CareFirst BlueChoice, Inc.

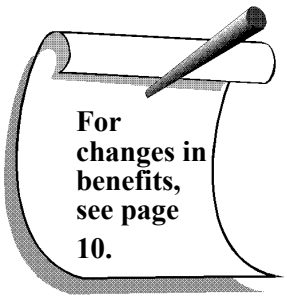
http://www.carefirst.com/fedhmo

2012

A Health Maintenance Organization

Serving: The State of Maryland, the Northern Virginia area and Washington, DC

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 9 for requirements.



Enrollment code for this Plan:

2G1 High Option Open Access - Self Only

2G2 High Option Open Access -Self and Family

2G4 Standard HealthyBlue - Self Only

2G5 Standard HealthyBlue - Self and Family

This Plan has Excellent accreditation from NCQA.
See the 2012 Guide for more information on accreditation.

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-718

Important Notice from CareFirst BlueChoice About
Our Prescription Drug Coverage and Medicare

OPM has determined that CareFirst BlueChoice prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Credible Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY 1-877-486-2048.

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Introduction

This brochure describes the benefits of CareFirst BlueChoice, Inc. under our contract (CS 2879) with the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for CareFirst BlueChoice administrative offices is:

CareFirst BlueChoice, Inc.
840 First Street N.E.
Washington D.C. 20065

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2012, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2012 and changes are summarized on page 10. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means CareFirst BlueChoice, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management Healthcare and Insurance, Federal Employee Insurance Operations, Program Analysis and Systems Support, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your health care provider, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.

- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at (toll free) 888/789-9065 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you may be responsible for all benefits paid during the period in which premiums were not paid. You may be billed directly by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.

- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

  "Exactly what will you be doing?"
  "About how long will it take?"
  "What will happen after surgery?"
  "How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Patient Safety Links:

-www.ahrq.gov/consumer/. The Agency for Healthcare Research Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

-www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

-www.talkable.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

-www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

-www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use CareFirst BlueChoice network providers under both the High Open Access and the Holdable options. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs neither your FEHB plan nor you will incur costs to correct the medical error.

Section 1. Facts about this HMO Plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

Questions regarding what protections apply may be directed to us at **888-789-9065.** You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General features of our High Open Access and Standard HealthyBlue Options

CareFirst offers and Open Access HMO, chose main features include: No deductible, no referrals, no member out-of-pocket for preventive care, and no copay for generic drugs. The plan also provides benefits for routine vision exam.

Our new Standard HealthyBlue offering includes all of the main features of the Open Access HMO, with the following additional provisions: no member copay for any care received from a BlueChoice primary care physician (including pediatricians), members have out of network benefits , and a deductible applies to some services. In addition, HealthyBlue offers a Healthy Reward that can reduce the deductible (see section 5 (h) for details on this benefit).

We have Open Access benefits

Our High Option HMO and our HealthyBlue option both offer Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in our network.

We have Point of Service (POS) benefits

Our HealthyBlue option, in addition to being Open Access, offers Point-of-Service benefits. This means you can receive covered services from an out-of-network provider who participates in another CareFirst network or a non-participating provider. However, if you receive services from a provider outside of our BlueChoice network, you may have higher out-of-pocket costs than you would have from our in-network providers.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. Under HealthyBlue, you will be responsible for charges in excess of our allowed benefit, in addition to any applicable deductible or copay, when you receive care from an out-of-network non-participating provider..

Your Rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- We are in compliance with Federal and State licensing and certification requirements
- We have been in existence since 1984
- We are a for profit corporation
- 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.

If you want more information about us, call (toll free) 888/789-9065 or write to Mail Administrator., P.O. Box 14114, Lexington, KY 40512-4114. You may also contact us by visiting our website at www.CareFirst.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is: The District of Columbia; the state of Maryland; in Virginia, the cities of Alexandria and Fairfax, Arlington County, the town of Vienna and the area of Fairfax and Prince William Counties in Virginia lying east of route 123.

Under CareFirst BlueChoice Open Access you must ordinarily get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval. Under HealthyBlue, if you elect to receive care outside of our service area, the care will be treated as out-of-network.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you may be able to take advantage of our Guest Membership Program. This program will allow you or your dependents, which reside out of the service area for an extended period of time, to utilize the benefits of an affiliated Blue Cross and Blue Shield HMO. Please contact us at (toll free) 888/789-9065 for more information on the Guest Membership Program. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2012

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- Sections 3, 7 and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordable Care Act, Public Law 111-148

Changes to the High option Open Access plan

- Your share of the non-Postal premium will increase for Self only and for Self and Family. See page xxx.
- The copay for Inpatient admissions will be $200 per admission effective January 1, 1012. Previously, the copay had been $150 per day with a $450 per admission maximum. See page 54
- CareFirst BlueChoice will cover coverer all generic medications with no copay. Previously, the $10 generic copay applied to these drugs. See page 63.
- CareFirst BlueChoice will no longer cover infertility drugs associated with infertility procedures we do not cover. Previously, we covered all medically necessary infertility drugs. See pages 28 and 64.
- CareFirst BlueChoice will revise our policy on coverage for brand name drugs when a generic equivalent is available. Beginning January 1, 1012, if a member requests a brand name drug and the prescriber did not indicate “Dispense as Written” or “Do not substitute”, the member will be responsible for the price difference between the brand name drug and the generic equivalent. Previously, the member only paid the applicable copay. See page 64
- CareFirst BlueChoice clarifies the infertility benefit for AI to indicate that the procedure is covered only if the couple has a relationship under which FEHBP recognizes each partner as a spouse of the other. Previously, no restrictions other than medical necessity were specified. See page 28.
- CareFirst has redefined "Plan allowance" as "allowed benefit". See page 83.
- CareFirst BlueChoice clarifies the wording that describes our service area to read: the District of Columbia; the state of Maryland; in Virginia, the cities of Alexandria and Fairfax, Arlington County, the town of Vienna and the area of Fairfax and Prince William Counties in Virginia lying east of route 123. See page 9.
- The information on Preventive care for adults has been revised to indicate conformance with American College of Gastroenterology, American Cancer Society, etc. Previously, specific ages were listed. See page 23.
- CareFirst has clarified the language for Speech, Physical and Occupational Therapy with current definitions. See page 31.
- CareFirst BlueChoice has added language regarding coverage for Pulmonary Rehabilitation. Previously, this care was not mentioned specifically in the brochure. See page 33.
- CareFirst BlueChoice has clarified language regarding non covered foot care with additional information on non-covered services. See page 36.
- CareFirst BlueChoice has added language to Chiropractic care indicating that benefits are limited to those aged 12 or older. See page 41.
- CareFirst has clarified the language for coverage for Bariatric surgery. See page 44.
- Non covered dental procedures have been clarified to update the list of non-covered procedures. See page 66..
- Language concerning Hospitalization solely for Acute Rehabilitation has been clarified to indicate that it is limited to 90 days per calendar year. See page 55.
- CareFirst BlueChoice has clarified the hospice care benefit to include specific language about Respite Care and Bereavement Services. See page 40.

- CareFirst BlueChoice has listed new items under non covered prescription drugs: Infertility drugs prescribed in conjunction with a non covered procedure and prescription drugs for cosmetic use. Previously, these exclusions were not specifically stated in the brochure. See page 64.
- CareFirst BlueChoice clarifies that certain chemotherapy drugs will be covered with zero copay. See page 64.
- CareFirst BlueChoice clarifies that we introduced the Patient Centered Medical Home provider model during 2011. Under this model, CareFirst BlueChoice will involve your Primary Care Provider (PCP) more intimately in management of your health, to include reimbursing the PCP for personalized care plans for treating chronic conditions. See pages 21 and 83.

New for 2012 – Standard option HealthyBlue

CareFirst BlueChoice introduces a new option, HealthyBlue. Specific features unique to this option include:

- A Dual option design, permitting the member to have benefits for care received outside of the BlueChoice network.
- No member out-of-pocket expenses for any service by a PCP; no copay for preventive care, for sick visits, or tests by an independent lab or radiology group.
- A calendar year deductible applicable to specific in network care and most of-of-network care. The deductible can apply to both facility and professional care. Sections 5 (a) through 5 (h) indicated when the deductible applies.
- Members have incentives to complete an online Health Assessment and a health and wellness evaluation performed by their PCP. The member can earn a Health Credit to be applied against the calendar year deductible. Self only contract holders can earn $300 and Self and family contract holders can earn up to $700 by following the steps outlined in Section 5 (h) of this brochure. See page 69..
- A higher calendar year deductible and copay apply to out of network services.
- After satisfying the deductible, a flat dollar copay for out of network facility inpatient care.
- Mandatory Generic benefit indicating that the member is responsible for the price difference between the brand name drug and its generic equivalent as well as the copay.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (toll free) 888/789-9065 or write to us at Mail Administrator, P.O. Box 14114, Lexington, KY 40512-4114.

Where you get covered care

You get care from "Plan providers" and "Plan facilities". You will only pay copayments, deductibles and/or coinsurance if you use BlueChoice providers under both the Open Access and HealthyBlue options. If you use the point-of-service feature under HealthyBlue you can also get care from providers in other CareFirst networks as well as non-participating providers. Under HealthyBlue, this will cost you more than using our BlueChoice network. Under both BlueChoice Open Access and HealthyBlue, you are not required to obtain a referral from your primary care physician or another participating physician in our network. You are still responsible for choosing a primary care physician and returning the Selection Form to us or notifying Member Services at 888/789-9065 of your selection.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. Each member may choose his or her primary care physician from our provider directory available on our web site, carefirst.com/fedhmo.

.

- **Primary care**

Your primary care physician can be a family practitioner, general practitioner, internist, or pediatrician. Your primary care physician will provide or coordinate most of your health care.

If you want to change primary care physicians or if your primary care physician leaves the plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician may refer you to a specialist for needed care or you may go directly to a specialist without a referral. Please remember that you must contact the behavioral health vendor, Magellan (800-245-7013) for all mental health and substance abuse care, as they comprise our BlueChoice network. Under HealthyBlue, you may use other providers, but out-of-network coverage levels will apply.

