

SERVICES	In-Network You Pay
ANNUAL DEDUCTIBLE (Benefit Period)²	
Individual	\$500
Individual & Child(ren) ⁴	\$1,000
Individual & Adult	\$1,000
Family	\$1,000
ANNUAL OUT-OF-POCKET LIMIT (Benefit Period)^{3, 6}	
Individual	\$2,500
Individual & Child(ren) ⁴	\$5,000
Individual & Adult	\$5,000
Family	\$5,000
LIFETIME MAXIMUM BENEFIT	No Limit
PREVENTIVE SERVICES	
Well-Child Care	
0-24 months	\$10 per visit
24 months-13 years (immunization visit)	\$10 per visit
24 months-13 years (non-immunization visit)	\$10 per visit
14-17 years	\$10 per visit
Adult Physical Examination	\$10 PCP/\$20 Specialist per visit
Routine GYN Visits	\$10 PCP/\$20 Specialist per visit
Mammograms	No charge*
Cancer Screening ⁵ (Pap Test, Prostate and Colorectal)	\$10 PCP/\$20 Specialist per visit
OFFICE VISITS, LABS & TESTING	
Office Visits for Illness	\$10 PCP/\$20 Specialist per visit, then deductible
Diagnostic Services ⁵	\$10 PCP/\$20 Specialist per visit, then deductible
X-ray and Lab Tests	No charge*
Allergy Testing ⁵	\$10 PCP/\$20 Specialist per visit
Allergy Shots ⁵	\$10 PCP/\$20 Specialist per visit
Outpatient Physical, Speech and Occupational Therapy (limited to 30 visits/condition/benefit period)	\$20 per visit, then deductible
Outpatient Spinal Manipulation (limited to 20 visits/benefit period)	\$20 per visit, then deductible
EMERGENCY CARE AND URGENT CARE	
Physician's Office	\$10 PCP/\$20 Specialist per visit, then deductible
Urgent Care Center	\$20 per visit, then deductible
Hospital Emergency Room	\$100 per visit, then deductible (waived if admitted as inpatient)
Ambulance (if medically necessary)	No charge*
HOSPITALIZATION	
Inpatient Facility Services	No charge* after deductible is met
Outpatient Facility Services	No charge* after deductible is met
Inpatient Physician Services	No charge* after deductible is met
Outpatient Physician Services	\$10 PCP/\$20 Specialist per visit, then deductible

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	\$10 PCP/\$20 Specialist per visit, then deductible (not to exceed 10 times the copay per pregnancy)
Delivery and Facility Services	No charge* after deductible is met
Nursery Care of Newborn	No charge* after deductible is met
Initial Office Consultation(s) for Infertility Services/Procedures	Deductible, then \$10 PCP/\$20 Specialist per visit
Artificial Insemination ¹	\$20 per visit, then deductible
In Vitro Fertilization Procedures ¹	Not covered
MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)	
Inpatient Facility Services (limited to 30 days/benefit period)	Deductible, then 50% of Allowed Benefit
Inpatient Physician Services (limited to 1 visit/day during covered admission)	\$25 per visit, then deductible
Outpatient Services (MH) (limited to 20 visits/benefit period)	\$25 per visit, then deductible
Outpatient Services (SA) (limited to 20 visits/benefit period)	\$25 per visit, then deductible
Partial Hospitalization (each day counts as 1/2 day towards inpatient limit)	Deductible, then 50% of Allowed Benefit
Medication Management Visit	\$10 PCP/\$20 Specialist per visit
MISCELLANEOUS	
Durable Medical Equipment (limited to a plan payment of \$7,500/benefit period)	Deductible, then 25% of Allowed Benefit
Acupuncture	Not covered (except when approved or authorized by the Plan when used for anesthesia)
Transplants	Covered as stated in Evidence of Coverage
Hearing Aids for ages 0-18 (limited to \$1,400 max per hearing aid every 3 years)	Not covered
VISION	
Routine Exam (limited to 1 visit/benefit period)	\$10 per visit
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers

¹ 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) services performed as treatment option for infertility are only available under the terms of the members contract. Preauthorization required.

² If you have two-party coverage, each Member must satisfy his/her own deductible by meeting the individual deductible. If you have family coverage, all Members' individual deductibles will be combined to meet the family deductible; however, no individual Member may contribute more than the individual deductible amount.

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

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

⁵ If office copayment has been paid, additional office copayment not required for this service.

⁶ The actual out-of-pocket limit may vary based on the types of coverage selected by your employer.

* No copayments or coinsurance.

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.

