

CareFirst BlueChoice, Inc.

www.carefirst.com/fedhmo/

Member Services
(888) 789-9065



2019

A Health Maintenance Organization (Standard Option) and a High Deductible Health Plan (HDHP)

This Plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8 for details. This Plan is accredited. See page 13.

Serving: 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 16 for requirements.

Enrollment Codes for this Plan:

2G4 Standard HealthyBlue - Self Only
2G6 Standard HealthyBlue - Self Plus One
2G5 Standard HealthyBlue - Self and Family

B61 HealthyBlue Advantage HDHP - Self Only
B63 HealthyBlue Advantage HDHP - Self Plus One
B62 HealthyBlue Advantage HDHP - Self and Family

IMPORTANT

- Rates: Back Cover
- Changes for 2019: Page 19
- Summary of benefits: Page 171

Special Notice: High Option Open Access will not be offered for the 2019 contract year.



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. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug 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 Medicare Part D 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 15 through December 7) 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 (800) 772-1213 (TTY (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 800-MEDICARE (800) 633-4227, TTY (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. Customer service may be reached at (888) 789-9065 or through our website: www.carefirst.com/fedhmo. The address for CareFirst BlueChoice administrative offices is:

Mail Administrator
P.O. Box 14114
Lexington, KY 40512-4114

This brochure is the official statement of benefits. No verbal 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 self only coverage, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or 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, 2019, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2019 and changes are summarized on page 19. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan meets the minimum value standard for the benefits the plan provides.

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 will tell you what they mean.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

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.
- Periodically review your claims history for accuracy to ensure we have not been billed for services you did not receive.
- 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 for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at (888) 789-9065 and explain the situation.

CALL - THE HEALTH CARE FRAUD HOTLINE

(877) 499-7295

OR go to

www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy and a quicker response time.

You can also write to:

**United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100**

- 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 (TCC).
- 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.

Discrimination is Against the Law

CareFirst BlueChoice, Inc. complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, CareFirst BlueChoice, Inc. does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

If a carrier is a covered entity, its members may file a 1557 complaint with HHS Office of Civil Rights, OPM, or FEHB Program carriers.

You can also file a civil rights complaint with the Office of Personnel Management by mail.

For purposes of filing a complaint with OPM, covered carriers should use the following:

Office of Personnel Management
Healthcare and Insurance
Federal Employee Insurance Operations
Attention: Assistant Director, FEIO
1900 E Street NW, Suite 3400-S
Washington, D.C. 20415-3610

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. 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, take notes, ask questions and understand answers.

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

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medication and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- 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 medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.

- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.

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

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic 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 or clinic.

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 or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.ahrq.gov/patients-consumers. The Agency for Healthcare Research and 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.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.npsf.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.
- 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.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.

Preventable Healthcare Acquired Conditions (“Never Events”)

When you enter the hospital for treatment of one medical problem, you do not 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, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a health care facility. These conditions and errors are sometimes called “Never Events” or “Serious Reportable Events.”

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 to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

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.
- **Minimum essential coverage (MEC)** Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.
- **Minimum value standard** Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is the actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.
- **Where you can get information about enrolling in the FEHB Program** See www.opm.gov/healthcare-insurance 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 that 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 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 do not 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 Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, and one eligible family member or your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. 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 Plus One or 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 Plus One or 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 Plus One or 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 are married.

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 members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLE's visit the FEHB website at www.opm.gov/health-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

• **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. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26 th birthday.
Foster children	Foster children are eligible for coverage until their 26 th 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 26 th 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 26 th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay. You can find additional information at www.opm.gov/healthcare-insurance.

- **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 Plus One or 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 in Self Plus One or 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 Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM;
- 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 Plus One or Self and Family, as appropriate, 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 Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM

As long as the court/administrative order is in effect, and you have at least one (1) 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 does not serve the area in which your child(ren) live, unless you provide documentation that you have other coverage for the child(ren).

If the court/administrative order is still in effect when you retire, and you have at least one (1) 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 does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1, 2019. 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 2019 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 2018 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 (5) 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 information about your coverage choices. You can also visit OPM's website at www.opm.gov/healthcare-insurance/healthcare/plan-information/.

- **Temporary Continuation of Coverage (TCC)** If you leave Federal service, Tribal employment or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Patient Protection Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal 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 or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **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 or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing 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 contact us in writing 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, a waiting period will not be imposed and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at (888) 789-9065 or visit our website at www.carefirst.com/fedhmo.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO) plan. OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. CareFirst holds the NCQA accreditation. To learn more about this plan's accreditation(s), please visit the following websites:

- National Committee for Quality Assurance (ncqa.org)

We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory. We give you a choice of enrollment in a High Option, a Standard Option, or a High Deductible Health Plan (HDHP).

HMOs emphasize preventive care such as routine office visits, physical exams, well-child 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.

General features of our Standard HealthyBlue Option

Our Standard HealthyBlue offering includes no referrals, no member out-of-pocket for preventive care, and no copay for generic drugs. The plan also provides benefits for routine vision exams. The following additional provisions are also available under this plan: 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. A \$100 deductible applies to all prescription drugs except for Tier 1 generics. In addition, Standard HealthyBlue offers Blue Rewards where members can earn pecuniary rewards and redeem these rewards using their medical expense debit card.

We have 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 Standard 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; a provider outside of our BlueChoice network who participates in another BlueChoice network or a non-participating provider. However, if you receive services from an out-of-network 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 cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies). Under Standard 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.

General Features of our HealthyBlue Advantage High Deductible Health Plan (HDHP)

Our HDHP is called the HealthyBlue Advantage HDHP. HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans. FEHB Program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles or annual limits when received only from a in-network provider.

Annual deductible

There is a \$500 Self Only deductible and \$1,000 Self Plus One and Self and Family deductible in-network and there is a \$3,000 Self Only deductible and \$6,000 Self Plus One and Self and Family deductible out-of-network under the Standard HealthyBlue offering. There is a \$100 deductible for prescription drugs Tier 2-5 under the Standard HealthyBlue Option. Under the Standard HealthyBlue Option, we indicate those services subject to the deductible or indicate that the deductible does not apply; the deductible never applies to preventive care services. Under the HealthyBlue Advantage HDHP Option, there is a \$1,400 Self Only deductible and \$2,800 Self Plus One and Self and Family deductible in-network and there is a \$3,000 Self Only deductible and \$6,000 Self Plus One and Self and Family deductible out-of-network. The annual deductible must be met before Plan benefits are paid for care other than preventive care.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, not received VA (except for veterans with a service-connected disability) or Indian Health Service (IHS) benefits within the last three (3) months, not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than \$6,750 for Self Only enrollment, and \$13,500 for a Self Plus One or Self and Family for the HDHP plan. Your specific plan limits may differ.

With the Standard Healthy Blue plan, your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed \$7,350 for Self Only enrollment, or \$14,700 for Self Plus One or Self and Family enrollment.

- For the Standard HealthyBlue Option, the catastrophic limit is \$2,500 per Self Only enrollment and \$5,000 per Self Plus One and Self and Family enrollment for in-network services. For out-of-network services, the catastrophic limit is \$4,500 per Self Only enrollment and \$9,000 per Self Plus One and Self and Family enrollment.
- For the HealthyBlue Advantage HDHP, the catastrophic limit is \$4,000 per Self Only enrollment and \$6,500 per Self Plus One and Self and Family enrollment for in-network services. For out-of-network services, the catastrophic limit is \$6,000 per Self Only enrollment and \$12,000 per Self Plus One and Self and Family enrollment.