Here are some other things you should know about specialty care:

- Your primary care physician will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. If your current specialist does not participate with us, you must receive treatment from a specialist who does. While HealthyBlue provides out-of-network benefits with higher out of pocket, our Open Access plan generally will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another in-network specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else. Under HealthyBlue, you may continue to see your current specialist, or see any out-of-network specialist, but your care would be paid at the out-of-network level.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause; or
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
  - reduce our service area and you enroll in another FEHB Plan,

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change and have in network benefits apply. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist at the in-network level until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (toll free) 888/789-9065. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center; or
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services.*

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, you physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

- Transplants
- Outpatient services
- Hospice care
- Skilled nursing facility
- Home health care
- Intravenous (IV)/Infusion therapy – Home IV and antibiotic therapy
- Growth hormone therapy
- Dialysis in a hospital setting
- Non-routine maternity admission rendered outside of the CareFirst Service Area and/ or by out-of- network non-participating providers require precertification under HealthyBlue.

How to request us to precertify an admission or give prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 866-773-2884 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility: and
- number of planned days of confinement.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

Under our High Open Access program, all non-emergency care received from an out-of-network provider will be the member's responsibility without prior authorization from CareFirst BlueChoice.

Under our Standard HealthyBlue option, certain services can be obtained from out-of-network providers. For services requiring prior authorization or pre-certification, refer to the "You need prior Plan approval for certain services" section on page 13.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

To file an appeal with OPM

After we reconsider your pre-service claim if you do not agree with our decision you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you see your primary care physician under the Open Access option, you pay a copayment of $25 per office visit.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of pocket costs (e.g. deductible, coinsurance, and copayment for the covered care you receive.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for those services.

HealthyBlue has a calendar year deductible of $500 per self only contract and $1,000 per self and family contract. Under the self and family contract , services for any or all members contribute to the deductible. Those services subject to the deductible are indicated in Sections 5 (a) through 5 (g). HealthyBlue members can qualify for a deductible credit of $300 per individual contract and up to $700 per family contract. Additional information on how to qualify for the deductible credit is found in section 5 (h). See page 69.

Coinsurance

Coinsurance is the percentage of our allowed benefit that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: In our Plan, you pay 25% of our allowed benefit for durable medical equipment.

Differences between our Plan's allowed benefit and bill

Our "a**llowed benefit**" is the amount we use to calculate our payment for certain types of covered services. Plans arrive at their allowances in different ways, so they may vary. For information on how we determine our allowed benefit, see the definition of allowed benefit in Section 10.

Often, the provider's bill is more than our allowed benefit. It is possible for a provider's bill to exceed the allowance by a significant amount. Whether or not you have to pay the difference will depend on the type of provider you use. BlueChoice has a network of providers who will always accept our allowed benefit. Under HealthyBlue, there are other providers contracted with CareFirst who will only bill you for the amount attributed to the deductible or the appropriate copay or coinsurance. Please check the Hearing Aid benefit for detail on when network providers may bill for balances (see page 38.)

Under HealthyBlue, non-participating providers who provide out-of-network services will bill you for any balances in excess of our allowance for covered services in addition to the appropriate deductible, copay or coinsurance amount.

Your catastrophic protection out-of-pocket maximum

Under the BlueChoice Open Access plan, once your expenses (copayments and coinsurance) total $1,900 per person or $5,500 per family in any calendar year, you do not have to pay anymore for covered services. However, copayments for the following services do not count towards your out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription drugs (See pages 63 to 65)
- External Prostheses (See pages 17, 37 and 39) and Durable medical equipment (See pages 39 and 40)

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

Under HealthyBlue, once your expenses for in-network care (copayments and deductible) total $1,900 pre self only contract or $5,500 for self and family contract, you do not have to pay anymore for covered services. All covered in-network care counts toward the catastrophic limit, The catastrophic limit for out-of network care is $3,600 per self only contract and $7,200 for self and family contract and only expenses up to our allowed benefit contribute;. any balances in excess of our allowed benefit do not contribute to the catastrophic limit and remain your liability.

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan year, we will credit the amount of covered expenses already accumulated the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits

See pages 10 and 11 for how our benefits changed this year, and for information on the new Standard HealthyBlue. Pages 94 through 97 contain the benefit summaries for both the High Open Access and the Standard HealthyBlue.

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Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center of the outpatient department of a hospital.
- We do not have a calendar year deductible under the BlueChoice Open Access program. HealthyBlue has a calendar year deductible of $500 per Self Only contract and $1,000 per Self and Family contract. The calendar year deductible applies to specific benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
Diagnostic and treatment services	**High Open Access**	**Standard HealthyBlue**
Professional services of physicians In a physician's office • Office medical consultation • Second surgical opinion • Development and Maintenance of a Care Plan by a PCMH panel provider • At home care	$25 per visit to your primary care physician $35 per visit to a specialist	In network: • No deductible • No copay for primary care physician • $35 per visit to a specialist Out-of-network: • Calendar Year deductible applies • $70 copay per visit • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
In a Plan urgent care center (see Emergency care 5(d))	$35 per visit	$35 per visit

Diagnostic and treatment services - continued on next page

Benefit Description	You pay	
Diagnostic and treatment services (cont.)	**High Open Access**	**Standard HealthyBlue**
Note: Benefit is limited to emergency services or unexpected, urgently required services.	$35 per visit	$35 per visit When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate copay.
Professional services received: - During a hospital Inpatient stay - During a facility outpatient stay - In a skilled nursing facility	Nothing	In Network: • Calendar year deductible applies • No professional copay Out of Network: • Calendar Year deductible applies • $70 copay for each professional provider per admission • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
Not covered: Test required for marriage, employment, attending schools or camp, foreign travel, or government licensing	*All charges*	*All charges*

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests	**High Open Access**	**Standard HealthyBlue**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing	In network: No charge Out-of-network: • Annual deductible applies • $70 copay • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
Preventive care, adult	**High Open Access**	**Standard HealthyBlue**
Routine physical every year which includes routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening are covered in accordance with the most recently published recommendations of the American College of Gastroenterology, in consultation with the most current American Cancer Society guidelines appropriate for age, family history and frequency. These test include: - Fecal occult blood test - Sigmoidoscopy, screening - Double contrast barium - Colonoscopy screening	Nothing	In Network: • No deductible • No copay Out of Network: • Calendar Year deductible applies • No office copay • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible.

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Open Access**	**Standard HealthyBlue**
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older in accordance with the most current American Cancer Society guidelines	Nothing	In Network: • No deductible • No copay Out of Network: • Calendar Year deductible applies • No copay • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible.
Routine Pap test A minimum of one annual pap smear, including tests performed using FDA approved gynecological cytology screening technologies, is covered. Additional medically necessary pap smear tests may be covered as determined appropriate by CareFirst BlueChoice.	Nothing	In Network: • No deductible • No copay Out of Network: • No deductible • No copay • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you will have no copay or deductible • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit.
Routine mammogram - covered for women age 35 and older, as follows: 1. From age 35 through 39, one during this five year period	Nothing	In Network: • No deductible • No copay

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Open Access**	**Standard HealthyBlue**
2. From age 40, one every calendar year	Nothing	In Network: • No deductible • No copay Out of Network: • No deductible • No copay • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you will have no deductible or copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit.
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC).	Nothing if you receive these services through a well child visit or a complete physical.	In Network: • No deductible • No copay Out of Network: • Calendar Year deductible applies • No copay • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible.
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*	*All charges*

Benefit Description	You pay	
Preventive care, children	**High Open Access**	**Standard HealthyBlue**
Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	In Network: • No deductible • No copay Out of Network: • Calendar Year deductible applies • No copay • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible.
• Well-child care charges for routine examinations, immunizations and care in accordance with the most recent guidance from the American Academy of Pediatrics. • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Ear exams through age 17 to determine the need for hearing correction	Nothing	In Network: • No deductible • No copay Out of Network: • Calendar Year deductible applies • No copay • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible.

Benefit Description	You pay	
Maternity care	**High Open Access**	**Standard HealthyBlue**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	$25 per visit to your primary care physician $35 per visit to a specialist ***Copay for routine obstetrical care is waived after the first maternity care visit.***	In Network: • No deductible for pre and post natal care • Calendar year deductible applies to delivery • No copay Out-of-Network: • Calendar Year deductible applies • No copay • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible, copay or coinsurance. ***Note: For non-routine maternity admissions, the member is responsible for obtaining authorization for services rendered outside of the Service Area and services rendered by out-of-network non-participating providers.***
Family planning	**High Open Access**	**Standard HealthyBlue**
A range of voluntary family planning services, limited to: • Voluntary sterilization - See Surgical procedures Section 5 (b) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible • No copay for primary care physician • $35 per visit to a specialist Out of Network: • Calendar Year deductible applies • $70 copay per visit

Family planning - continued on next page

Benefit Description	You pay	
Family planning (cont.)	**High Open Access**	**Standard HealthyBlue**
Note: We cover oral contraceptives under the prescription drug benefit.	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible • No copay for primary care physician • $35 per visit to a specialist Out of Network: • Calendar Year deductible applies • $70 copay per visit • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling* • *Fertility drugs for procedures excluded under this contract. See Section 5 (a) and Section 5 (f)*	*All charges*	*All charges*
Infertility services	**High Open Access**	**Standard HealthyBlue**
Diagnosis and treatment of infertility such as: • Artificial insemination: - Intravaginal Insemination (IVI) - Intracervical Insemination (ICI) - Intrauterine Insemination (IUI) Note:	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • Calendar year deductible applies • 50% coinsurance Out of Network: • Calendar Year deductible applies • 50% coinsurance