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These benefits are issued under policy form numbers: VA/CC/GC 5/01; VA/CFBC/EOC (R. 1/06); VA/CC/DOC 5/01; VA/BC-OOP/SOB (R. 6/04); VA/CFBC/ATTC (R. 5/05) and any amendments or riders.

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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 the Plan.
- B. Services that are Experimental or Investigational as determined by the Plan.
- C. The cost of services that:
 - 1. Are furnished without charge; or
 - 2. Are normally furnished without charge to persons without health insurance coverage;
 - 3. Would have been furnished without charge if you were not covered under this Certificate or under any health insurance.
- D. Services that are not described as covered in this Certificate or that do not meet all other conditions and criteria for coverage, as determined by the Plan. Referral by a Primary Care Physician and/or the provision of services by a Plan Provider does not, by itself, entitle a Member to benefits if the services are non-covered or do not otherwise meet the conditions and criteria for coverage.
- E. Routine foot care including any service related to hygiene including the trimming of corns or calluses, flat feet, fallen arches, chronic foot strain, or partial removal of a nail without the removal of the matrix except when we determine that Medically Necessary treatment was required because of an underlying health condition such as diabetes, and that all other conditions for coverage have been met.
- F. 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; false teeth; or any other dental services or supplies. These services may be covered under a separate rider or endorsement purchased by your Group and attached to this Certificate.
- G. Cosmetic surgery (except benefits for Breast 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 the Plan.
- H. Treatment rendered by a health care provider who is a member of the Member's family (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 Certificate or a rider or endorsement purchased by your Group and attached to this Certificate.
- J. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
- K. Services to reverse voluntary surgically induced infertility such as a reversal of sterilization.
- L. All assisted reproductive technologies (except artificial 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 or endorsement purchased by your Group and attached to this Certificate.
- M. Fees or charges relating to fitness programs, weight loss or weight control programs; physical conditioning; pulmonary rehabilitation programs; exercise programs; physical conditioning; use of passive or patient-activated exercise equipment.
- N. Treatment for obesity except for the surgical treatment of Morbid Obesity.
- O. 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.
- P. Services furnished as a result of a referral prohibited by law.
- Q. 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 the Plan.
- R. Health education classes and self-help programs, other than birthing classes or for the treatment of diabetes.
- S. Acupuncture services except when approved or authorized by the Plan when used for anesthesia.
- T. 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 the Plan even though they may have therapeutic value or be provided by a health care provider.
- U. Cardiac rehabilitation programs.
- 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. Benefits will not be provided for Habilitative Services. Benefits for physical therapy, occupational therapy and speech therapy do not include benefits for Habilitative Services.

10.2 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 the Plan.
- D. Services for a Member who is an organ donor when the recipient is not a Member.
- E. Any service, supply or device related to a transplant that is not listed as a benefit in this Certificate.

10.3 Inpatient Hospital Services. Benefits will not be provided for the following:

- A. Private room, unless Medically Necessary and authorized or approved by the Plan. 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.
- C. A Hospital admission or any portion of a Hospital admission that had not been authorized or approved by the Plan, whether or not services are Medically Necessary and/or meet all other conditions for coverage.
- D. Private duty nursing unless authorized or approved by the Plan.

10.4 Hospice Benefits. The following are not covered:

- A. Services, visits, medical equipment or supplies that are not included in the Plan-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. Reimbursement for volunteer services.
- G. Domestic or housekeeping services.
- H. Meal on Wheels or similar food service arrangements.
- I. Rental or purchase of renal dialysis equipment and supplies.

10.5 Outpatient Mental Health and Substance Abuse. Benefits will not be provided for:

- A. Psychological testing, unless Medically Necessary, as determined by the Plan, 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 Plan's Medical Director.
- C. Mental retardation, after diagnosis.
- D. Psychoanalysis.

10.6 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 Plan's Medical Director.
- B. Custodial Care.
- C. Observation or isolation.

10.7 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-Plan Provider after the Member could reasonably be expected to travel to the nearest Plan Provider.
- D. Charges for services when the claim filing and notice procedures stated in Section 7 of this Certificate have not been followed by the Member.
- E. Charges for follow-up care received in the Emergency or Urgent Care facility outside of the Service Area unless the Plan 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, whether or not recommended by a Plan Provider.

8.8 Limitations and Exclusions for Medical Devices. Benefits will not be provided for the purchase, rental or repair of the following:

- A. Convenience item. Any item that increases physical comfort or convenience without serving a Medically Necessary purpose (e.g., elevators, hoist/stair lifts, 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, hearing aids, dental prostheses or appliances.
- G. Corrective shoes, unless they are an integral part of the lower body brace, shoe lifts or special shoe accessories.