Health education resources and account management tools

We make available a wide variety of self-service tools and resources to help you take personal control of your health. Below is a list of some of these tools and resources, many of which are available through our website at www.carefirst.com/fedhmo.

- Health education resources — preventive guidelines, patient safety tips, wellness and disease information, prescription drug interaction and pricing tools, and newsletters
- Account management tools — online claims payment history and HSA or HRA balance information
- Consumer choice information — online provider directory and health services pricing tool
- Care support information — case management programs

For more information about these and other available tools and resources, please see the HDHP Section.

Your rights and responsibilities

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities from OPM's FEHB website (www.opm.gov/healthcare-insurance), which 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 non-profit corporation
- CareFirst BlueChoice, Inc. is an independent licensee of the BlueCross and BlueShield Association, a registered trademark of the BlueCross and BlueShield Association and a registered trademark of CareFirst of Maryland, Inc.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website www.carefirst.com/fedhmo. You can also contact us to request that we mail a copy to you.

By law, you have the right to access your personal health information (PHI). For more information regarding access to PHI, visit our website www.carefirst.com/fedhmo. You can also contact us to request that we mail you a copy of that Notice.

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/fedhmo.

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 the Standard HealthyBlue and HealthyBlue Advantage HDHP, 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 outside of the service 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 outside 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 toll free at (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. Changes for 2019

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.

Changes to High Option Open Access, Standard HealthyBlue, and HealthyBlue Advantage HDHP

- **High Option Open Access** - Carefirst BlueChoice will not offer this product for the 2019 contract year.
- **Standard HealthyBlue** - Your share of the non-Postal premium will increase for Self Only; increase for Self Plus One; and increase for Self and Family. See page 182.
- **HealthyBlue Advantage** - Your share of the non-Postal premium will decrease for Self Only; decrease for Self Plus One; and decrease for Self and Family. See page 182.

Changes to Standard HealthyBlue

- **Prescription drugs:** This Plan will add a \$100 deductible for pharmacy for the Standard Option. Generic medications will not be subject to the deductible.
- **Prescription drugs:** This Plan will decrease the copay for Tier 4 preferred specialty drugs to \$100 for a 34-day supply and \$200 for a 90-day supply.
- **Labs/X-ray/Other diagnostic services:** In-network services in an office or freestanding setting will have a \$40 copay and a \$40 copay after the deductible for out-of-network services.
- **Labs/X-ray/Other diagnostic services:** Out-of-network services in an outpatient hospital setting will be subject to 20% coinsurance after the deductible.
- **Specialty Imaging:** In-network services in an office or freestanding setting will have a \$60 copay and out-of-network services will have a \$60 copay after the deductible.
- **Specialty Imaging:** In-network services in an outpatient hospital setting will have a \$60 copay after the deductible and subject to 20% coinsurance after the deductible for out-of-network services.
- **Durable Medical Equipment:** The Plan will increase member cost sharing to 25% coinsurance after the deductible per device in-network and 50% coinsurance after the deductible per device out-of-network.
- **Orthopedic and Prosthetic Devices:** The Plan will increase member cost sharing to 25% coinsurance after the deductible per device in-network and 50% coinsurance after the deductible per device out-of-network.
- **Sleep Studies:** In-network services in an office or freestanding setting will be subject to a \$50 copay for services provided in the home setting after the deductible.
- **Infusion Services:** In-network services in an office or freestanding setting will no longer be subject to the deductible and will be subject to a \$200 copay for Services provided in an outpatient hospital setting after the deductible.
- **Mental Health Services:** Treatment in an outpatient hospital setting will be subject to a \$50 copay.
- **Ambulance Services:** Members will pay a \$50 copay per trip in-network after the deductible and a \$100 copay per trip after the deductible out-of-network.
- **Inpatient Hospital Admissions:** Members will pay 20% coinsurance after the deductible in-network and 30% coinsurance after the deductible out-of-network.
- **Emergency Room Services:** Members will pay a \$200 copay after the deductible.
- **Urgent Care Centers:** Members will pay a \$50 copay in-network and a \$80 copay after the deductible out-of-network.

- **Outpatient Center Services/Ambulatory Surgical Center (Facility):** Members will pay the following cost share based on the site of service
 - In-network:
 - Outpatient Hospital (non-surgical) - a \$40 copay, no deductible
 - Outpatient Hospital (surgical) - a \$150 copay after the deductible
 - Freestanding/Ambulatory surgical center - a \$100 copay, no deductible
- **Healthy Blue Reward Program:** Changes for participation, ongoing and coaching rewards. The total amount of Blue Rewards a subscriber and/or their spouse may earn is now up to \$400 per calendar year.

Changes for HealthyBlue Advantage HDHP Option only

- **Prescription drugs:** Select Generic medications will not be subject to the deductible. For a list of applicable medications, please visit our website <https://member.carefirst.com/carefirst-resources/pdf/healthyblue-select-generics.pdf>.
- **Prescription drugs:** This Plan will decrease the copay for Tier 4 preferred specialty drugs to \$100 for a 34-day supply and \$200 for a 90-day supply.
- **Premium pass through:** The amount will increase to \$75 for Self Only enrollment and \$150 Self Plus One and Self and Family enrollments.
- **Labs/X-ray/Other diagnostic services:** Services in an office or freestanding setting will have the following cost share:
 - In-Network:
 - Labs: No copay after the deductible
 - X-rays: A \$35 copay after the deductible
 - Other diagnostic services: A \$35 copay after the deductible
 - Specialty imaging: A \$50 copay after the deductible
 - Out-of-Network: Labs, X-rays, other diagnostic services and specialty imaging will be subject to 20% coinsurance after the deductible.
- **Durable Medical Equipment:** Members will pay 25% coinsurance after the deductible per device.
- **Sleep Studies:** Services in an office/freestanding setting will have a \$35 copay after the deductible in-network and a \$50 copay after the deductible for services provided in the home setting.
- **Infusion Services:** In-network services provided in an home, office or freestanding setting will have a \$20 copay after the deductible.
- **Inpatient Hospital Admissions:** Members will pay 20% coinsurance after the deductible in-network and 30% coinsurance after the deductible out-of-network.
- **Labs/X-ray/Other diagnostic services:** Services in an outpatient hospital setting members will pay 20% coinsurance after the deductible.
- **Skilled Nursing Services:** Members will pay the following cost share:
 - In-Network
 - Facility: 20% coinsurance after the deductible
 - Professional services: PCP - No copay after deductible; Specialist - \$35 copay after deductible
 - Out-of-Network
 - Facility: 30% coinsurance after the deductible
 - Professional services: PCP - \$80 copay after deductible; Specialist - \$80 copay after deductible
- **Healthy Blue Reward Program:** Changes for participation, ongoing and coaching rewards. The total amount of Blue Rewards a subscriber and/or their spouse may earn is now up to \$400 per calendar year.

Section 3. How You Get Care

Identification cards	<p>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.</p> <p>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 toll free at (888) 789-9065 or write to us at Mail Administrator, P.O. Box 14114, Lexington, KY 40512-4114.</p>
Where you get covered care	<p>You get care from "Plan providers" and "Plan facilities". You will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies) 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.</p>
<ul style="list-style-type: none">• Plan providers	<p>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.</p> <p>We list Plan providers in the provider directory, which we update periodically. The list is also on our website.</p>
<ul style="list-style-type: none">• Plan facilities	<p>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 website.</p>
What you must do to get covered care	<p>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 website, www.carefirst.com/fedhmo.</p>
<ul style="list-style-type: none">• Primary care	<p>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.</p> <p>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.</p>
<ul style="list-style-type: none">• Specialty care	<p>Your primary care physician may refer you to a specialist for needed care or you may go directly to a specialist without a referral. Under HealthyBlue, you may use other providers, but out-of-network coverage levels will apply.</p> <p>Here are some other things you should know about specialty care:</p>

- 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, your 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 approval for:

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

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 days requested for hospital stay.