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High Open Access**	**Standard HealthyBlue**
• We cover drugs for the treatment of infertility, unless they are prescribed for procedures not covered under this plan. When covered, Injectable drugs are medical benefits, and oral drugs are benefits under prescription drug coverage. See section 5 (g). • Prior authorization for the treatment must be obtained from CareFirst BlueChoice. • Benefits are limited to six attempts per live birth. • The Member's Spouse's sperm is used. Any charges associated with the collection of the Member's Spouse's sperm will not be covered unless the Spouse is also a Member. • The Member is responsible for the Copayment or Coinsurance for AI stated in the Schedule of Benefits. • Coverage is subject to the exclusions listed in the Exclusions and Limitations Section at the end of this Description of Covered Services. • Procedure is covered if the couple has a relationship under which the FEHBP Program recognizes each partner as a spouse of the other.	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • Calendar year deductible applies • 50% coinsurance Out of Network: • Calendar Year deductible applies • 50% coinsurance • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible, copay or coinsurance. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible, copay or coinsurance.
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg.*	*All charges*	*All charges*
Allergy care	**High Open Access**	**Standard HealthyBlue**
• Testing and treatment • Allergy injections	$25 primary care physician office visit may apply $35 specialist office visit copay may apply	In Network: • No deductible • No copay for primary care physician • $35 per visit to a specialist Out of Network:

Allergy care - continued on next page

Benefit Description	You pay	
Allergy care (cont.)	**High Open Access**	**Standard HealthyBlue**
		• Calendar Year deductible applies • $70 copay per visit: • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
Allergy serum	$25 primary care office visit copay may apply $35 specialist office visit copay may apply	In Network: • No deductible • No copay for primary care physician • $35 per visit to a specialist Out of Network: • Calendar Year deductible applies • $70 copay per visit • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
Not covered: Provocative food testing and Sublingual allergy desensitization	*All charges*	*All charges*

Benefit Description	You pay	
Treatment therapies	**High Open Access**	**Standard HealthyBlue**
Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on pages 29 through 34. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. *Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Other services under You need prior Plan approval for certain services on page 13.*	$25 per visit to your primary care physician $35 per visit to a specialist Nothing if provided as part of home health services (see page 25) See Section 5 (c) for information on outpatient facility services.	In Network: • No deductible • No copay for primary care physician • $35 per visit to a specialist Out of Network: • Calendar Year deductible applies • $70 copay per visit: • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
Physical, Occupational, and Speech therapies	**High Open Access**	**Standard HealthyBlue**
Up to 60 visits (combined physical, occupational and/or speech therapy) per condition per benefit period for the services of the following qualified providers: • Physical therapists • Occupational therapists • Speech therapists Note: Coverage shall include Physical Therapy, Occupational Therapy and Speech Therapy for the treatment of individuals who have sustained an illness or injury that CareFirst BlueChoice determines to be subject to improvement	$35 per visit to a specialist visit Nothing during a covered inpatient admission See section 5 (c) for outpatient facility services.	In Network: • No deductible • $35 per visit to a specialist Out of Network: • Calendar Year deductible applies • $70 copay per visit: • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay.

Physical, Occupational, and Speech therapies - continued on next page

Benefit Description	You pay	
Physical, Occupational, and Speech therapies (cont.)	**High Open Access**	**Standard HealthyBlue**
Note: Occupational Therapy is limited to the use of purposeful activity or interventions designed to achieve functional outcomes that promote health, prevent injury or disability, and that develop, improve, sustain or restore the highest possible level of independence of an individual. Brochure language also states under member liability: • Other than any applicable inpatient or outpatient facility copay, member has no copay or coinsurance during an approved inpatient stay.	$35 per visit to a specialist visit Nothing during a covered inpatient admission See section 5 (c) for outpatient facility services.	In Network: • No deductible • $35 per visit to a specialist Out of Network: • Calendar Year deductible applies • $70 copay per visit: • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Maintenance therapy*	*All charges*	*All charges*
Cardiac Rehabilitation	**High Open Access**	**Standard HealthyBlue**
• Up to 90 visits per condition per benefit period Note: Cardiac Rehabilitation benefits are provided to Members who: • have been diagnosed with significant cardiac disease, • suffered a myocardial infarction • undergone invasive cardiac treatment immediately preceding referral Service must be pre-approved and provided at a CareFirst BlueChoice approved place of service See section 5 (c) for outpatient facility services.	$35 per visit to a specialist visit Nothing during a covered inpatient admission.	In Network: • No deductible • $35 per visit to a specialist Out of Network: • Calendar Year deductible applies • $70 copay per visit: • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay.

Cardiac Rehabilitation - continued on next page

Benefit Description	You pay	
Cardiac Rehabilitation (cont.)	**High Open Access**	**Standard HealthyBlue**
		• When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
Note: Benefits are not provided for maintenance cardiac rehabilitation	*All charges*	*All charges*
Pulmonary Rehabilitation	**High Open Access**	**Standard HealthyBlue**
Pulmonary Rehabilitation • For those who have significant pulmonary disease or who have undergone certain surgical procedures of the lung. • Limited to one (1) pulmonary rehabilitation program per lifetime. • *Benefits are not provided for maintenance programs* See section 5 (c) for outpatient facility services.	$25 primary care copay $35 Specialist copay $50 hospital outpatient facility copay	In Network: • No deductible • $35 per visit to a specialist Out of Network: • Calendar Year deductible applies • $70 copay per visit: • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
Habilitative therapy	**High Open Access**	**Standard HealthyBlue**
Habilitative Services are services, including Occupational Therapy, Physical Therapy, and Speech Therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. Benefits for Habilitative Services will be provided for: • Children under the age of 21 year; and	$35 per visit to a specialist visit Nothing during a covered inpatient admission	In Network: • No deductible • $35 per visit to a specialist Out of Network: • Calendar Year deductible applies • $70 copay per visit

Habilitative therapy - continued on next page

Benefit Description	You pay	
Habilitative therapy (cont.)	**High Open Access**	**Standard HealthyBlue**
• Include Occupational Therapy, Physical Therapy, and Speech Therapy. Benefits are subject to the applicable Occupational Therapy, Physical Therapy, and Speech Therapy co-payment, but are not counted toward any visit maximum for therapy services. See section 5 (c) for outpatient facility services.	$35 per visit to a specialist visit Nothing during a covered inpatient admission	In Network: • No deductible • $35 per visit to a specialist Out of Network: • Calendar Year deductible applies • $70 copay per visit • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay. ***Note: Member is responsible for obtaining authorization for services rendered outside of the Service Area and services by out-of-network no-participating providers.***
Benefits are not covered for Habilitative Services delivered through early intervention or school services. Prior authorization is required.	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**High Open Access**	**Standard HealthyBlue**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D. D.O, or audiologist *Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) Preventive care.*	$35 Specialist copay per visit	In Network: • No deductible • $35 per visit to a specialist Out of Network: • Calendar Year deductible applies • $70 copay per visit:

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay	
Hearing services (testing, treatment, and supplies) (cont.)	**High Open Access**	**Standard HealthyBlue**
		• When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aid (BAHA) and cochlear implants. *Note: For benefits for the devices, see Section 5(a) Orthopedic and prosthetic devices.*		
Not covered: • *Hearing services that are not shown as covered.*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Open Access**	**Standard HealthyBlue**
• One pair of eyeglasses or contact lenses to correct an impairment directly related to intraocular surgery (such as for cataracts) Note: This is a medical benefit not a vision benefit.	$25 per visit to your primary care physician $35 per visit to a specialist Nothing for the eyeglasses for the first pair after covered surgery for medical condition.	In Network: • No deductible • No copay for primary care physician • $35 per visit to a specialist Out of Network: • Calendar Year deductible applies • $70 copay per visit: • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay.

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay	
Vision services (testing, treatment, and supplies) (cont.)	**High Open Access**	**Standard HealthyBlue**
		• When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
• Annual eye exams Note: See *Preventive care, children* for eye exams for children	$10 per visit to an optometrist or ophthalmologist	In Network: • No deductible • $10 per visit to for Davis Vision Providers • $35 per visit to a specialist Out of Network: • Plan pay $33 dollars and member pays the balance.
Not covered: • *Eyeglasses or contact lenses (except as listed above)* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*
Foot care	**High Open Access**	**Standard HealthyBlue**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible • No copay for primary care physician • $35 per visit to a specialist Out of Network: • Calendar Year deductible applies • $70 copay per visit: • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay.

Foot care - continued on next page

Benefit Description	You pay	
Foot care (cont.)	**High Open Access**	**Standard HealthyBlue**
		• When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
Not covered: • *Other routine palliative or cosmetic care of the feet including flat foot conditions, supportive devices for the foot, treatment of sublaxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, week feet, chronic foot strain, and symptomatic complaints of the feet.*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Open Access**	**Standard HealthyBlue**
- Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy. - Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. - Hair Prosthesis (wig) is covered when prescribed by a treating oncologist and the hair loss is the result of chemotherapy. The Plan will cover up to $350 for one hair prosthesis per benefit period. - Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants. - Internal prosthetic devices such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Notes: For information on the professional charges for the surgery to insert an implant. See Section 5(b) Surgical procedures. For information on the hospital and or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance service. Note: Externally worn prosthetics and devices are treated as Durable Medical Equipment (DME). See page 39.	$25 per visit to your primary care physician $35 per visit to a specialist Nothing for hair prostheses for hair loss due to chemotherapy up to the specified limit. Note: Copays apply to professional services not to the devices.	In Network: • No deductible • $35 per device Out of Network: • Calendar Year deductible applies • $70 per device • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**High Open Access**	**Standard HealthyBlue**
Hearing Aids One Medically Necessary Hearing aid per ear is covered up to our allowed amount each 36 months. Medical devices, such as bone anchored hearing aids (BAHA) and cochlear implants, that are surgically implanted have no separate copay and are included in the facility copay or surgical allowance, dependent on who bills for the device.	Providers may bill for services related to external hearing aids for an amount in excess of our allowance if they provide written advance notice.	In Network: • Calendar year deductible applies • Paid to our allowed benefit with no copay • Provider may bill for services in excess of our allowance with written advance notice Out of Network: • Calendar year deductible applies • Paid to our allowed benefit with no copay • Provider may bill any amount in excess of our allowance. Participating providers will advise you in writing in advance if you will have a balance.
Not covered: • *Orthopedic and corrective shoes* • *Arch supports, heel pads, and heel cups (except as listed under Durable Medical Equipment)* • *Foot orthotics (except as listed under Durable Medical Equipment).* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Wigs, including cranial prostheses, unless otherwise specified* • *Prosthetic replacements provided less than 3 years after the last one we covered* • *Prosthetic devices such as artificial limbs and lenses following cataract removal unless covered under the DME benefit (see Durable Medical Equipment below)* • *Prosthetic replacements provided less than 3 years after the last one we covered.*	*All charges*	*All charges*

