BlueChoice HMO • *Open Access*

HRA/HSA BlueFund & Compatible Plans *Summary of Benefits*

Services	In-Network You Pay
ANNUAL DEDUCTIBLE[1]	
Individual	$1,200
Individual & Child(ren)[2]	$2,400
Individual & Adult	$2,400
Family	$2,400
ANNUAL OUT-OF-POCKET LIMIT[1]	
Individual	$2,400
Individual & Child(ren)[2]	$4,800
Individual & Adult	$4,800
Family	$4,800
LIFETIME MAXIMUM BENEFIT	None
PREVENTIVE SERVICES	
Well-Child Care	
0-24 months	No charge*
24 months-13 years (immunization visit)	No charge*
24 months-13 years (non-immunization visit)	No charge*
14-17 years	No charge*
Adult Physical Examination	No charge*
Routine GYN Visits	No charge*
Mammograms	No charge*
Cancer Screening[3] (Pap Test, Prostate and Colorectal)	No charge*
OFFICE VISITS, LABS AND TESTING	
Office Visits for Illness	Deductible, then $15 PCP/$25 Specialist per visit
Diagnostic Services[3]	Deductible, then $15 PCP/$25 Specialist per visit
X-ray and Lab Tests	No charge* after deductible is met
Allergy Testing[3]	Deductible, then $15 PCP/$25 Specialist per visit
Allergy Shots[3]	Deductible, then $15 PCP/$25 Specialist per visit
Outpatient Physical, Speech and Occupational Therapy	Deductible, then $25 per visit (limited to 30 visits/condition/benefit period)
Outpatient Spinal Manipulation	Deductible, then $25 per visit (limited to 20 visits/benefit period)
EMERGENCY CARE AND URGENT CARE	
Physician's Office	Deductible, then $15 PCP/$25 Specialist per visit
Urgent Care Center	Deductible, then $25 per visit
Hospital Emergency Room	Deductible, then $100 per visit (waived if admitted)
Ambulance (if medically necessary)	No charge* after deductible is met
HOSPITALIZATION	
Inpatient Facility Services	Deductible, then $250 per admission
Outpatient Facility Services	No charge* after deductible is met
Inpatient Physician Services	No charge* after deductible is met
Outpatient Physician Services	Deductible, then $15 PCP/$25 Specialist per visit

Services	In-Network You Pay
HOSPITAL ALTERNATIVES	
Home Health Care	No charge* after deductible is met
Hospice	No charge* after deductible is met
Skilled Nursing Facility	No charge* after deductible is met
MATERNITY	
Prenatal and Postnatal Office Visits	Deductible, then $15 PCP/$25 Specialist per visit
Delivery and Facility Services	Deductible, then $250 per admission
Nursery Care of Newborn	No charge* after deductible is met
Initial Office Consulation(s) for Infertility Services/Procedures	Deductible, then $25 Specialist copay
Artificial Insemination[4]	Not covered
In Vitro Fertilization Procedures[4]	Not covered
MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)	
Inpatient Facility Services (limited to 30 days/benefit period)	Deductible, then $250 per admission
Inpatient Physician Services	No charge* after deductible is met (limited to 1 visit per day during a covered admission)
Outpatient Services (MH & SA)	$10 per visit after deductible is met (limited to 20 visits/benefit period)**
Partial Hospitalization	No charge* after deductible is met (every 2 days are counted as 1 toward inpatient limit)
Medication Management Visit	Deductible, then $15 PCP/$25 Specialist per visit
MISCELLANEOUS	
Durable Medical Equipment	Deductible, then 25% of Allowed Benefit
Acupuncture	Not covered (except when approved or authorized by plan when used for anesthesia)
Transplants	Covered as stated in Evidence of Coverage
Hearing Aids	Not covered
VISION	
Routine Exam (limited to 1 visit/benefit period)	HRA Plan - $10 per visit at participating vision provider HSA Plan - Not covered
Eyeglasses and Contact Lenses	HRA Plan - Discounts from participating vision center HSA Plan - Not covered

* No copayments or coinsurance.
** If the visit is applied toward the deductible; the visit will not contribute towards the visit limit.
[1] The deductible can be met entirely by one Member or by combining eligible expenses of two or more Members. The Out-of-Pocket Limit can be met in the same way.
[2] Please refer to your Evidence of Coverage to determine your coverage level.
[3] If office copayment has been paid, additional copayment not required for this service.
[4] Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment option for infertility. However, assisted reproduction (AI) services performed as treatment option for infertility are only available under the terms of the member's contract. Preauthorization required.

HSA plans must be sold with a combined RX benefit and that HRA plans have the option of combined Rx benefits or a separate plan.

Note: Upon enrollment in CareFirst BlueChoice, you will need to select a Primary Care Physician (PCP). To select a PCP, go to www.carefirst.com for the most current listing of PCPs from our online provider directory.You may also call the Member Services toll free phone number on the front of your CareFirst BlueChoice ID card for assistance in selecting a PCP or obtaining a printed copy of the CareFirst BlueChoice provider directory.

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.

Policy Form Numbers: VA/CFBC/GC (R. 7/10) • VA/CFBC/EOC (R. 1/09) • VA/CFBC/DOL APPEAL (R. 8/06) • VA/CFBC/DOCS (R. 1/09) • VA/BC-OOP/SOB HDHP (9/06) • VA/CFBC/ATTC (R. 1/10) • VA/CFBC/RX3 (R. 12/08) and any amendments.

www.carefirst.com

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.

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. 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, hoyer/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.

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 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.)