HealthyBlue Standard

Prior authorization is required for all In-Network outpatient services performed in the outpatient department of a hospital, including but not limited to, outpatient surgery, specialty imaging, diagnostic, laboratory and X-ray services, Outpatient Rehabilitative Services and Infusion Services.

Benefits will not be approved at these locations if CareFirst BlueChoice determines that the procedure can be provided in a medically appropriate manner within a physician's office or other less intensive and less costly setting.

If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are not covered. Prior authorization for in-network services is the responsibility of the in-network provider and a member cannot be held liable when an in-network provider fails to obtain prior authorization.

Out-of-network participating providers will also obtain prior authorization for out-of-network covered services for which prior authorization is required. For purposes of this Evidence of Coverage, out-of-network participating provider means any physician, health care professional or health care facility located in the CareFirst BlueChoice Service Area and has contracted with CareFirst BlueCross Blue Shield to be paid directly for rendering Covered Services to Members. Members may obtain out-of-network benefits from out-of-network participating providers.

HealthyBlue Advantage Plan:

Prior authorization from CareFirst BlueChoice will be obtained by in-network providers and out-of-network participating providers located in the CareFirst BlueChoice Service Area. If these providers fail to obtain prior authorization, the Member shall be held harmless. Except for Urgent Care, Emergency Services and follow-up care after emergency surgery, it is the Member's responsibility to obtain prior authorization for (1) Medical Devices and Supplies for In-Network Covered Services, (2) when services are rendered outside of the CareFirst BlueChoice Service Area and (3) for services rendered by out-of-network non-participating providers.

Failure of the Member to meet the utilization management requirements or to obtain prior authorization for services listed in (1), (2) or (3) above, may result in a reduction or denial of the Member's benefits even if the services are Medically Necessary. Refer to the Schedule of Benefits to determine the Utilization Management Non-Compliance penalty.

- **Maternity care**

Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **Non-urgent care claims**

For non-urgent care claims, we will 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 or not it is an urgent care claim by applying the judgment of a prudent lay person that 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 let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required 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.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at (888) 789-9065. You may also call OPM's Health Insurance 3 at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simulation review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at (888) 789-9065. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

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, we will make a decision within 24 hours after we receive the claim.

- **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 (2) 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, 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 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 22.

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.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite 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:

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.

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, and when you go in the hospital, under the Open Access option, you pay a copayment of \$200 per admission.

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

The Standard HealthyBlue has a \$500 Self Only enrollment deductible, and a \$1,000 Self Plus One and Self and Family deductible. The in-network deductible is included in the out-of-network total. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach \$500 under the Standard HealthyBlue Option. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach \$1,000 under the Standard HealthyBlue Option. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$1,000 under the Standard HealthyBlue Option.

The Standard HealthyBlue Option has a calendar year in-network deductible of \$500 per Self Only enrollment and \$1,000 for Self Plus One and Self and Family enrollment, and an out-of-network deductible of \$3,000 per Self Only enrollment and \$6,000 for Self Plus One and Self and Family enrollment. The in-network deductible is included in the out-of-network total. There is a \$100 deductible for Tier 2-5 prescription drugs under the Standard HealthyBlue Option.

Under the Self Only, Self Plus One, and Self and Family enrollments, 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).

The HealthyBlue Advantage HDHP has a deductible of \$1,400 per Self Only enrollment or \$2,800 per Self Plus One and Self and Family enrollment for in-network services and \$3,000 per Self Only enrollment and \$6,000 per Self Plus One and Self and Family enrollment for out-of-network care each calendar year. The Self Plus One and Self and Family deductible can be satisfied by one or more enrolled, eligible members. The deductible applies to all benefits excluding all preventive services.

Note: If you change plans during Open Season, you do not have to start a new deductible under your old plan option between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Coinsurance Coinsurance is the percentage of our allowed benefit that you must pay for your care. Coinsurance does not begin until you have met your calendar year 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 "**allowed 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 **our Standard and HDHP** HealthyBlue options, there are other providers contracted with CareFirst who will only bill you for the amount attributed to the deductible or the appropriate copayment or coinsurance. Please check the Hearing Aid benefit for detail for when network providers may bill for balances (See page 46 and page 107)

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, copayment or coinsurance amount.

Your catastrophic protection out-of-pocket maximum

Under Standard HealthyBlue, once your expenses for in-network care (copayments and deductible) total \$2,500 for Self Only contract or \$5,000 per Self Plus One and Self and Family in any calendar year 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 \$4,500 for Self Only contract and \$9,000 per Self Plus One and Self and Family in any calendar year, and only expenses up to our allowed benefit contribute; any balances in excess of our allowed benefit and expenses for durable medical equipment do not contribute to the catastrophic limit and remain your liability. Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

Under the HealthyBlue Advantage HDHP option, once your expenses for in-network services are met (copayments and deductible totaling \$4,000 for Self Only contract or \$6,500 per Self Plus One and Self and Family in any calendar year), you do not have to pay any more for covered in-network services. All covered in-network care counts toward the catastrophic limit. The catastrophic limit for out-of-network care is \$6,000 for Self Only contract and \$12,000 per Self Plus One and Self and Family in any calendar year, and only expenses up to our allowed benefit contribute; any balances in excess of our allowed benefit and expenses for durable medical equipment do not contribute to the catastrophic limit and remain your liability.

Please note that the out-of-pocket maximums will be combined for both in-network and out-of-network services for the Standard HealthyBlue and HDHP HealthyBlue Advantage options.

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 in 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. Standard HealthyBlue Option

See page 19 on how our benefits changed this year. Page 171 contains the benefit summary the Standard HealthyBlue product.

Note: This benefits section is divided into subsections. Please read **Important things you should keep in mind** at the beginning of each subsection. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at (888) 789-9065 or at our website at www.carefirst.com/fedhmo.

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Section 5. Standard HealthyBlue Overview

This Plan offers a Standard HealthyBlue Option. The benefit package is described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The Standard HealthyBlue Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about the Standard HealthyBlue Option benefits, contact us at (888) 789-9065 or on our website at www.carefirst.com/fedhmo.

Standard HealthyBlue Option

There is no member out-of-pocket expenses for any service by a PCP (to include pediatricians) for preventive care or sick visits

- A Dual option design, permitting the member to have benefits for care received outside of the BlueChoice network or tests by an independent lab or radiology group.
- A calendar year deductible applicable to specific in network care and most out-of-network care. The deductible can apply to both facility and professional care. Sections 5(a) through 5(h) indicate when the deductible applies.
- Under Standard HealthyBlue, you have access to Blue Rewards and can earn up to \$400. This reward can be used to pay for expenses related to the health plan including copays, coinsurance, and deductibles for medical, prescription drug, dental and vision.
- 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.
- Prescriptions: There is a \$100 deductible for Tiers 2 - Tiers 5 prescription drugs.

