنی چاہیے۔ سبھی دیگر لوگ 855-258-6518 پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں۔ ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبان بتائیں اور مترجم سے مربوط ہو جائیں گے۔

فارسی (Farsi) توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و لازم است تا تاریخ مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی را به صورت رایگان به زبان خودتان دریافت کنید. اعضا باید با شماره درج شده در پشت کارت شناسایی شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518 تماس بگیرند و منتظر بمانند تا از آنها خواسته شود عدد 0 را فشار دهند. بعد از پاسخگویی توسط یکی از اپراتورها، زبان مورد نیاز را تنظیم کنید تا به مترجم مربوطه وصل شوید.

اللغة العربية (Arabic) تنبيه: يحتوي هذا الإخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد نهائية محددة. يحق لك الحصول على هذه المساعدة والمعلومات بلغتك بدون تحمل أي تكلفة. ينبغي على الأعضاء الاتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم. يمكن للآخرين الاتصال على الرقم 855-258-6518 والانتظار خلال المحادثة حتى يطلب منهم الضغط على رقم 0. عند إجابة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحد المترجمين الفوريين.

中文繁体 (Traditional Chinese) 注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。



Notice of Nondiscrimination and Availability of Language Assistance Services

Igbo (Igbo) Nrubama: Okwa a nwere ozi gbasara mkpuchi nchekwa onwe gi. O nwere ike inwe ubochi ndi di mkpa, i nwere ike ime ihe tupu ufodu ubochi njedebe. I nwere ikike inweta ozi na enyemaka a n'asusu gi na akwughị ugwo o bula. Ndi otu kwesiri ikpo akara ckwenti di n'azu nke kaadi njirimara ha. Ndi ozọ niile nwere ike ikpo 855-258-6518 wee chere ububo ahụ ruo mgbe amanyere ipi 0. Mgbe onye nnochite anya zara, kwuo asusu i choro, a ga-ejikọ gi na onye okwọ okwu.

Deutsch (German) Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

Français (French) Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

한국어(Korean) 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아닌 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Diné Bizaad (Navajo) Ge': Díí bee íł hane'ígíí bii' dahólq bee éédahózin béeso ách'ááh naanil ník'ist'i'ígíí bá. Bii' dahólq doo íiyisí yoolkáálgíí dóó t'áádoó le'é ádadoolyíllígíí da yókeedgo t'áá doo bee e'e'aahí ájiil'íh. Bee ná ahóót'i' díí bee íł hane' dóó níká'ádoowot' t'áá nínizaad bee t'áá jiik'é. Atah danilínígíí béesh bee hane'é bee wólta'ígíí nit'izgo bee nee hódolzinígíí bikéédéé' bikáá' bich'í' hodoonihjí'. Aadóó nááná'la' éi kóji' dahódoonih 855-258-6518 dóó yíi diilts'íł yaltí'ígíí t'áá níléijí áádóó éi bikéé'dóó naasbaas bił adidiilchíł. Áká'ánidaalwó'ígíí neidiitáágo, saad bee yánilt'i'ígíí yíi diikił dóó ata' halne'é lá níká'ádoowot'.



Rights & Responsibilities

Notice of privacy practices

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively, CareFirst) are committed to keeping the confidential information of members private. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to send our Notice of Privacy Practices to members of fully insured groups only. The notice outlines the uses and disclosures of protected health information, the individual's rights and CareFirst's responsibility for protecting the member's health information.

To obtain a copy of our Notice of Privacy Practices, go to **www.carefirst.com** and click on *Privacy Statement* at the bottom of the page, click on *Health Information* then click on *Notice of Privacy Practices*. Or call the Member Services telephone number on your member ID card. Members of self-insured groups should contact their Human Resources department for a copy of their Notice of Privacy Practices. If you don't know whether your employer is self-insured, please contact your Human Resources department.



Member satisfaction

CareFirst wants to hear your concerns and/or complaints so that they may be resolved. We have procedures that address medical and non-medical issues. If a situation should occur for which there is any question or difficulty, here's what you can do:

- If your comment or concern is regarding the quality of service received from a CareFirst representative or related to administrative problems (e.g., enrollment, claims, bills, etc.) you should contact Member Services. If you send your comments to us in writing, please include your member ID number and provide us with as much detail as possible regarding any events. Please include your daytime telephone number so that we may contact you directly if we need additional information.
- If your concern or complaint is about the quality of care or quality of service received from a specific provider, contact Member Services. A representative will record your concerns and may request a written summary of the issues. To write to us directly with a quality of care or service concern, you can:
 - ☐ Send an email to:
quality.care.complaints@carefirst.com
 - ☐ Fax a written complaint to: (301) 470-5866
 - ☐ Write to: **CareFirst BlueCross BlueShield**
Quality of Care Department, P.O. Box 17636
Baltimore, MD 21297

CareFirst appreciates the opportunity to improve the level of quality of care and services available for you. As a member, you will not be subject to disenrollment or otherwise penalized as a result of filing a complaint or appeal.

