BluePreferred

Services	Preferred Providers In-Network You Pay[2]	Non-Preferred Providers Out-Of-Network You Pay[3]
ANNUAL DEDUCTIBLE (Benefit Period)[4, 8]		
Individual	$1,000	$2,000
Individual & Child(ren)[7]	$2,000	$4,000
Individual & Adult	$2,000	$4,000
Family	$2,000	$4,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit Period)[5]		
Individual	$3,500	$7,000
Individual & Child(ren)[7]	$7,000	$14,000
Individual & Adult	$7,000	$14,000
Family	$7,000	$14,000
LIFETIME MAXIMUM	None	
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months	No charge[6]	Plan pays 100% of Allowed Benefit
24 months-13 years (immunization visit)	No charge[6]	Plan pays 100% of Allowed Benefit
24 months-13 years (non-immunization visit)	No charge[6]	Plan pays 100% of Allowed Benefit
14-17 years	No charge[6]	Plan pays 100% of Allowed Benefit
Adult Physical Examination	$20 per visit	Deductible, then 30% of Allowed Benefit
Routine GYN Visits	$20 per visit	Deductible, then 30% of Allowed Benefit
Mammograms	No charge[6]	Plan pays 100% of Allowed Benefit
Cancer Screening		
Pap Test and Prostate	No charge[6]	CareFirst pays 100% of Allowed Benefit
Colorectal	No charge[6]	CareFirst pays 100% of Allowed Benefit
OFFICE VISITS, LABS & TESTING		
Office Visits for Illness	$20 per visit	Deductible, then 30% of Allowed Benefit
Diagnostic Services	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
X-ray and Lab Tests	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Allergy Testing	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Allergy Shots	$5 per visit	Deductible, then 30% of Allowed Benefit
Outpatient Physical, Speech and Occupational Therapy	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Outpatient Spinal Manipulation	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
EMERGENCY CARE AND URGENT CARE		
Physician's Office	$20 per visit	Deductible, then 30% of Allowed Benefit
Urgent Care Center	$20 per visit	Paid as in-network
Hospital Emergency Room (limited to emergency services)	Deductible, then 10% of Preferred Provider Allowance plus $50 per visit	Paid as in-network
Ambulance (if medically necessary)	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
HOSPITALIZATION		
Inpatient Facility Services	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Outpatient Facility Services	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Inpatient Physician Services	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Outpatient Physician Services	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit

Services	Preferred Providers In-Network You Pay[2]	Non-Preferred Providers Out-Of-Network You Pay[3]
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 90 visits per episode of care)	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Hospice (limited to a maximum 180 day Hospice eligibility period)	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Skilled Nursing Facility (limited to 60 days per benefit period)	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
MATERNITY[7]		
Prenatal and Postnatal Office Visits	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Delivery and Facility Services	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Nursery Care of Newborn	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Initial Office Consultation(s) for infertility Services/Procedures	$20 per visit	Deductible, then 30% of Allowed Benefit
Artificial Insemination[1]	Not covered	Not covered
In Vitro Fertilization Procedures[1]	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Facility Services (Under age 19, limited to 25 days per benefit period, Age 19 and over, limited to 20 days per benefit period)	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Inpatient Physician Services	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Outpatient Services (limited to 20 visits per benefit period)		
Visits 1 – 5	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Visits 6 – 20	Deductible, then 50% of Preferred Provider Allowance	Deductible, then 50% of Allowed Benefit
Partial Hospitalization (limited to 15 days per benefit period)	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% of Allowed Benefit
Medication Management Visit	$20 per visit	Deductible, then 30% of Allowed Benefit
MISCELLANEOUS		
Durable Medical Equipment	Deductible, then 10% of Preferred Provider Allowance	Deductible, then 30% 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 for ages 0-18	Not covered	Not covered
VISION		
Routine Exam (limited to 1 visit/benefit period)	$10 per visit at participating vision providers	Total charge minus $33
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers	Not covered

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. In-network: When you have care rendered by a provider in the Preferred Provider network. In-network coinsurances are based on a percentage of the Preferred Provider Allowance. The Preferred Provider Allowance 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, an allowance may be established by law.
3. Out-of-network: When you have care 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 Participating Providers have agreed to accept as payment of covered services. These payments are established by CareFirst, however, in certain circumstances, an allowance may be established by law. When services are rendered by Non-Participating Providers, charges in excess of the Allowed Benefit are the member's responsibility.
4. 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.
5. 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.
6. No copayments or coinsurance.
7. Please refer to your Evidence of Coverage and Schedule of Benefits to determine your coverage level.
8. Copayment or portion of deductible may be required at the point of sale while in the deductible period. Member will never be required to pay more than CareFirst's Allowed Benefit for service rendered.

The benefit described are issued under form numbers: VA/CF/GC (R. 1/09); VA/CF/BP/EOC (7/08); VA/CF/BP/DOCS (7/08); VA/CF/SOB-CDH (7/08); VA/CF/ATTC (R. 1/08); VA/CF/Vision (R. 1/06) and any amendments.

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BRC6346-6P (6/09) ■ VA ■ Option 15

Exclusions

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.

MM. Elective abortions.

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, hoyer 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.

Exclusions To Vision Care Rider:

The following services are excluded from coverage under the Vision Care Rider:

1. Diagnostic services, except as listed in Vision Care Rider.
2. Medical care or surgery. Covered services related to medical conditions of the eye may be covered under the evidence of coverage to which the Vision Care Rider is attached.
3 Prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the evidence of coverage or a rider or endorsement purchased by your Group and attached to the evidence of coverage to which the Vision Care Rider is attached.
4. Services or supplies not specifically approved by the Vision Care Designee where required in Vision Care Rider.
5. Orthoptics, vision training and low vision aids.
6. Glasses, sunglasses or contact lenses.
7. Vision Care services for cosmetic use.