Retail up to a 34- day supply per copay:

\$0 Tier 1 generics (no deductible)
 After deductible, \$35 Tier 2 preferred brand
 After deductible, \$65 Tier 3 non-preferred brand
 After deductible, \$100 Tier 4 preferred specialty
 After deductible, \$150 Tier 5 non-preferred specialty

Maintenance drugs up to 90-day supply per copay:

\$0 Tier 1 generics (no deductible)
 After deductible, \$70 Tier 2 preferred brand
 After deductible, \$130 Tier 3 non-preferred brand
 After deductible, \$200 Tier 4 preferred specialty
 After deductible, \$300 Tier 5 non-preferred specialty

Mandatory Generic Drug Substitution 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 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.
- 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. Please refer to Section 5(c) for additional information.
- Under Standard HealthyBlue, when you receive out-of-network care from providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay.
- Under Standard HealthyBlue, when you receive out-of-network care from 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 plus the appropriate deductible and copay.
- Standard HealthyBlue has a calendar year in-network deductible of \$500 per Self Only enrollment and \$1,000 per Self Plus One and Self and Family enrollment, and an out-of-network deductible of \$3,000 for Self Only enrollment and \$6,000 for Self Plus One and Self and Family enrollment. The in-network deductible is included in the out-of-network total.
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
- 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
Professional Services	Standard HealthyBlue Option
Professional services of physicians <ul style="list-style-type: none"> • In a physician's office • In a skilled nursing facility • Office medical consultation • Second surgical opinion • Advanced care planning 	<p>Office/Outpatient Hospital</p> <p>In-network:</p> <ul style="list-style-type: none"> • PCP- No deductible, no copay • Specialist - No deductible then, \$40 copay <p>Out-of-network:</p> <p>Deductible then, \$80 copay</p> <p>Inpatient Hospital/Skilled Nursing</p> <p>In-network:</p> <ul style="list-style-type: none"> • Deductible then, \$40 copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay
Convenience Care (Retail Health Clinic)	<p>In-network:</p> <p>No deductible, then \$0 copay</p>

Professional Services - continued on next page

Benefit Description	You pay
Professional Services (cont.)	Standard HealthyBlue Option
<p>While primary care providers should be the first line of defense for members, there are tiered care alternatives members can access when their PCP is not available such as CVS MinuteClinic, Walgreens TakeCare and Target Clinic who can serve as the immediate backup to PCPs. (after hours)</p>	<p>In-network: No deductible, then \$0 copay</p> <p>Out-of-network: Deductible, then \$80 copay per visit</p>
<p>Professional Services (Surgical)</p>	<p>In-Network:</p> <p>Outpatient Hospital (Surgical)-</p> <ul style="list-style-type: none"> • PCP - Deductible, then no copay • Specialist - Deductible, then \$40 <p>Inpatient Hospital (Surgical)</p> <ul style="list-style-type: none"> • PCP - Deductible, then no copay • Specialist - Deductible, then \$40 <p>Out-of-Network:</p> <p>Outpatient Hospital (Surgical)-</p> <ul style="list-style-type: none"> • Deductible, then \$80 <p>Inpatient Hospital-</p> <ul style="list-style-type: none"> • Deductible, then \$80
Telehealth Services	Standard HealthyBlue Option
<p>Telemedicine visits - Video Visits - are fully covered by CareFirst BlueChoice, Inc. and are reimbursed at the same level as an in-office Evaluation and Management (E&M) visit.</p> <p>Pathway to Telemedicine Services</p> <p>Pathway #1</p> <p>Members seeking treatment advice for common conditions (e.g., allergies, bronchitis, strep throat, eye or ear infections, etc.) have 24/7 access to on-demand video consultations with board certified physicians through www.carefirstvideovisit.com.</p>	<p>No deductible, then \$0 copay per video visit with a PCP</p>
Diagnostic Services (Professional)	Standard HealthyBlue Option
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound 	<p>Office/Freestanding Setting: In-Network</p> <ul style="list-style-type: none"> • Labs - No deductible, then \$0 • X-Rays - No deductible, then \$40 • Other Diagnostic Services - No deductible, then \$40 <p>Out-of-Network</p> <ul style="list-style-type: none"> • Labs - Deductible, then \$0 • X-Rays/Other Diagnostic Services - Deductible, then \$40

Diagnostic Services (Professional) - continued on next page

Benefit Description	You pay
Diagnostic Services (Professional) (cont.)	
<ul style="list-style-type: none"> • Electrocardiogram and EEG 	<p>Office/Freestanding Setting: In-Network</p> <ul style="list-style-type: none"> • Labs - No deductible, then \$0 • X-Rays - No deductible, then \$40 • Other Diagnostic Services - No deductible, then \$40 <p>Out-of-Network</p> <ul style="list-style-type: none"> • Labs - Deductible, then \$0 • X-Rays/Other Diagnostic Services - Deductible, then \$40
<p>Specialty Imaging:</p> <ul style="list-style-type: none"> • MRA/MRS • MRI • PET • CAT scans 	<p>In-Network:</p> <p>No deductible then, \$60</p> <p>Out-of-Network:</p> <p>Deductible then, \$60</p>
Preventive care, adult	
<p>Routine physical every year which includes screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol • Depression • Diabetes • High Blood Pressure • HIV • 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: <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy screening - every five (5) years starting at age 50 - Colonoscopy screening - every ten (10) years starting at age 50 - Lung Cancer screenings - adults age 55 to 80 who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. <ul style="list-style-type: none"> • Screening will be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. 	<p>In-network:</p> <ul style="list-style-type: none"> • No deductible • No copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • No office copay

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	Standard HealthyBlue Option
<ul style="list-style-type: none"> Individual counseling on prevention and reducing health risks 	<p>In-network:</p> <ul style="list-style-type: none"> No deductible No copay <p>Out-of-network:</p> <ul style="list-style-type: none"> Calendar year deductible applies No office copay
<p>Routine Prostate Specific Antigen (PSA) test - one (1) annually for men age 40 and older in accordance with the most current American Cancer Society guidelines.</p>	<p>In-network:</p> <ul style="list-style-type: none"> No deductible No copay <p>Out-of-network:</p> <ul style="list-style-type: none"> Calendar year deductible applies No copay

Preventive care, adult - continued on next page

Benefit Description	You pay
<p>Preventive care, adult (cont.)</p> <p>Well woman care - including, but not limited to:</p> <ul style="list-style-type: none"> • Cervical cancer screening (Pap smear) • Human Papillomavirus (HPV) testing • Chlamydia/Gonorrhea screening • Osteoporosis screening • Breast cancer screening • Counseling for sexually transmitted infections • Counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling on an annual basis • Screening and counseling for interpersonal and domestic violence. • Screening for women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). • Women with positive screening results are eligible to receive genetic counseling and testing, if indicated after counseling. <p>Note: Women's preventive services: Please refer to the specific link to women's preventive services. https://www.healthcare.gov/preventive-care-women/.</p>	<p>Standard HealthyBlue Option</p> <p>In-network:</p> <ul style="list-style-type: none"> • No deductible • No copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • No copay
<p>Routine mammogram - covered for women</p>	<p>In-network:</p> <ul style="list-style-type: none"> • No deductible • No copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • No deductible • No copay
<p>Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule</p> <p>Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at www.uspreventiveservicestaskforce.org/</p> <p>And HHS at: www.healthcare.gov/preventive-care-benefits/</p>	<p>In-network:</p> <ul style="list-style-type: none"> • No deductible • No copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • No deductible • No copay

Preventive care, adult - continued on next page

Benefit Description	You pay
<p>Preventive care, adult (cont.)</p> <p>CDC: www.cdc.gov/vaccines/schedules/index.html</p> <p>Women's preventive services: www.healthcare.gov/preventive-care-women/</p> <p>For additional information: healthfinder.gov/myhealthfinder/default.aspx</p> <p>Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.</p>	<p>Standard HealthyBlue Option</p> <p>In-network:</p> <ul style="list-style-type: none"> • No deductible • No copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • No deductible • No copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	<p><i>All charges</i></p>
<p>Preventive care, children</p> <p>Well-child visits examinations, and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics</p> <p>Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org/Pages/default.aspx</p> <p>Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/</p> <p>HHS: www.healthcare.gov/preventive-care-benefits/</p> <p>For additional information: healthfinder.gov/myhealthfinder/default.aspx</p> <p>Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.</p>	<p>Standard HealthyBlue Option</p> <p>In-network:</p> <ul style="list-style-type: none"> • No deductible • No copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • No copay

