BlueChoice Advantage

Summary of Benefits

Services	BlueChoice Providers In-Network You Pay[1]	Non-BlueChoice Providers Out-of-Network You Pay[2]
ANNUAL DEDUCTIBLE (BENEFIT PERIOD)[3]		
Individual	None	$1,000
Individual & Child(ren)[4]	None	$2,000
Individual & Adult	None	$2,000
Family	None	$2,000
ANNUAL OUT-OF-POCKET LIMIT		
Individual	$1,500	$3,000
Individual & Child(ren)[4]	$3,000	$6,000
Individual & Adult	$3,000	$6,000
Family	$3,000	$6,000
LIFETIME MAXIMUM BENEFIT	None	None
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months	No charge*	40% of Allowed Benefit
24 months-13 years (immunization visit)	No charge*	40% of Allowed Benefit
24 months-13 years (non-immunization visit)	No charge*	40% of Allowed Benefit
14-17 years	No charge*	40% of Allowed Benefit
Adult Physical Examination	No charge*	40% of Allowed Benefit
Routine GYN Visits	No charge*	40% of Allowed Benefit
Mammograms	No charge*	40% of Allowed Benefit
Cancer Screening[5] (Pap Test, Prostate and Colorectal)	No charge*	40% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	$20 per visit	Deductible, then 40% of Allowed Benefit
Diagnostic Services[5]	$20 per visit	Deductible, then 40% of Allowed Benefit
X-ray and Lab Tests	No charge*	Deductible, then 40% of Allowed Benefit
Allergy Testing[5]	10% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Allergy Shots[5]	$5 per visit	Deductible, then 40% of Allowed Benefit
Outpatient Physical, Speech and Occupational Therapy[8] (limited to 30 visits/condition/benefit period)	$20 per visit	Deductible, then 40% of Allowed Benefit
Outpatient Spinal Manipulation (limited to 20 visits/benefit period)	$20 per visit	Deductible, then 40% of Allowed Benefit
EMERGENCY CARE AND URGENT CARE		
Physician's Office	$20 per visit	Deductible, then 40% of Allowed Benefit
Urgent Care Center	$20 per visit	Deductible, then 40% of Allowed Benefit
Hospital Emergency Room	$100 per visit (copay waived if admitted)	Paid as in-network
Ambulance (if medically necessary)	10% of Allowed Benefit	10% of Allowed Benefit
HOSPITALIZATION		
Inpatient Facility Services	$250 per admission	Deductible, then 40% of Allowed Benefit
Outpatient Facility Services	$250 per visit	Deductible, then 40% of Allowed Benefit
Inpatient Physician Services	10% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Outpatient Physician Services	10% of Allowed Benefit	Deductible, then 40% of Allowed Benefit

Services	BlueChoice Providers In-Network You Pay[1]	Non-BlueChoice Providers Out-of-Network You Pay[2]
HOSPITAL ALTERNATIVES		
Home Health Care	10% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Hospice	10% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Skilled Nursing Facility	10% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
MATERNITY		
Prenatal and Postnatal Office Visits	10% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Delivery and Facility Services	$250 per admission	Deductible, then 40% of Allowed Benefit
Nursery Care of Newborn	10% of Allowed Benefit	Deductible, then 10% of Allowed Benefit
Initial Office Consulation(s) for Infertility Services/Procedures	$20 per visit	Deductible, then 40% of Allowed Benefit
Artificial Insemination[6]	Not covered	Not covered
In Vitro Fertilization Procedures[6]	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Facility Services	$250 per admission	Deductible, then 40% of Allowed Benefit
Inpatient Physician Services	No charge*	Deductible, then 40% of Allowed Benefit
Outpatient Facility Services	$20 per visit	Deductible, then 40% of Allowed Benefit
Outpatient Physician Services	$20 per visit	Deductible, then 40% of Allowed Benefit
Office Visits	$20 per visit	Deductible, then 40% of Allowed Benefit
Partial Hospitalization Facility Services	$20 per visit	Deductible, then 30% of Allowed Benefit
Partial Hospitalization Physician Services	$20 per visit	Deductible, then 30% of Allowed Benefit
Medication Management	$20 per visit	Deductible, then 40% of Allowed Benefit
MISCELLANEOUS		
Durable Medical Equipment	25% of Allowed Benefit	25% of Allowed Benefit
Acupuncture	Not covered, only when Plan approved for anesthesia	Not covered, only when Plan approved for anesthesia
Transplants	Covered as stated in the Evidence of Coverage	Covered as stated in the Evidence of Coverage
Hearing Aids	Not covered	Not covered
VISION		
Routine Exam (limited to 1 visit/benefit period)	$10 per visit at participating vision provider	Total charge minus $33 Allowed Benefit
Eyeglasses and Contact Lenses	Discounts from participating vision centers	Not covered

* No copayments or coinsurance.

[1] In-network: When covered services are rendered by a provider in the BlueChoice Provider network, care is reimbursed at the in-network level. In-network coinsurances are based on a percentage of the BlueChoice Allowed Benefit. The BlueChoice Allowed Benefit is generally the contracted rates or fee schedules that 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.

[2] Out-of-network: When covered services are rendered by a provider in the CareFirst BlueCross BlueShield Provider network or a Non-Participating Provider, 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 Participating Providers have agreed to accept as payment of covered services. These payments are established by CareFirst BlueCross Blueshield, however, in certain circumstances, an allowance may be established by law. When services are rendered by Non-Participating Providers, the member may be responsible for charges in excess of the Allowed Benefit.

[3] If you have two-party coverage, each Member must satisfy his/her own out-of-network deductible by meeting the individual out-of-network deductible. If you have family coverage, all Members' individual expenses will be combined to meet the family deductible; however, no individual Member may contribute more than the individual out-of-network deductible amount.

[4] Please refer to your Evidence of Coverage to determine your coverage level.

[5] If you have two-party coverage, each Member must satisfy his/her own out-of-pocket maximum by meeting the individual out-of-pocket maximum. If you have family coverage, all Members' individual expenses will be combined to meet the family out-of-pocket maximum; however, no individual Member may contribute more than the individual out-of-pocket amount.

[6] Diagnostic services performed at LabCorp only paid at the in-network level. Services performed by any other provider will be considered out-of-network.

[7] 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, IVF & Intrauterine Insemination) services performed as treatment option for infertility are only available under the terms of the members contract. Prior Authorization required.

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

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.

These benefits are issued under policy form numbers: VA/CFBC/GC (7/10) • VA/CFBC/HPN/EOC (6/10) • VA/CFBC/PPN DOCS (6/10) • VA/CFBC/PPN SOB (R. 6/10) • VA/CFBC/ATTC (R. 1/10) • VA/CFBC/RX3 (R. 12/08) and any amendments or riders.

CareFirst BlueChoice

CareFirst BlueCross BlueShield

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BRC6573-1P (12/11) ■ VA ■ Option 5

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, 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 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.