Benefit Description	You pay	
Durable medical equipment (DME)	**High Open Access**	**Standard HealthyBlue**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Canes • Diabetic shoes • Commodes • Glucometers • Suction machines • Medical supplies (i.e. ostomy and catheter supplies, dialysis supplies, medical foods for inherited metabolic diseases and inborn deficiencies of amino acid metabolism) • Externally worn non-surgical durable devices which replace a body part or assist a patient in performing a bodily function (unless otherwise described in the "orthopedic and prosthetic devices" section above) • Externally worn braces which improve the function of a limb • Medically Necessary molded foot orthotics • Medically Necessary fitted compression stockings *Note:*	25% coinsurance up to allowed benefit. Services do not contribute to the Catastrophic limit.	In Network: • Deductible applies • $35 copay per device Out of Network: • Calendar Year deductible applies • $70 copay per device • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay. *Note: Services do contribute to the catastrophic limit.*
Not covered: • *Eye glasses and contact lenses (except as listed under Vision Services)* • *Dental prosthetics (except as listed under Orthopedic and Prosthetics above)* • *Environment control products* • *Over the counter orthotics* • *Over the counter compression stockings* • *Medical equipment of an expendable nature (i.e. ace bandages, incontinent pads)*	*All charges*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**High Open Access**	**Standard HealthyBlue**
• *Replacement of DME equipment not due to normal wear and tear* • *Comfort and convenience items* • *Over the counter items, except as listed above* • *Exercise equipment* • *Equipment that can be used for non-medical purposes*	*All charges*	*All charges*
Home health services	**High Open Access**	**Standard HealthyBlue**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	Nothing	In Network: • Calendar year deductible applies • $35 per visit copay Out of Network: • Calendar year deductible applies • $70 copay per visit • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*	*All charges*

Benefit Description	You pay	
Chiropractic	**High Open Access**	**Standard HealthyBlue**
Chiropractic services, limited to spinal manipulation, evaluation, and treatment up to a maximum of 20 visits per calendar year benefit period when provided by a Plan chiropractor. *Benefits are limited to those aged 12 or older.*	$35 per visit to a specialist	In Network: • No deductible • $35 per visit to a specialist Out of Network: • Calendar Year deductible applies • $70 copay per visit • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
Not covered: *Services other than for musculoskeletal conditions of the spine.*	*All charges*	*All charges*
Alternative treatments	**High Open Access**	**Standard HealthyBlue**
Acupuncture – by a doctor of medicine or osteopathy for: • anesthesia • pain relief	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible • $35 per visit to a specialist Out of Network: • Calendar Year deductible applies • $70 copay per visit: • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay.

Alternative treatments - continued on next page

Benefit Description	You pay	
Alternative treatments (cont.)	**High Open Access**	**Standard HealthyBlue**
		• When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback*	*All charges*	*All charges*
Educational classes and programs	**High Open Access**	**Standard HealthyBlue**
Coverage is provided for: • Diabetes self-management (Sponsored by the Plan's Health Education Department) • Tobacco programs, including individual group telephone counseling, drugs approved by the FDA to treat tobacco dependence. (All medications will require a prescription to be covered, to include those that are available over the counter), • Prescribed medications approved by the FDA to treat tobacco dependence will be covered in full under the pharmacy benefit. See page 63. • Childhood obesity as part of routine child care visit • Birthing classes	Nothing Nothing for counseling for up to two quit attempts per year.	In Network: • No deductible • No copay Out of Network: • Calendar Year deductible applies • No copay • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible.
Other Education Classes conducted by approved providers for: • Diabetes self management • Childhood obesity education • Medically necessary nutrition therapy • Medically necessary professional nutritional counseling	$25 primary care copay $35 Specialist copay $50 hospital outpatient facility copay	In Network: • No deductible • No copay for Primary Care • $35 copayment outpatient facility copay Out of Network:

Educational classes and programs - continued on next page

Benefit Description	You pay	
Educational classes and programs (cont.)	**High Open Access**	**Standard HealthyBlue**
		• Calendar Year deductible applies • $70 copay for Professional or Facility Care • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
Note: *Benefits for all other types of health Education classes and self-help programs that are not part offered through the Plan's Health Education program are not covered.*	*All charges.*	*All charges*

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We do not have a calendar year deductible under the BlueChoice Open Access program. HealthyBlue has a calendar year deductible of $500 per Self Only contract and $1,000 per Self and Family contract. The calendar year deductible applies to specific benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require preservation and identify which surgeries require precertification.

Benefit Description	You pay	
Surgical procedures	**High Open Access**	**Standard HealthyBlue**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) Note: You must meet certain criteria to be eligible for bariatric surgery. They include: • A body mass index that is greater than 40 kilograms per meter squared; or • Equal to or greater than 35 kilograms per meter squared with a co-morbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility Out of Network: • Calendar Year deductible applies • $70 copay per office visit • $70 physician copay while an inpatient or outpatient in a facility if the physician's services are not billed as part of the facility bill.

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Open Access**	**Standard HealthyBlue**
Please contact Member Services at 888/789-9065 for more details on bariatric surgery. • Insertion of internal prosthetic devices. See 5 (a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. No additional copay is required for internal prostheses (devices). Note: See Section 5(c) about possible outpatient facility or inpatient hospital admission copayment	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility Out of Network: • Calendar Year deductible applies • $70 copay per office visit • $70 physician copay while an inpatient or outpatient in a facility if the physician's services are not billed as part of the facility bill. • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*	*All charges*

Benefit Description	You pay	
Reconstructive surgery	**High Open Access**	**Standard HealthyBlue**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Note: See Section 5(c) about possible outpatient facility or inpatient hospital admission copayment	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility Out of Network: • Calendar Year deductible applies • $70 copay per office visit • $70 per physician per admission while an inpatient or outpatient in a facility if the physician's services are not billed as part of the facility bill. • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*	*All charges*

Benefit Description	You pay	
Oral and maxillofacial surgery	**High Open Access**	**Standard HealthyBlue**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and Other surgical procedures that do not involve the teeth or their supporting structures. Note: See Section 5(c) about possible outpatient facility or inpatient hospital admission copayment	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility Out of Network: • Calendar Year deductible applies • $70 copay per office visit • $70 per physician per admission while an inpatient or outpatient in a facility if the physician's services are not billed as part of the facility bill. • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Removal of impacted teeth*	*All charges*	*All charges*

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay	
Oral and maxillofacial surgery (cont.)	**High Open Access**	**Standard HealthyBlue**
• *Any other dental surgery not listed or the result of traumatic injury or treatment of cleft pallet*	*All charges*	*All charges*
Organ/tissue transplants	**High Open Access**	**Standard HealthyBlue**
These **solid organ transplants** are subject to medical necessity and experimental/ investigational review by the plan. Refer to Other services in Section 3 for prior authorization procedures. • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas • Kidney • Liver • Lung single/bilateral • Pancreas These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to other services in Section 3 for prior authorization procedure. • Autologous tandem transplant for - AL Amyloidosis - Multiple myeloma (de movo and treated) - Recurrent germ cell tumors (including testicular cancer) Note: See Section 5(c) about possible outpatient facility or inpatient hospital admission copayment	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility Out of Network: • Calendar Year deductible applies • $70 copay per office visit • $70 per physician per admission while an inpatient or outpatient in a facility if the physician's services are not billed as part of the facility bill. • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Open Access**	**Standard HealthyBlue**

Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.
 	
Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant.
• Autologous transplants for
  • Advanced Childhood kidney cancers
  • Advanced Ewing sarcoma
  • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia
  • Advanced Hodgkin's lymphoma with reoccurrences (relapsed)
  • Advanced non-Hodgkin's lymphoma with reoccurrences (relapsed)
  • Amyloidosis
  • Breast Cancer (limited to clinical trials)
  • Childhood rhabdomyosarcoma
  • Ependymoblastoma
  • Epithelial ovarian cancer (limited to clinical trials)
  • Ewing's sarcoma
  • Mantle Cell (Non-Hodgkin Lymphoma)
  • Multiple myeloma
  • Medulloblastoma
  • Pineoblastoma
  • Neuroblastoma
  • Testicular Mediastinal, Retroperitoneal, and ovarian germ cell tumors
	$25 per visit to your primary care physician
	
	$35 per visit to a specialist
		In Network:
		• No deductible for office care
		• Deductible applies to care received while an outpatient or inpatient in a facility
		• No copay for primary care physician in the office
		• $35 per office visit to a specialist
		• No professional copay while an inpatient or outpatient in a facility
		