Benefit Description	You pay
<p>Maternity Care</p> <p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Screening for gestational diabetes for pregnant women • Delivery • Postnatal care <p>NOTE: Members are responsible for both physician and facility fees. Please refer to section 5C for outpatient or inpatient facility fees.</p> <p>1. Preventive Services:</p> <p>a) Preventive outpatient obstetrical care of an uncomplicated pregnancy, including prenatal evaluation and management office visits and one postpartum office visit;</p> <p>b) Prenatal laboratory tests and diagnostic services related to the outpatient care of an uncomplicated pregnancy, including those identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of ""A"" or ""B"" or provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration;</p> <p>c) Preventive laboratory tests and services rendered to a newborn during a covered hospitalization for delivery, identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of ""A"" or ""B,"" the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, including the collection of adequate samples for hereditary and metabolic newborn screening and newborn hearing screening; and</p> <p>d) Breastfeeding support, supplies and consultation.</p> <p>2. Non-Preventive Services:</p> <p>a) Outpatient obstetrical care and professional services for all prenatal and post-partum complications, including prenatal and post-partum office visits and ancillary services provided during those visits, including Medically Necessary laboratory tests and diagnostic services;</p> <p>b) Birthing classes, one course per pregnancy, at a CareFirst BlueChoice approved facility;</p> <p>c) Inpatient care for delivery;</p>	<p>Standard HealthyBlue Option</p> <p>In-network:</p> <ul style="list-style-type: none"> • Preventive- No charge • Non-Preventive- No charge <p>Out-of-network:</p> <ul style="list-style-type: none"> • Preventive- Deductible then, no charge • Non-Preventive- Deductible then, no charge <p><i>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.</i></p>

Benefit Description	You pay
Maternity Care (cont.)	
<p>d) Coverage for care rendered at a CareFirst BlueChoice approved birthing center;</p> <p>e) Non-preventive professional services rendered to the newborn during a covered hospitalization for delivery. Non-preventive care of the newborn, either during or following the mother's covered hospitalization, requires that the newborn be covered as a Member in the newborn's own right.</p> <p>f) Services, drugs, or supplies related to abortions, 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.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • Preventive- No charge • Non-Preventive- No charge <p>Out-of-network:</p> <ul style="list-style-type: none"> • Preventive- Deductible then, no charge • Non-Preventive- Deductible then, no charge <p><i>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.</i></p>
<p>Breastfeeding support, supplies and counseling for each birth.</p> <p>Note: Benefit coverage for breastfeeding support, supplies and counseling for each birth begin immediately after delivery.</p> <p>Note: Breastfeeding support benefits include but are not limited to the following: comprehensive lactation support, lactation counseling, and rental or purchase of a breast pump and related supplies in conjunction with each birth. These benefits begin immediately following delivery.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • No copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • After deductible, no copay
<p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your vaginal delivery; see page 23 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal 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 Plus One or 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. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). 	

Maternity Care - continued on next page

Benefit Description	You pay
Maternity Care (cont.)	Standard HealthyBlue Option
<p>Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.</p>	
Family planning	Standard HealthyBlue Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization • Voluntary sterilization for a woman • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms • Contraceptive counseling on an annual basis at no cost sharing. <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • No copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • After deductible, no copay
<p>Contraceptive procedures for men</p> <p>Hospital services are covered under Sect. 5(c)</p> <p>Surgical benefits are covered under Sect. 5(b)</p>	<p>In-network:</p> <ul style="list-style-type: none"> • No deductible • No copay for PCP/ \$40 per visit to a specialist <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies, then \$80 copay per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic testing and counseling</i> • <i>Fertility drugs for procedures excluded under this contract.</i> • <i>Elective Abortion</i> 	<p><i>All charges</i></p>

Benefit Description	You pay
Infertility services	Standard HealthyBlue Option
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - Intravaginal Insemination (IVI) - Intracervical Insemination (ICI) - Intrauterine Insemination (IUI) <p>Note:</p> <ul style="list-style-type: none"> • 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 (6) attempts per live birth. • Any charges associated with the collection of the sperm will not be covered unless the partner is also a member. • The member is responsible for the copayment or coinsurance for artificial insemination 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 regardless of whether the couple has a relationship under which the FEHB Program recognizes each partner as a spouse of the other. • Members are responsible for both physician and facility fees. Please refer to Section 5(c) for outpatient or inpatient facility fees. 	<p>In-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • 50% coinsurance <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • 50% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>In vitro fertilization (IVF)</i> • <i>Embryo transfer and gamete intra-fallopian transfer (GIFT),</i> • <i>Zygote intra-fallopian transfer (ZIFT)</i> • <i>Intrauterine and Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>Services and supplies related to ART procedures</i> - <i>Cost of donor sperm</i> - <i>Cost of donor egg</i> - <i>Drugs for non-covered procedure</i> 	<p><i>All charges</i></p>

Benefit Description	You pay
Allergy care	Standard HealthyBlue Option
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>In-network:</p> <ul style="list-style-type: none"> • No deductible • No copay for PCP • \$40 per visit to a specialist <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$80 copay per visit
Allergy serum	<p>In-network:</p> <ul style="list-style-type: none"> • No deductible • No copay for PCP • \$40 per visit to a specialist <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$80 copay per visit
<i>Not covered: Provocative food testing and Sublingual allergy desensitization</i>	<i>All charges</i>
Treatment therapies	Standard HealthyBlue Option
<ul style="list-style-type: none"> • Radiation therapy • Respiratory and inhalation therapy • Dialysis - hemodialysis and peritoneal dialysis • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Members are responsible for both physician and facility fees. Please refer to section 5C for outpatient or inpatient facility fees.</p> <p><i>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.</i></p> <p><i>For services rendered by Home Health provider see Home Health benefits on page 50.</i></p>	<p>In-network:</p> <ul style="list-style-type: none"> • No deductible • No copay for PCP • \$40 per visit to a specialist <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$80 copay per visit

Treatment therapies - continued on next page

Benefit Description	You pay
<p>Treatment therapies (cont.)</p> <ul style="list-style-type: none"> • Chemotherapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 58.</p>	<p>Standard HealthyBlue Option</p> <p>In-network:</p> <ul style="list-style-type: none"> • No deductible • No copay for PCP • \$40 per visit to a specialist <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$80 copay per visit
<p>Physical, Occupational, and Speech therapies</p> <p>Up to 60 visits (combined physical, occupational and/or speech therapy) per condition per benefit period for the services of the following qualified providers:</p> <ul style="list-style-type: none"> • Physical therapists • Occupational therapists • Speech therapists <p>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</p> <p>Note: We only cover therapy when a physician:</p> <ul style="list-style-type: none"> - orders the care - identifies the specific professional skills the patient requires and the medical necessity for skilled services; and - indicates the length of time the services are needed. <p>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.</p> <p>Brochure language also states under member liability:</p> <ul style="list-style-type: none"> • Other than any applicable inpatient or outpatient facility copay, member has no copay or coinsurance during an approved inpatient stay. <p>See Section 5 (c) for information on outpatient facility services.</p>	<p>Standard HealthyBlue Option</p> <p>In-network:</p> <ul style="list-style-type: none"> • No deductible • \$40 per visit to a specialist <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$80 copay per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> 	<p><i>All charges</i></p>