Rights & Responsibilities

If you send your comments to us in writing, please include your identification number and provide us with as much detail as possible regarding the event or incident. Please include your daytime telephone number so that we may contact you directly if we need additional information. Our Quality of Care Department will investigate your concerns, share those issues with the provider involved and request a response. We will then provide you with a summary of our findings. CareFirst member complaints are retained in our provider files and are reviewed when providers are considered for continuing participation with CareFirst.

These procedures are also outlined in your Evidence of Coverage.

If you wish, you may also contact the appropriate jurisdiction's regulatory department regarding your concern:

VIRGINIA:

Complaint Intake, Office of Licensure and Certification,
Virginia Department of Health, 9960 Maryland Drive,
Suite 401, Richmond, VA 23233-1463
Phone #: (800) 955-1819 or (804) 367-2106
Fax #: (804) 527-4503

Office of the Managed Care Ombudsman,
Bureau of Insurance, P.O. Box 1157, Richmond, VA 23218
Phone #: 1-877-310-6560 or (804) 371-9032

DISTRICT OF COLUMBIA:

Department of Insurance, Securities and Banking
801 1st Street, NE, Suite 701, Washington, DC 20002
Phone #: (202) 727-8000

Hearing impaired

To contact a Member Services representative, please choose the appropriate hearing impaired assistance number below, based on the region in which your coverage originates.

Maryland Relay Program: (800) 735-2258

National Capital Area TTY: (202) 479-3546

Please have your Member Services number ready.

Language assistance

Interpreter services are available through Member Services. When calling Member Services, inform the representative that you need language assistance.

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Confidentiality of subscriber/ member information

All health plans and providers must provide information to members and patients regarding how their information is protected. You will receive a Notice of Privacy Practices from CareFirst or your health plan, and from your providers as well, when you visit their office.

CareFirst has policies and procedures in place to protect the confidentiality of member information. Your confidential information includes Protected Health Information (PHI), whether oral, written or electronic, and other nonpublic financial information. Because we are responsible for your insurance coverage, making sure your claims are paid, and that you can obtain any important services related to your health care, we are permitted to use and disclose (give out) your information for these purposes. Sometimes we are even required by law to disclose your information in certain situations. You also have certain rights to your own protected health information on your behalf.

Our responsibilities

We are required by law to maintain the privacy of your PHI, and to have appropriate procedures in place to do so. In accordance with the federal and state Privacy laws, we have the right to use and disclose your PHI for treatment, payment activities and health care operations as explained in the Notice of Privacy Practices. We may disclose your protected health information to the plan sponsor/employer to perform plan administration function. The Notice is sent to all policy holders upon enrollment.

Your rights

You have the following rights regarding your own Protected Health Information. You have the right to:

- Request that we restrict the PHI we use or disclose about you for payment or health care operations.
- Request that we communicate with you regarding your information in an alternative

manner or at an alternative location if you believe that a disclosure of all or part of your PHI may endanger you.

- Inspect and copy your PHI that is contained in a designated record set including your medical record.
- Request that we amend your information if you believe that your PHI is incorrect or incomplete.
- An accounting of certain disclosures of your PHI that are for some reasons other than treatment, payment, or health care operations.
- Give us written authorization to use your protected health information or to disclose it to anyone for any purpose not listed in this notice.

Inquiries and complaints

If you have a privacy-related inquiry, please contact the CareFirst Privacy Office at (800) 853-9236 or send an email to privacy.office@carefirst.com.

Members' rights and responsibilities statement

Members have the right to:

- Be treated with respect and recognition of their dignity and right to privacy.
- Receive information about the health plan, its services, its practitioners and providers, and members' rights and responsibilities.
- Participate with practitioners in decision-making regarding their health care.
- Participate in a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities.
- Voice complaints or appeals about the health plan or the care provided.

Members have a responsibility to:

- Provide, to the extent possible, information that the health plan and its practitioners and providers need in order to care for them.
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Follow the plans and instructions for care that they have agreed on with their practitioners.
- Pay copayments or coinsurance at the time of service.
- Be on time for appointments and to notify practitioners/providers when an appointment must be canceled.

Eligible individuals' rights statement wellness and health promotion services

Eligible individuals have a right to:

- Receive information about the organization, including wellness and health promotion services provided on behalf of the employer or plan sponsors; organization staff and staff qualifications; and any contractual relationships.
- Decline participation or disenroll from wellness and health promotion services offered by the organization.
- Be treated courteously and respectfully by the organization's staff.
- Communicate complaints to the organization and receive instructions on how to use the complaint process that includes the organization's standards of timeliness for responding to and resolving complaints and quality issues.





The CareFirst BlueCross BlueShield
family of health care plans

www.carefirst.com



CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are both independent licensees of the Blue Cross and Blue Shield Association.
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