		Out of Network:
		• Calendar Year deductible applies
		• $70 copay per office visit
		• $70 per physician per admission while an inpatient or outpatient in a facility if the physician's services are not billed as part of the facility bill.
		• When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay.
		• When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Open Access**	**Standard HealthyBlue**
Mini-transplants performed in a clinical trial setting (non-myeloblative reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan Refer to *Other Services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPD's) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e. Fanconi's PNH. Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Noctumal Hemoglobimuria - Severe combined immunodeficiency - Sever or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i. e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Neuroblastoma Note: See Section 5c about possible outpatient facility or inpatient hospital admission copayment	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility Out of Network: • Calendar Year deductible applies • $70 copay per office visit • $70 per physician per admission while an inpatient or outpatient in a facility if the physician's services are not billed as part of the facility bill. • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Open Access**	**Standard HealthyBlue**
These blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for: - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Multiple myeloma - Multiple scleraes • Mini-transplants (nonmyeloablative allogenic transplants, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small cell lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MSDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility Out of Network: • Calendar Year deductible applies • $70 copay per office visit • $70 per physician per admission while an inpatient or outpatient in a facility if the physician's services are not billed as part of the facility bill. • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Open Access**	**Standard HealthyBlue**
- Renal cell carcinoma - Sickle Cell Disease • Autologous Transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast Cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Small cell lung cancer • National Transplant Program (NTP) Note: We cover related medical and hospital expenses of the donor when we cover the recipient who is not covered by other insurance. We cover donor testing for the actual solid organ donor or up to four bone marrow/ stem cell transplant donors in addition to the testing of family member. Note: See Section 5c about possible outpatient facility or inpatient hospital admission copayment	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility Out of Network: • Calendar Year deductible applies • $70 copay per office visit • $70 per physician per admission while an inpatient or outpatient in a facility if the physician's services are not billed as part of the facility bill. • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*

Benefit Description	You pay	
Anesthesia	**High Open Access**	**Standard HealthyBlue**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility Out of Network: • Calendar Year deductible applies • $70 copay per office visit • $70 per physician per admission while an inpatient or outpatient in a facility if the physician's services are not billed as part of the facility bill. • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We do not have a calendar year deductible under the BlueChoice Open Access program. HealthyBlue has a calendar year deductible of $500 per Self Only contract and $1,000 per Self and Family contract. The calendar year deductible applies to specific benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
Inpatient hospital	**High Open Access**	**Standard HealthyBlue**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$ 200 per admission copayment.	In Network: • Calendar year deductible applies • $200 per admission copay Out-of-network: • Calendar year deductible applies • $500 per admission copay • If member chooses an out-of-network facility without prior approval, the member will be responsible for any amount in excess of our allowed benefit. If the admission is urgent or a medical emergency, the member will only be responsible for the per admission copay.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services	Nothing	Nothing

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Open Access**	**Standard HealthyBlue**
• Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Acute Inpatient Rehabilitation • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home. *Note: Hospitalization solely for Acute Rehabilitation is limited to 90 days per calendar year.*	Nothing	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care, except when medically necessary*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Open Access**	**Standard HealthyBlue**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Professional services, such as those listed in sections 5 (a), that are the sole service and billed by the hospital. Examples include, but are not limited to, covered education classes, physical therapy and cardiac rehabilitation.	$50 per outpatient visit	In Network: • Calendar year deductible applies • $35 per visit copay Out-of-network: • Calendar year deductible applies • $70 per admission copay • Non-participating facilities may bill the member for any amount in excess of our allowed benefit.

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay	
Outpatient hospital or ambulatory surgical center (cont.)	**High Open Access**	**Standard HealthyBlue**
Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$50 per outpatient visit	In Network: • Calendar year deductible applies • $35 per visit copay Out-of-network: • Calendar year deductible applies • $70 per admission copay • Non-participating facilities may bill the member for any amount in excess of our allowed benefit.
Extended care benefits/Skilled nursing care facility benefits	**High Open Access**	**Standard HealthyBlue**
If a Plan doctor determines that you need full-time skilled nursing care or need to stay in a skilled nursing facility, and we approve that decision, we will give you the comprehensive range of benefits with no dollar or day limit. • Bed, board, and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	Nothing	In Network: • Calendar year deductible applies • No per admission copay Out-of-network: • Calendar year deductible applies • $70 per admission copay • If member chooses an out-of-network facility without prior approval, the member will be responsible for any amount in excess of our allowed benefit. If the admission is urgent or a medical emergency, the member will only be responsible for the per admission copay.
Not covered: Custodial care	*All charges*	*All charges*
Hospice care	**High Open Access**	**Standard HealthyBlue**
If terminally ill, you are covered for supportive and palliative care in your home or at a hospice. This includes inpatient and outpatient care and family counseling. A Plan doctor, who certifies that you are in the terminal stages of illness, with a life expectancy of approximately six months or less, will direct these services. Respite Care is limited to 3 periods of 48 hours during the Hospice Eligibility Period. Bereavement Services are provided for up to 3 visits during the 90 days following the patient's death.	Nothing	In Network: • Calendar year deductible applies • $35 copay per visit Out-of-network: • Calendar year deductible applies • $70 per copay per visit

Hospice care - continued on next page

Benefit Description	You pay	
Hospice care (cont.)	**High Open Access**	**Standard HealthyBlue**
		• If member chooses an out-of-network facility without prior approval, the member will be responsible for any amount in excess of our allowed benefit. If the admission is urgent or a medical emergency, the member will only be responsible for the per admission copay.
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*
Ambulance	**High Open Access**	**Standard HealthyBlue**
• Local professional ambulance service when medically appropriate • Air Ambulance Service when medically appropriate	Nothing	In Network • Calendar year deductible does not apply • $50 per trip Out-of-Network • Calendar year deductible does not apply • $50 per trip • Non-participating providers may bill the member for the amount in excess of our allowed benefit..

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- CareFirst Blue Choice Open Access has no calendar year deductible; Healthy Blue has a calendar year deductible that may apply to certain services.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Benefits are provided for emergency services that you obtain when you have acute symptoms of sufficient severity-including severe pain-such that a prudent layperson who possesses average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention would result in serious jeopardy to the person's health, serious impairment of bodily function, serious dysfunction of any bodily organ or part, or with respect to a pregnant woman, serious jeopardy to the health of the woman and/or her unborn child.

If you experience a medical emergency, you should call 911 or go directly to the nearest emergency facility. No authorization is needed for you to receive emergency services. Be sure to tell the workers in the emergency room that you are a Plan member so they can notify the Plan.

Urgent Care

An urgent condition is a condition that is not a threat to your life, limbs, or bodily organs, but does require prompt medical attention.

For urgent situations, please call your primary care physician. If your PCP is unavailable, call FirstHelp at 800/535-9700 and a registered nurse will give you health care advice.

Emergencies inside our service area:

You are encouraged to seek care from Plan providers in cases of accidental injury or medical emergency. However, if you need care immediately and cannot access a Plan provider, we will provide benefits for the initial treatment provided in the emergency room of the hospital, even if the hospital is not a plan hospital. If you need to stay in a facility our plan does not designate (a non-Plan facility), you must notify the Plan at 800/367-1799 or 202/646-0090 within 48 hours or on the first working day after the day they admitted you, unless you cannot reasonably do so. If you stay in a non-Plan facility and a Plan doctor believes that a Plan hospital can give you better care, then the facility will transfer you when medically feasible and we will fully cover any ambulance charges.

For this Plan to cover you, only Plan-providers can give you follow-up care that the non-Plan providers recommend.

Emergencies outside our service area:

- We will provide benefits for any medically necessary health service that you require immediately because of injury or unforeseen illness.

- If you need to stay in a medical facility, you must notify the Plan at 800/367-1799 or 202/646-0090 within 48 hours or on the first working day after the date they admit you, unless not reasonably possible to do so. If a Plan doctor believes a Plan hospital can give you better care, then the facility will transfer you when medically feasible, and we will fully cover any ambulance charges.
- For this Plan to cover you, Plan providers must provide any of the follow-up care that non-Plan providers may recommend to you.

Benefit Description	You pay	
Emergency within our service area	**High Open Access**	**Standard HealthyBlue**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, *Note: If emergency room and treating physician bill separately, both copays will apply*	$25 per visit to your primary care physician $35 per visit to a specialist $100 per non-participating urgent care center visit; $35 per participating urgent care center visit $100 per hospital emergency room visit	In Network: • Calendar year deductible does not apply • No copay for care in the office of a primary care provider • $35 copay in a specialist's office or a provider bills separate from a facility • $50 copay in an Urgent Care Center • $100 Emergency Room copay Out-of-network: • Calendar year deductible does not apply • $35 copay in a specialist's office or a provider bills separate from a facility • $50 copay in an Urgent Care Center Emergency Room copay • $100 Emergency Room copay Non-participating providers may charge you for the amount in excess of our allowed benefit.
Not covered: Elective care or non-emergency care	*All charges*	*All charges*
Emergency outside our service area	**High Open Access**	**Standard HealthyBlue**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services	$25 Primary Care/$35 Specialist, per office visit $100 per hospital emergency room or urgent care center visit. *Note: If emergency room and treating physician bill separately, both copays will apply*	In Network: • Calendar year deductible does not apply • No copay for care in the office of a primary care provider • $35 copay in a specialist's office or a provider bills separate from a facility • $50 copay in an Urgent Care Center

Emergency outside our service area - continued on next page

Benefit Description	You pay	
Emergency outside our service area (cont.)	**High Open Access**	**Standard HealthyBlue**
		• $100 Emergency Room copay Out-of-network: • Calendar year deductible does not apply • $35 copay in a specialist's office or a provider bills separate from a facility • $50 copay in an Urgent Care Center Emergency Room copay • $100 Emergency Room copay No-participating providers may bill you for any amount in excess of our allowance.
Ambulance	**High Open Access**	**Standard HealthyBlue**
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	Nothing	In Network: • Calendar year deductible does not apply • $50 copay Out-of-network: • Calendar year deductible does not apply • $50 copay Non-participating providers may bill you for any amount in excess of out allowance.
Not covered: Air ambulance, unless medically necessary	*All charges*	*All charges*

Section 5(e). Mental health and substance abuse benefits

Cost-sharing and limitations for Plan mental health and substance abuse benefits will be not greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We do not have a calendar year deductible under the BlueChoice Open Access program. HealthyBlue has a calendar year deductible of $500 per Self Only contract and $1,000 per Self and Family contract. The calendar year deductible applies to specific benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS. Please refer to Section 3 for more information about precertification.
- We administer mental health and substance abuse benefits under a contract with Magellan Behavioral Health (or another vendor we determine). If you think you need mental health or substance abuse services you must first call Magellan at 800/245-7013. If you need treatment, Magellan will refer you to one of their network providers. Magellan must coordinate all mental health and substance services, not your primary care doctor.