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

Benefit Description	You pay
<p>Physical, Occupational, and Speech therapies (cont.)</p>	<p>Standard HealthyBlue Option</p>
<ul style="list-style-type: none"> • <i>Exercise programs</i> • <i>Maintenance therapy</i> 	<p><i>All charges</i></p>
<p>Habilitative therapy</p>	<p>Standard HealthyBlue Option</p>
<ul style="list-style-type: none"> • 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 are subject to the applicable Occupational Therapy, Physical Therapy, and Speech Therapy copay but are not counted toward any visit maximum for therapy services • Habilitative therapy (cont.), Page 42 ABA coverage for Autism Spectrum Disorder include Verbal Behavior Therapy, Occupational Therapy, Physical Therapy and Speech Therapy from 18 months to 19 years of age. There will be no visit maximums and preauthorization will be required. • Note: Members are responsible for both physician and facility fees. Please refer to section 5(c) for outpatient facility fees. 	<p>In-network:</p> <ul style="list-style-type: none"> • No deductible • \$40 per visit to a specialist <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$80 copay per visit • Note: Member is responsible for obtaining authorization for services rendered outside of the service area and services by out-of-network non-participating providers.
<p><i>Not Covered: Benefits for Habilitative Services delivered through early intervention or school services.</i></p>	<p><i>All charges</i></p>
<p>Cardiac Rehabilitation</p>	<p>Standard HealthyBlue Option</p>
<p>Up to 90 visits per condition per benefit period</p> <p>Note: Cardiac Rehabilitation benefits are provided to Members who:</p> <ul style="list-style-type: none"> • have been diagnosed with significant cardiac disease • suffered a myocardial infarction • undergone invasive cardiac treatment immediately preceding referral <p>Note: Members are responsible for both physician and facility fees. Please refer to section 5(c) for outpatient or inpatient facility fees.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • No deductible • \$40 per visit to a specialist <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$80 copay per visit
<p><i>Note: Benefits are not provided for maintenance cardiac rehabilitation</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay
<p>Pulmonary Rehabilitation</p> <p>Pulmonary Rehabilitation</p> <ul style="list-style-type: none"> 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. <i>Benefits are not provided for maintenance programs</i> <p>Note: Members are responsible for both physician and facility fees. Please refer to section 5(c) for outpatient or inpatient facility fees.</p>	<p>Standard HealthyBlue Option</p> <p>In-network:</p> <ul style="list-style-type: none"> No deductible \$40 per visit to a specialist <p>Out-of-network:</p> <ul style="list-style-type: none"> Calendar year deductible applies \$80 copay per visit
<p>Hearing services (testing, treatment, and supplies)</p> <ul style="list-style-type: none"> For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O. or audiologist <p><i>Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) Preventive care.</i></p>	<p>Standard HealthyBlue Option</p> <p>In-network:</p> <ul style="list-style-type: none"> No deductible \$40 per visit to a specialist <p>Out-of-network:</p> <ul style="list-style-type: none"> Calendar year deductible applies \$80 copay per visit
<p>Hearing Aids</p> <ul style="list-style-type: none"> <i>One (1) medically necessary hearing aid per ear is covered up to our allowed amount each 36 months.</i> <p>Note: Medical devices, such as bone anchored hearing aids (BAHA) and cochlear implants, (that or which) are surgically implanted have no separate copay and are included in the facility copay or surgical allowance, dependent on who bills for the device. For additional details, see page 48 under the Orthopedic and prosthetic supplies.</p>	<p>In-network:</p> <ul style="list-style-type: none"> Calendar year deductible applies Paid up to our allowed benefit with no copay <p>Out-of-network:</p> <ul style="list-style-type: none"> Calendar year deductible applies Paid up to our allowed benefit with no copay <p>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</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Hearing services that are not shown as covered.</i> 	<p><i>All charges</i></p>
<p>Vision services (testing, treatment, and supplies)</p> <ul style="list-style-type: none"> One (1) pair of eyeglasses or contact lenses to correct an impairment directly related to intraocular surgery (such as for cataracts) <p>Note: This is a medical benefit not a vision benefit.</p>	<p>Standard HealthyBlue Option</p> <p>In-network:</p> <ul style="list-style-type: none"> No deductible No copay for PCP \$40 per visit to a specialist <p>Out-of-network:</p> <ul style="list-style-type: none"> Calendar year deductible applies; \$80 copay per visit

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

Benefit Description	You pay
Standard HealthyBlue Option	
<p>Vision services (testing, treatment, and supplies) (cont.)</p> <p>Routine eye exams</p> <p>Note: See Preventive care, children for eye exams for children</p> <p>Note: Eye care and exams related to medical conditions are subject to the specialist copay</p>	<p>In-network:</p> <ul style="list-style-type: none"> • No deductible • \$10 per visit at Davis Vision Providers • \$35 per visit to a specialist <p>Out-of-network:</p> <ul style="list-style-type: none"> • All charges above \$33
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses (except as listed above)</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> • <i>Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses except as provided by Davis Vision.</i> • <i>Deluxe eyeglass frames or lens features for eyeglasses or contact lenses such as special coating, polarization, UV treatment, etc.</i> • <i>Multifocal, accommodating, toric, or other premium intraocular lenses (IOLs) including Crystalens, ReStor, and ReZoom</i> • <i>Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described above</i> • <i>LASIK, INTACS, radial keratotomy, and other refractive surgical services</i> • <i>Refractions, including those performed during an eye examination related to a specific medical condition.</i> 	<p><i>All charges</i></p>
Standard HealthyBlue Option	
<p>Foot care</p> <p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • No deductible • No copay for PCP • \$40 per visit to a specialist <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$80 copay per visit

Foot care - continued on next page

Benefit Description	You pay
Foot care (cont.)	Standard HealthyBlue Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Other routine palliative or cosmetic care of the feet including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.</i> 	<p><i>All charges</i></p>
Orthopedic and prosthetic devices	Standard HealthyBlue Option
<ul style="list-style-type: none"> • 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. • 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. • Medically Necessary molded foot orthotics <p>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.</p>	<p>In-Network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • 25% coinsurance of plan allowance per device <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • 50% coinsurance of plan allowance per device
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports, heel pads, and heel cups (except as listed under Durable Medical Equipment)</i> • <i>Over the counter orthotics</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Wigs, including cranial prostheses, unless otherwise specified</i> • <i>Prosthetic replacements provided less than three (3) years after the last one we covered</i> 	<p><i>All charges</i></p>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
<p>Orthopedic and prosthetic devices (cont.)</p>	<p>Standard HealthyBlue Option</p>
<ul style="list-style-type: none"> • <i>Prosthetic devices such as artificial limbs and lenses following cataract removal unless covered under the DME benefit (see Durable Medical Equipment below)</i> 	<p><i>All charges</i></p>
<p>Durable medical equipment (DME)</p>	<p>Standard HealthyBlue Option</p>
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • 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 fitted compression stockings <p><i>Note: Prior authorization is required for In Network covered services. In Network providers will obtain prior authorization on behalf of the member.</i></p>	<p>In-Network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • 25% coinsurance up to allowed benefit <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • 50% coinsurance up to allowed benefit.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eye glasses and contact lenses (except as listed under Vision Services)</i> • <i>Dental prosthetics (except as listed under Orthopedic and Prosthetics above)</i> • <i>Foot orthotics (except as listed under Orthopedic and Prosthetics above)</i> 	<p><i>All charges</i></p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Standard HealthyBlue Option	
<p>Durable medical equipment (DME) (cont.)</p> <ul style="list-style-type: none"> • <i>Environment control products</i> • <i>Over the counter compression stockings</i> • <i>Medical equipment of an expendable nature (i.e. ace bandages, incontinent pads)</i> • <i>Replacement of DME equipment not due to normal wear and tear</i> • <i>Comfort and convenience items</i> • <i>Over the counter items, except as listed above</i> • <i>Exercise equipment</i> • <i>Equipment that can be used for non-medical purposes</i> 	<p><i>All charges</i></p>
Standard HealthyBlue Option	
<p>Home health services</p> <ul style="list-style-type: none"> • 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. • Home health care-Postpartum visits limited to two (2) per plan year. • Home health care-Post Mastectomy/Testicle Removal visits limited to four (4) per plan year. 	<p>In-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$40 per visit copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$80 copay per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> • <i>Private duty nursing</i> 	<p><i>All charges</i></p>
Standard HealthyBlue Option	
<p>Chiropractic</p> <p>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.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • No deductible • \$40 per visit to a specialist <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$80 copay per visit
<p><i>Not covered:</i></p> <p><i>Services other than for musculoskeletal conditions of the spine.</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay
Alternative treatments	Standard HealthyBlue Option
<p>Acupuncture, Limited to 20 visits per Benefit Period.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • No deductible • \$40 per visit to a specialist <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$80 copay per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Naturopathic services • Hypnotherapy • Biofeedback 	<p><i>All charges</i></p>
Educational classes and programs	Standard HealthyBlue Option
<p>Coverage is provided for:</p> <ul style="list-style-type: none"> • 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. Coverage for counseling for up to two quit attempts per year. (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 76. • Childhood obesity as part of routine child care visit • Birthing classes • Medically necessary nutrition therapy • Medically necessary professional nutritional counseling 	<p>In-network:</p> <ul style="list-style-type: none"> • No deductible • No copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • No copay
<p><i>Note:</i></p> <p>Benefits for all other types of health education classes and self-help programs that are not offered through the Plan's Health Education program are not covered.</p>	<p><i>All charges</i></p>

Benefit Description	You pay
Sleep Studies	Standard HealthyBlue Option
<p>CareFirst BlueChoice has created a network of providers that have agreed to oversee this program. The main objective of this approach is diligent monitoring of sleep apnea patients to ensure compliance with their treatment and reducing any further medical complications arising from sleep disorders. CareFirst BlueChoice has also removed barriers, such as prior authorizations, to acquiring sleep apnea equipment such as CPAP machines.</p>	<p>In-network:</p> <p>Home - No Deductible, then \$0 Office - No Deductible, then \$40 Freestanding - No Deductible, then \$40 Outpatient Hospital - Deductible, then \$150</p> <p>Out-of-network:</p> <p>Home - Deductible, then \$50 Office - Deductible, then \$80 Freestanding - Deductible, then \$80 Outpatient Hospital - Deductible, then \$200</p>
Infusion Services	Standard HealthyBlue Option
<p>Infusion Services: Prior Authorization required for Specialty Drugs</p>	<p>In network:</p> <p>Home/Office/Freestanding - No Deductible, \$40 Outpatient Hospital- Deductible, then \$200</p> <p>Out-of-network:</p> <p>Home/Office/Freestanding - No Deductible, \$80 Outpatient Hospital- Deductible, then \$200</p>

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.
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require prior authorization and identify which surgeries require precertification.
- Surgical procedures may involve the services of a co-surgeon, surgical assistant or assistant-at surgery who may bill separately from the primary surgeon.
- Under Standard HealthyBlue, when you receive out-of-network care from providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay.
- Under Standard HealthyBlue, when you receive out-of-network care from 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.
- Standard HealthyBlue has a calendar year in-network deductible of \$500 per Self Only enrollment and \$1,000 per Self Plus One and Self and Family contract, and an out-of-network deductible of \$3,000 per Self Only enrollment and \$6,000 for Self Plus One and Self and Family enrollment. The in-network deductible is included in the out-of-network total.
- 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 services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.

Benefit Description	You pay
Surgical procedures	Standard HealthyBlue Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • 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 <i>Reconstructive surgery</i>) 	<p>In-network</p> <p>Office:</p> <ul style="list-style-type: none"> • PCP – No deductible, no copay • Specialist – No deductible, then \$40 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay

Surgical procedures - continued on next page
Standard HealthyBlue Option Section 5(b)

Benefit Description	You pay
Standard HealthyBlue Option	
<p>Surgical procedures (cont.)</p> <ul style="list-style-type: none"> Surgical treatment of morbid obesity (bariatric surgery) <p>Note: You must meet certain criteria to be eligible for bariatric surgery. They include:</p> <ul style="list-style-type: none"> 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. <p>Please contact Member Services at 888/789-9065 for more details on bariatric surgery.</p> <ul style="list-style-type: none"> Insertion of internal prosthetic devices. See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information Voluntary sterilization (e.g., vasectomy) Treatment of burns <p>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).</p> <p>Note: See Section 5(c) about possible outpatient facility or inpatient hospital admission copayment</p>	<p>In-network</p> <p>Office:</p> <ul style="list-style-type: none"> PCP – No deductible, no copay Specialist – No deductible, then \$40 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> PCP – Deductible then, no copay Specialist – Deductible, then \$40 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> PCP – Deductible then, no copay Specialist – Deductible, then \$40 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> Deductible then, \$40 copay <p>Out-of-Network</p> <p>Office:</p> <ul style="list-style-type: none"> Deductible then, \$80 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> Deductible then, \$80 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> Deductible then, \$80 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> Deductible then, \$80 copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Reversal of voluntary sterilization Routine treatment of conditions of the foot (see <i>Foot care</i>) 	<p><i>All charges</i></p>
Standard HealthyBlue Option	
<p>Reconstructive surgery</p> <p>Transgender Surgery -</p>	<p>In-network</p> <p>Office:</p> <ul style="list-style-type: none"> PCP – No deductible, no copay Specialist – No deductible, then \$40 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> PCP – Deductible then, no copay Specialist – Deductible, then \$40 copay

Reconstructive surgery - continued on next page

Benefit Description	You pay
<p>Reconstructive surgery (cont.)</p> <p>We cover medically necessary care including where appropriate gender reassignment surgery, hormone therapy, and psychotherapy. Transgender services include, but are not limited to, medical counseling, behavioral health services, hormonal therapy, reconstructive surgery and cosmetic surgery. Please note some cosmetic surgery may be specifically excluded. Prior authorization for transgender services is required. The provider must submit a request for services and clinical information prior to the anticipated date of service through the CareFirst BlueChoice authorization portal or by fax. The clinical information is reviewed for persistent, well-documented gender dysphoria, the capacity to make a fully informed decision and to consent for treatment, age of majority in a given state, documentation to support any significant medical or mental health concerns are reasonably well controlled, and a history of hormone therapy for certain procedures. The request is reviewed according to the member’s contract, CareFirst BlueChoice’s Operating Procedure for Transgender Services, and CareFirst BlueChoice’s Medical Policy for Cosmetic and Reconstructive Surgery. The request is then reviewed by a Medical Director for final determination.</p>	<p align="center">Standard HealthyBlue Option</p> <p>In-network</p> <p>Office:</p> <ul style="list-style-type: none"> • PCP – No deductible, no copay • Specialist – No deductible, then \$40 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$40 copay <p>Out-of-Network</p> <p>Office:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - 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: 	<p>In-network</p> <p>Office:</p> <ul style="list-style-type: none"> • PCP – No deductible, no copay • Specialist – No deductible, then \$40 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$40 copay