Benefit Description	You pay	
Mental health and substance abuse benefits	**High Open Access**	**Standard HealthyBlue**
• Outpatient and office Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Outpatient and office Medication management	$25 professional office copay	In Network: • Calendar year deductible does not apply • No office copay Out-of-network: • Calendar year deductible applies • $70 copay • Non-participating providers will bill the member for any charges in excess of our allowed amount.
Diagnostic tests	Nothing	*Nothing*
Inpatient services provided by a hospital or other facility	$200 per admission copayment	In Network • Calendar Year deductible applies • $200 per admission copay Out-of-network • Calendar year deductible applies

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay	
Mental health and substance abuse benefits (cont.)	**High Open Access**	**Standard HealthyBlue**
		• $500 per admission copay apples • Non-participating facilities may bill the member for any charges in excess of our allowed benefit.
Outpatient facility treatment Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment.	$50 per visit *Note: Professional services billed in addition to outpatient facility services will be subject to the professional office copay.*	In Network: • Calendar year deductible does not apply • No per vsit copay Out-of-network: • Calendar year deductible applies • $70 copay • Non-participating providers will bill the member for any charges in excess of our allowed amount.
Not covered: • *Inpatient admissions not precertified through Case Management* • *Care determined not to meet medically accepted levels of care.*	*All charges*	*All charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We do not have a calendar year deductible under the BlueChoice Open Access Option, and the calendar year deductible does not apply to prescription drugs under the HealthyBlue option.

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription**. A licensed physician or other authorized prescriber must write the prescription.
- **Where you can obtain them**. You may fill the prescription at a Plan pharmacy, or by mail. You may contact Argus at 800/241-3371 to get more information on the mail order service through Wal-Green.
- **We use a formulary**. A formulary is a preferred list of drugs that we selected to meet patient needs at a lower cost. The formulary includes both generic and brand name drugs. You will be responsible for higher charges if your doctor prescribes a drug not on our formulary list. However, non-formulary drugs will be covered when prescribed by a Plan doctor.
- **We have an open formulary**. If your provider believes a name brand product is necessary or there is no generic available, a name brand drug from a formulary list may be prescribed. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call Argus at 800-241-3371.
- **These are the dispensing limitations.** You can receive up to 34 days worth of medication for each fill of prescriptions at a local Plan pharmacy. In addition, you can receive up to 90 days of medications through our mail order pharmacy program or through a local pharmacy, but will pay 3 copays at a retail pharmacy and 2 copays through mail order. Your copay will be $0, $30, or $50 for a 34-day supply or less at the retail pharmacy and twice that amount for 35-day supply or greater up to 90 days by mail. You can purchase the same prescriptions through the mail order service that can be purchased through your community pharmacy. In most cases, you can get a refill once you have taken 75% of the medication. Your prescription will not be refilled prior to the 75% usage guidelines. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. Certain drugs require clinical prior authorization. Contact the Plan for a listing of which drugs are subject to the prior authorization policy. Prior authorization may be initiated by the Prescriber or the pharmacy by calling Argus at 800/241-3371 (or other vendor as determined by the Plan).
- **Why use generic drugs?** A generic drug is the chemical equivalent of a corresponding brand name drug dispensed at a lower cost. You can reduce your out-of-pocket expenses by choosing a generic drug over a brand name drug.
- **When you do have to file a claim.** Call our preferred drug vendor, Argus, at 800/241-3371 to order prescription drug claim forms. You will send the prescription drug claim form to: Argus Health Systems, PO Box 419019 Kansas City, MO 64141.

Benefit Description	You pay	
Covered medications and supplies	**High Open Access**	**Standard HealthyBlue**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (Subject to dosage limitations. Contact us for these limitations.) • Contraceptive drugs and devices • Diabetic supplies including insulin syringes, needles, glucose test strips, lancets, and alcohol swabs • Allergy serum Notes: • Intravenous fluids and medications for home use, implantable drugs (such as Norplant), some injectable drugs (such as Depo Provera), and IUDs are covered under the Medical and Surgical Benefits. • Injectable coverage will be limited to those medications that are usually self-injected. • Glometers are covered as Durable Medical Equipment under the Medical and Surgical Benefits. See page 39.	Retail: $0 per unit or refill for generic prescriptions $30 per unit or refill for prescriptions on our formulary brand name list $50 per unit or refill for all other prescriptions Mail order: $0 per 90-day supply for mail order generic prescriptions $60 per 90-day supply for mail order prescriptions on our formulary brand name list $100 per 90-day supply for all other mail order prescriptions Notes: • If there is no generic equivalent available, you will still have to pay the brand name copay. • If a drug is available in generic, and your physician has not indicated "Do not substitute" or "Dispense as written on the prescription, you will be responsible for the price difference between brand named drugs and their generic equivalent as well as the tier 2 or tier 3 copay.	Retail: $0 per unit or refill for generic prescriptions $30 per unit or refill for prescriptions on our formulary brand name list $50 per unit or refill for all other prescriptions Mail order: $0 per 90-day supply for mail order generic prescriptions $60 per 90-day supply for mail order prescriptions on our formulary brand name list $100 per 90-day supply for all other mail order prescriptions Notes: • If there is no generic equivalent available, you will still have to pay the brand name copay. • If a drug is available in generic, you will be responsible for the price difference between brand named drugs and their generic equivalent as well as the tier 2 or tier 3 copay.
Smoking deterrents Note: Medications approved by the FDA to treat tobacco dependence are covered under the tobacco cessation benefits and dispensed under our pharmacy program. To be covered, the medications must be prescribed by a physician, even if it is available over-the-counter. See page 42.	Nothing up to two attempts per year	Nothing up to two attempts per year
The following prescription drugs are covered in full: • Prenatal vitamins for women during pregnancy are covered in full. • Fluoride will be paid for children older than 6 months of age whose primary water source is deficient in fluoride.	Nothing	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Open Access**	**Standard HealthyBlue**
• Iron supplements for asymptomatic children aged 6 to 12 months who are at increased risk of iron deficiency anemia • Chemotherapy medications received through a pharmacy. Please refer to our website *carefirst.com/fedhmo* for any updates to this list and for additional information on how these items are covered.	Nothing	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Medical supplies such as dressings and antiseptics* • *Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them, except as listed above* • *Nonprescription medicines* • *Drugs for weight loss* • *Drugs to treat infertility and related to procedures excluded under this contract (see Section 5 (a) and Section 5 (f).*	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHBP Plan will be First Primary payor of any Benefit payment and your FEDVIP Plan is secondary to your FEHBP Plan, See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We do not have a calendar year deductible under the BlueChoice Open Access program. HealthyBlue has a calendar year deductible of $500 per Self Only contract and $1,000 per Self and Family contract. The calendar year deductible applies to specific benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
Accidental injury benefit	**High Open Access**	**Standard HealthyBlue**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible • No copay for primary care physician • $35 per visit to a specialist Out of Network: • Calendar Year deductible applies • $70 copay per visit • When seeing providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay. • When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
We have no other dental benefits	*All charges*	*All charges*

Section 5(h). Special features

Feature	Description
Feature	**High Option**
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may disputed our regular contract benefits decision under the OPM disputed claim process (see Section 8).
24-hour nurse line	If you have any health concerns, call FirstHelp at 800-535-9700, 24 hours a day, 7 days a week and talk with a registered nurse who will discuss treatment options and answer your health questions.
Care Team Program	We provide programs for members diagnosed with coronary artery disease, congestive heart failure, diabetes, cancer, asthma and other chronic conditions. These programs are designed to help you better understand and manage your condition. Our Care Team Program benefits may include: • Educational materials, such as self-monitoring charts, resource listings, self-care tips, and a quarterly newsletter • A health assessment and nurse consultation • Access to a 24-hour Nurse Advisor help line Please call us at 800/783-4582 for more information about our Care Team Program

Feature - continued on next page

Feature	Description
Feature (cont.)	**High Option**
Guest membership	If you or one of your covered family member move outside of our service area for an extended period of time (for example, if your child goes to college in another state), you may be able to take advantage of our Guest Membership Program. This program would allow you or your dependents the option to utilize the benefits of an affiliated BlueCross BlueShield HMO. Please contact us at 888/452-6403 for more information on the Guest Membership Program.
CareFirst.com **Visit our expanded web option**	***My Account*** This tool gives members access to their claims and benefit eligibility information when they log in to the secure, password-protected site. Each covered member over the age of 14 may create his or her own user ID and password. After creating a password, members can: • View who is covered under their contract • Current and historical claims status • Order a new ID card Additional features include: • Drug pricing tool • Hospital comparison tool • Treatment cost estimator • Provider Directory with special information • Health Risk Assessment ***My CareFirst*** This is our member health and wellness section. Here you can find: • Health Library of Medical Conditions • Health Lifestyle Section-Nutrition, Fitness, etc. • Personal Health page, with tracking tools and assistance setting health and wellness goals.
Telephonic Health Coaching	The healthy lifestyle coaching program fills a void between healthy employees and those who suffer from chronic diseases. Employees who are at high risk for future disease as identified by MyHealthProfile are invited to participate in healthy lifestyle coaching sessions. These are scheduled phone conversations where employees develop a relationship with a clinician (health coach) trained in Motivational Interviewing and in Behavior Change Theory. The health coach identifies a number of factors including the employee's existing barriers to change and their readiness to change. The health coach then helps the employee set achievable short-term and long-term goals so they can make a permanent change in health behavior.

Feature - continued on next page

Feature	Description
Feature (cont.)	**High Option**
Healthy Reward	Under HealthyBlue, you can earn a Healthy Reward for $300 per individual contract or up to $700 on **a** family contract. This reward is used to reduce your calendar year deductible, and could reduce your liability to $200 per individual contract and $300 for a family. To earn the Healthy Reward you must complete the following steps: • Choose a Primary Care Physician (PCP) • Complete the online Health Assessment (Adult 18+ only)* • Follow the steps to complete the electronic signature on the Consent Authorization form included with the Health Assessment (Adult 18+ only)* • Work with your PCP to complete the Health and Wellness Evaluation Form • Return the Health and Wellness Evaluation form to CareFirst. • Complete all steps within 120 days (4 months) of your effective date Credits are accumulated at the rate of $300 per adult member and $25 per minor dependent up to a family maximum of $700. The Health and Wellness Evaluation Form can be returned to us in any of the following ways: • Upload the information in the My Account section of CareFirst.com/fedhmo on the Manage My Health tab. • Scan as a JPG, PDF or TIFF form and upload through the Manage My Health tab. • Fax to 800-354-8205 • Mail to: - Mail Administrator - P.O. Box 14116 - Lexington, KY 40512-4116 **You and your eligible dependents can print the Health Risk Assessment and the Consent Authorization Form to paper, sign the forms where indicated, and mail them to the address on the Health Risk Assessment.*

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums. These programs and materials are the responsibility of the Plan and all appeals must follow their guidelines. For additional information, contact the Plan at 888/789-9065 or visit their website at www.carefirst.com.

Options

As a member of CareFirst BlueChoice HMO, you can receive discounts on alternative therapies including acupuncture, massage therapy and chiropractic care. Discounts are also available on laser vision correction and hearing aids. Please visit our website at CareFirst.com for more information.

Dental savings plan (Available under the BlueChoice Open Access Option only)

Your BlueChoice benefits include a dental savings plan. This savings plan provides you discounts on a wide range of dental services including cleaning, fillings, extractions, crowns, root canals, and orthodontics. You must use a plan dentist to receive your discount. Please visit our website at CareFirst.com for a list of dentists. You may also contact Member Services at 888/789-9065 to verify dentists that participate or request a pamphlet that provides additional information on the dental discount services.

Additional Coverage - and Coverage for Dependents

CareFirst offers many types of coverage for you and your family members. If you have a parent, child or partner who is not eligible as a dependent under the FEHBP, CareFirst can help with a wide range of Consumer Direct health plans.

With access to large provider networks and the assurance that your card will be recognized anywhere you go, our plans offer convenience and peace of mind.

Every CareFirst Consumer Direct medical policy covers preventive care office visits, screenings and well-child visits at no charge – not even a copay.

Each plan varies in benefit levels and monthly premiums. The snapshots below preview the many benefits of each plan type. To request more information, or to speak with a knowledgeable product specialist, contact us today at **1-800-544-8703** or visit **www.carefirst.com.**

For Maryland, District of Columbia and Northern Virginia residents

BluePreferred and **BluePreferred-Saver – PPO Coverage**

Our PPO plans provide access to more than 33,000 physicians working out of over 68 hospitals within CareFirst's highly respected Preferred Provider Organization (PPO) network.

Consumer Direct HealthyBlue

HealthyBlue combines the out-of-network coverage of a point-of-service plan with the care management of our CareFirst BlueChoice Open Access programs and adds wellness incentives. Vision coverage is also included.

MediGap-65 and **Supplement-65 Medicare Supplemental Plans:**

These plans give you protection against the important costs Medicare doesn't cover—costs that can add up to thousands of dollars each year.

Individual Select Preferred – Dental Plan

Our dental plan provides access to a network of over 4,000 dentists in the region with no referrals, no deductibles, and no claim forms to file when you stay in the network.

For Maryland and District of Columbia residents

CareFirst BlueChoice – HMO Coverage

Our HMO plan offers access to a regional network of more than 26,000 physicians and specialists working out of over 68 hospitals throughout Maryland, the District of Columbia and Northern Virginia. These plans feature predictable copays for office visits to primary care physicians and specialists. Vision coverage is also included.

For Maryland, District of Columbia and Delaware residents

Medicare Part D Prescription Drug Plans: BlueRx Standard and **BlueRx Enhanced**

Our Medicare Part D plans are offered through Medi-CareFirst BlueCross BlueShield. Members can get a 34-day prescription drug supply for the price of a 30-day supply and a 90-day supply of maintenance medications for only two copays at network retail pharmacies. BlueRx Enhanced Prescription Drug Program features a $0 deductible and coverage for Generics in the coverage gap at a predictable copay.

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior approval for certain services.*

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);.
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;.
- Services, drugs, or supplies related to sex transformations;.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage;.
- Services or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption;.
- Services or supplies furnished or billed by a non-covered facility, except that medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to plan limits;.
- Charges which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 81), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see page 81), or State premium taxes however applied.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received).

See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures.

How to claim benefits

To obtain claim forms, claims filing advice or answers about our benefits, contact us at (888) 789-9065, or at our Web site at *carefirst.com/fedhmo*.

In most cases, providers and facilities file claims for you. Your physician must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form.

When you must file a claim – such as for services you received overseas or when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Patient's name, date of birth, address, phone number and relationship to enrollee
- Patient's Plan identification number
- Name and address of person or company providing the service or supply
- Dates that services or supplies were furnished
- Diagnosis
- Type of each service or supply
- Charge for each service or supply

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

In addition:

- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- If your claim is for the rental or purchase of durable medical equipment; private duty nursing; and physical therapy, occupational therapy, or speech therapy, you must provide a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies must include receipts that show the prescription number, name of drug or supply, prescribing physician's name, date, and charge.
- We will provide translation and currency conversion services for claims for overseas (foreign) services.

Deadline for filling your claim

Send us all the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service. If you could not file on time because of Government administrative operations or legal incapacity you must submit your claim as soon as reasonably possible. Once we pay benefits there is a three-year limitation on the reissuance of uncashed checks.

Post service claims procedure

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Overseas claims

For covered services you receive in hospitals outside the United States and Puerto Rico and performed by physicians outside the United States, send a completed Overseas Claim Form and the itemized bill to:

BlueCard Worldwide Service Center, P.O. Box 72017, Richmond, VA 23255-2017 USA. Obtain Overseas Claim Forms from opn our website, carefirst.com/fedhmo. If you have questions about the processing of overseas claims contact 800-810-2583.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information notified to process your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visitwww.carefirst.com/fedhmo or call us at 888/789-9065.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

Disagreements between you and the CDHP or HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Mail Administrator, P.O. Box 14114, Lexington, KY 40512-4114; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or. c) Ask you or your provider for more information You or your provider must send the information so that we receive it with 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

The disputed claims process – continued on next page

The disputed claims process*(continued)*

Step	Description
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 2, 1900 E Street, NW, Washington, DC 20415-3650. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (888)789-9065. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 2 at (202) 606-3818 between 8 a.m. and 5 p.m. eastern time

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage". (Having coverage under more than two health plans may change the order of benefits determined on this chart).

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at anytime both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan PCP, or precertified as required.

Claims process when you have the Original Medicare Plan - You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 888/789-9065 or see our Web site at www.carefirst.com.

We do not waive any costs if the Original Medicare Plan is your primary payor.

You can find more information about how one plan coordinates benefits with Medicare in *CAREFIRST BLUECHOICE at* www.carefirst.com.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have as this coverage may affect the primary secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHBP coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

When you have Federal Employees Dental and Vision Insurance Plan coverage (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and or vision plan on ***BENEFEDS.com,*** you will be asked to provide information on your FEHB plan so that your plan can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs-costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.

- Extra care costs-costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan covers some of these costs, providing the plan determines the services are medically necessary. For more specific information. (See pages 31 to 33). We encourage you to contact the plan to discuss specific services if you if you participate in a clinical trial.
- Research costs-costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials; this plan does not cover these costs.

Section 10. Definitions of terms we use in this brochure

Allowed benefit

For a contracting physician or contracting provider, the allowed benefit is the lesser of:

The actual charge; or the amount CareFirst BlueChoice allows for the service in effect on the date that the service is rendered.

The benefit payment is made directly to the contracting physician or the contracting provider and is accepted as payment is full, except for any applicable deductible, copayment or coinsurance as stated in the Schedule of Benefits. The member is responsible for any applicable deductible, copayment or coinsurance stated in the Schedule of Benefits and the contracting physician or contracting provider may bill the member directly for such amounts.

For a non-contracting physician or a non-contracting provider, the allowed benefit for a covered service will be determined in the same manner as the allowed benefit for a contracting physician or contracting provider. Benefits may be paid to the member or to the non-contracting physician or non-contracting provider at the discretion of CareFirst BlueChoice. When benefits are paid to the member, it is the member's responsibility to apply any CareFirst BlueChoice payments to the claim from the non-contracting physician or non-contracting provider.

Note that, under the Hearing aid benefit, the provider may have the member sign a document requiring them to pay an amount which exceeds our allowed benefit for certain services. See page 38.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Care Plan

A plan of action developed and submitted to CareFirst by a Primary Care Provider (PCP) who is a member of a Primary Care Medical Home panel. This is a customized program designed for members who are at risk for, or suffering form, a chronic disease or illness.

Clinical Trials Cost Categories

- Routine care costs-costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition. whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs-costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs-costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 17.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 17.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. deductible, coinsurance and copayments) for the covered care you receive.

Covered services

Care we provide benefits for, as described in this brochure.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 17.

Experimental or investigational service

We consider services experimental or investigational if they do not meet the following criteria:

- Services legally used in testing or other studies on human patients
- Services recognized as safe and effective for the treatment of a specific condition.
- Services approved by any governmental authority whose approval is required.
- Services approved for human use by the Federal Food and Drug Administration in the case a drug, therapeutic regimen, or device is used.

Group health coverage Health coverage made available through employment or membership with a particular organization or group.

Health Care Professional A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity Medically Necessary or Medical Necessity means health care services or supplies that a health care provider, exercising clinical judgment, renders to or recommends for, a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. These health care services are:

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's illness, injury or disease;
3. not primarily for the convenience of a patient or health care provider; an
4. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and views of health care providers practicing in relevant clinical areas, and any other relevant factors.

The fact that a health care provider may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Contract.

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral result in a reduction of benefits.

Primary Care Medical Home (PCMH) CareFirst created these provider panels, composed of members of our BlueChoice network, to improve health care quality and help slow rising health care costs over time.

Our Primary Care Medical Home (PCMH) program focuses on the relationship between you and your primary care provider (PCP). It's designed to provide your PCP – whether it's a physician or nurse practitioner – with a more complete view of your health needs, as well as the care you're receiving from other providers. As the leader of your health care team, your PCP will be able to use this information to better manage and coordinate your care, a key to better health.

Us/We Us and We refer to CareFirst BlueChoice, Inc.

You You refers to the enrollee and each covered family member.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 888-789-9065. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment
- How you can cover your family members
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
- What happens when your enrollment ends
- When the next open season for enrollment begins

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26 including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family member is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted children and stepchildren and covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer - provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/insure.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2012 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2011 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 26, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program.* See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12. Other Federal Programs

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program,** also known as **FSAFEDS** lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program** (**FEDVIP**), provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered by the FEHB Program.

The Federal Flexible Spending Account Program - *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?	Visit www.FSAFEDS.com or call an FSAFEDS Benefits Coordinator toll-free at 1-877-FSAFEDS (1-877-372-3337) Monday through Friday, 9 a.m. until 9 p.m. Eastern Time. TTY 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program-*FEDVIP*

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program, and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-condition limitations for enrollment. FEDVIP is available to eligible Federal and Postal Service employees, retires, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.
Dental Insurance	All dental plans provide a comprehensive range of services, including : • Class A (Basic) service, which include oral examinations, prophylaxis, diagnostic evaluations, sealants, and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges, and prosthodontics services such as complete dentures. • Class D (Orthodontic) services with up to a 24-month waiting period for dependent children up to age 19.
Vision Insurance	All vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
Additional Information	You can find a comparison of the plans and their premiums on the OPM website at www.opm.gov/insure/vision and www.opm.gov/insure/dental. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll?	You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY) 1-877-889-5680).

The Federal Long Term Care Insurance Program - *FLTCIP*

It's important protection	The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living - such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more Information, call 1-800-LTC-FEDS (1-800-582-3337) (TIY 1-800-843-3557) or visit www.ltcfeds.com.

Other Federal Programs: Pre-existing Condition Insurance Program (PCIP)

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit ***www.pcip.gov*** and/or ***www.healthcare.gov*** or call 1-866-717-5826 (TTY): 1-866-561-1604.

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Family...4-6,9-13,17-18,21,23,27-28,40,-44,52,54,56,61,66,68-70,74, 77-78,80-81,84,86-87, 89-97
Plan.....13
Mental Health/Substance Abuse Benefits 12,61-62,94,96
Never Events.....7
Newborn care.....27
Nurse.....6,40,58,67,73,82,83,84,94,97
Licensed Practical Nurse (LPN)...40,73
Nurse Anesthetist (NA).....55
Obstetrical care.....8,27
Occupational therapy...10,31-32,33-34,72,73
Office visits...8,17,21,23,29,30,44-53,59-62-,70-71,94,96
Oral and maxillofacial surgical.....47-48
Out-of-pocket expenses...8,11,17-18,63,70,-78,81,83,90,95,97
Outpatient hospital...14,21,31-34,42,44-53,-55-56,59,61-62,72,94,96
Oxygen.....39,40,55
Pap test.....23-24
Patient Centered Medical Home (PCMH) 11
Physical Therapy.....31,33-34,55,73
Physician...8-9,12-17,21,27-31,35-37,40-41-,44-54,58-59,61,63-66,69-71,73-76,78,8-2-85,90,94,96
Plan allowance.....10
Post-service.....15,73-75,84-85
Pre-service.....13-16,73,75,84-85
Precertification.....14-15,44,54,61,76,84
Prescription drugs...5,9,11-12,17,28-29,31,-39,42,63-65,71-73,77,79,94,96
Preventive care, adult.....23-25
Preventive care, children.....26,36
Preventive services.....8
Prior approval/prior authorization...8-9,13-1-5,29,31,34,48,50,54,56-57,63,72-73,75-76,84
Prosthetic devices.....35-39,45-46
Psychologist.....61
Radiation therapy.....31
Room and board.....54
Second surgical opinion.....21
Skilled nursing facility care...13,14,22,53,56
Social worker.....61
Speech therapy.....10,31-34,72-73
Splints.....54
Subrogation.....81
Substance abuse.....12,61-62,94,96
Surgery.....6,10,14,35-37,44-48,54,91
Anesthesia.....6,41,44,53,55
Oral.....47-48,91
Outpatient.....55-56
Reconstructive.....44,46
Syringes.....64
Temporary Continuation of Coverage (TCC).....5,80,88-89
Tobacco cessation.....42,64
Transplants.....14,31,47,48-52,72
Treatment therapies.....31
TRICARE.....81
Urgent care.....14-16,21,58-60,73-74,76,85
Vision care or services...8,26,35-36,39,70--71,81,90-91,94,97
Wheelchairs.....39
Workers Compensation.....80,81
X-rays.....23,51,54-55,81,83,91

Summary of Benefits - High Open Access 2012

Do not rely on this chart alone.

All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Open Access Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	In network: No copay for preventive care; $25 Primary Care Physician and $35 Specialist Out of network: You pay all charges	21
Services provided by a hospital:		
• **Inpatient**	In network: $200 per admission copay Out of network: You pay all charges	54
• **Outpatient**	In network: $50 copay for medical and surgical services Out of network: You pay all charges	55
Emergency benefits:		
• **In-area**	$100 per emergency room visit	59
• **Out-of-area**	$100 per emergency room visit	59
Mental health and substance abuse treatment:	Regular cost-sharing	61
Prescription drugs:	No copay for generic drugs; $30 formulary brand copay; $50 copay for non-formulary drugs for a 30 day supply. Mail Order has 2 copays for a 90 day supply. *If a drug is available in generic, and your doctor specifies that you are not to take the generic, you pay only the copay. If your doctor does not specify, and you get the brand name drug, you will pay the cost difference between the brand and the generic as well as the copay.*	64
Dental care:	No benefit except for services related to an accidental injury	66
Vision care:	In network: $10 copay per visit Out of network: You pay all charges	35
Special features: 24 hr nurse line; Care team program; Guest membership program	No additional cost	67

High Open Access Option Benefits	You pay	Page
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $1,900/Self Only or $5,500 Family enrollment per year Some costs do not count toward this protection	17

Summary of Benefits - Standard HealthyBlue for 2012

Do not rely on this chart alone.

All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

•If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

•Where indicated, the care is subjected to the calendar year deductible of $500 per individual contract and $1,000 per family contract. The member can receive a Healthy Reward deductible credit of up to $300 per self only contract or $700 per self and family contract. See page 69 for details on how to earn the Healthy Reward.

•We only cover services provided or arranged by Plan physicians, except in emergencies.

Standard HealthyBlue	You pay	Page
Medical services provided by a physician		
Diagnostic and treatment services provided in the office	In Network: No deductible or copy for primary care provider and $35 for a specialist Out of Network: After calendar year deductible, $70 copay	21
Services provided in a hospital:		
• **Inpatient**	In Network: After calendar year deductible, $200 per admission copay Out of Network: After calendar year deductible, $500 per admission copay	54
• **Outpatient**	In Network: After deductible, $35 copay Out of Network: After calendar year deductible, $70 copay	55
Emergency Benefits:		
• **In-area**	$100 per emergency room visit	59
• **Out-of-area**	$100 per emergency room visit	59
Mental health and substance abuse treatment:	Regular cost sharing	61
Prescription drugs:	No copay for generic drugs; $30 formulary brand copay; $50 copay for non-formulary drugs for a 30 day supply. Mail Order has 2 copays for a 90 day supply. *If a drug is available in generic, and the brand name drug is dispensed, you are responsible for the difference between price of the brand and the generic in addition to the appropriate copay.*	64
Dental care:	No benefit except for services related to an accidental injury	66

Standard HealthyBlue	You pay	Page
Vision care:	Davis network providers: $10 per visit copay for routine eye exams.	35
Special features: 24 hour nurse line; Care team program; Guest membership. Care plans, Healthy Reward.	No additional cost	67
Protection against catastrophic costs (out-of-pocket maximum)	In network: Nothing after $1,900 Self only or $5,500 family per year based on contract, not members Out-of-network: After $3,600 Self only or $7,200 family per year based on contract, the member is liable for charges in excess of our allowed benefit. Some costs do not count toward this protection	17

2012 Rate Information for CareFirst BlueChoice, Inc.

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Postal Category 1 rates apply to career employees covered by the National Postal Mail Handlers Union (NPMHU), National Association of Letter Carriers (NALC) and Postal Police bargaining units.

Postal Category 2 rates apply to other non-APWU, non-PCES, non-law enforcement Postal Service career employees, including management employees, and employees covered by the National Rural Letter Carriers' Association bargaining unit.

Special Guides to Benefits are published for American Postal Workers Union (APWU) employees (see RI 70-2A) including Material Distribution Center, Operating Services and Information Technology/Accounting Services employees and Nurses; Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees (see RI 70-2IN), Postal Career Executive Service (PCES) employees (see RI 70-2EX), and noncareer employees (see RI 70-8PS).

Career APWU employees hired before May 23, 2011, will have the same rates as the Category 2 rates shown below. In the Guide to Benefits for APWU Employees (RI 70-2A) this will be referred to as the "Current" rate; otherwise, "New" rates apply.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center
1-877-477-3273, option 5
TTY: 1-866-260-7507

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable *Guide to Federal Benefits*.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
The State of Maryland, the Northern Virginia area and Washington, DC							
High Option Self Only	2G1	$185.75	$64.61	$402.46	$139.99	$43.98	$41.40
High Option Self and Family	2G2	$414.35	$148.87	$897.76	$322.55	$102.83	$97.07
Standard Option Self Only	2G4	$178.39	$59.46	$386.51	$128.83	$39.25	$36.87
Standard Option Self and Family	2G5	$401.30	$133.76	$869.48	$289.82	$88.28	$82.93