Benefit Description	You pay
<p>Reconstructive surgery (cont.)</p> <ul style="list-style-type: none"> - 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) <p>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.</p> <p>Note: See Section 5(c) about possible outpatient facility or inpatient hospital admission copayment</p>	<p align="center">Standard HealthyBlue Option</p> <p>In-network</p> <p>Office:</p> <ul style="list-style-type: none"> • PCP – No deductible, no copay • Specialist – No deductible, then \$40 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$40 copay <p>Out-of-Network</p> <p>Office:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> 	<p><i>All charges</i></p>
<p>Oral and maxillofacial surgery</p> <p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • 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 	<p align="center">Standard HealthyBlue Option</p> <p>In-network</p> <p>Office:</p> <ul style="list-style-type: none"> • PCP – No deductible, no copay • Specialist – No deductible, then \$40 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay
<p>Oral and maxillofacial surgery (cont.)</p> <ul style="list-style-type: none"> Other surgical procedures that do not involve the teeth or their supporting structures. <p>Note: See Section 5(c) for outpatient facility or inpatient hospital admission copays</p>	<p>Standard HealthyBlue Option</p> <p>In-network</p> <p>Office:</p> <ul style="list-style-type: none"> PCP – No deductible, no copay Specialist – No deductible, then \$40 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> PCP – Deductible then, no copay Specialist – Deductible, then \$40 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> PCP – Deductible then, no copay Specialist – Deductible, then \$40 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> Deductible then, \$40 copay <p>Out-of-Network</p> <p>Office:</p> <ul style="list-style-type: none"> Deductible then, \$80 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> Deductible then, \$80 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> Deductible then, \$80 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> Deductible then, \$80 copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> 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 Any other dental surgery not listed or the result of traumatic injury or treatment of cleft pallet 	<p><i>All charges</i></p>

Benefit Description	You pay
<p>Organ/tissue transplants</p> <p>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.</p> <ul style="list-style-type: none"> • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis. • Cornea • Heart • Heart/lung • Intestinal transplant <ul style="list-style-type: none"> - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-Pancreas • Liver • Lung single/bilateral/lobar • Pancreas <p>These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to <i>other services</i> in Section 3 for prior authorization procedure.</p> <ul style="list-style-type: none"> • Autologous tandem transplant for: <ul style="list-style-type: none"> - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) <p>Note: See Section 5(c) about possible outpatient facility or inpatient hospital admission copayment.</p>	<p>Standard HealthyBlue Option</p> <p>In-network</p> <p>Office:</p> <ul style="list-style-type: none"> • PCP – No deductible, no copay • Specialist – No deductible, then \$40 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$40 copay <p>Out-of-Network</p> <p>Office:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay
<p>Blood or marrow stem cell transplants</p> <p>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.</p> <ul style="list-style-type: none"> • Allogeneic transplants for: 	<p>In-network</p> <p>Office:</p> <ul style="list-style-type: none"> • PCP – No deductible, no copay • Specialist – No deductible, then \$40 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Outpatient Hospital:</p>

Benefit Description	You pay
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL SLL) - Hemoglobinopathy - Infantile malignant osteoporosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and Related Disorders (i.e. Fanconi's PNH, pure red cell aplasia) - Mucopolisaccharidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: <ul style="list-style-type: none"> - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis 	<p>Standard HealthyBlue Option</p> <p>In-network</p> <p>Office:</p> <ul style="list-style-type: none"> • PCP – No deductible, no copay • Specialist – No deductible, then \$40 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$40 copay <p>Out-of-Network</p> <p>Office:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay

Organ/tissue transplants - continued on next page

Benefit Description	You pay
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - Breast Cancer - Childhood rhabdomyosarcoma - Ependymblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Mantle Cell (Non-Hodgkin Lymphoma) - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular Mediastinal, Retroperitoneal, and ovarian germ cell tumors <p>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.</p> <p>Refer to <i>Other Services</i> in Section 3 for prior authorization procedures:</p> <ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (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 Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia 	<p>Standard HealthyBlue Option</p> <p>In-network</p> <p>Office:</p> <ul style="list-style-type: none"> • PCP – No deductible, no copay • Specialist – No deductible, then \$40 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$40 copay <p>Out-of-Network</p> <p>Office:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay

Organ/tissue transplants - continued on next page

Benefit Description	You pay
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma <p>Note: See Section 5c about possible outpatient facility or inpatient hospital admission copayment.</p>	<p align="center">Standard HealthyBlue Option</p> <p>In-network</p> <p>Office:</p> <ul style="list-style-type: none"> • PCP – No deductible, no copay • Specialist – No deductible, then \$40 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$40 copay <p>Out-of-Network</p> <p>Office:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay
<p>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.</p> <p>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.</p> <ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Advanced Hodgkin's lymphoma 	<p>In-network</p> <p>Office:</p> <ul style="list-style-type: none"> • PCP – No deductible, no copay • Specialist – No deductible, then \$40 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$40 copay

Benefit Description	You pay
<p>Organ/tissue transplants (cont.)</p>	<p>Standard HealthyBlue Option</p>
<ul style="list-style-type: none"> - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelinating polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple scleraes or sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic transplants, reduced intensity conditioning or RIC) for: <ul style="list-style-type: none"> - 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 (MPDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle Cell anemia • Autologous Transplants for: <ul style="list-style-type: none"> - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma 	<p>In-network</p> <p>Office:</p> <ul style="list-style-type: none"> • PCP – No deductible, no copay • Specialist – No deductible, then \$40 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$40 copay <p>Out-of-Network</p> <p>Office:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay

Organ/tissue transplants - continued on next page
 Standard HealthyBlue Option Section 5(b)

Benefit Description	You pay
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - 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) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis • National Transplant Program (NTP) <p>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 members.</p> <p>Note: See Section 5c about possible outpatient facility or inpatient hospital admission copayment.</p>	<p>Standard HealthyBlue Option</p> <p>In-network</p> <p>Office:</p> <ul style="list-style-type: none"> • PCP – No deductible, no copay • Specialist – No deductible, then \$40 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$40 copay <p>Out-of-Network</p> <p>Office:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except as shown above • Implants of artificial organs • Transplants not listed as covered 	<p><i>All charges</i></p>
<p>Anesthesia</p> <p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center • Office • Skilled Nursing 	<p>Standard HealthyBlue Option</p> <p>In-network</p> <p>Office:</p> <ul style="list-style-type: none"> • PCP – No deductible, no copay • Specialist – No deductible, then \$40 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay

Anesthesia - continued on next page

Benefit Description	You pay
Anesthesia (cont.)	Standard HealthyBlue Option
	<p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – Deductible then, no copay • Specialist – Deductible, then \$40 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$40 copay <p>Out-of-Network</p> <p>Office:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Ambulatory Surgical Center (ASC):</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Outpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$80 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • Deductible then, \$80 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.
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.
- Standard HealthyBlue has a calendar year in-network deductible of \$500 per Self Only enrollment and \$1,000 per Self Plus One and Self and Family enrollment, and an out-of-network deductible of \$3,000 per Self Only enrollment and \$6,000 per Self Plus One and Self and Family enrollment. The in-network deductible is included in the out-of-network total.
- 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 outlined in Sections 5 (a) or (b).
- If a 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.

Benefit Description	You pay
Inpatient hospital	Standard HealthyBlue Option
<p>Room and board, such as:</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • Calendar year deductible then 20% of plan allowance <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible then 30% of plan allowance
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Acute Inpatient Rehabilitation 	<p>In-network:</p> <ul style="list-style-type: none"> • Deductible, then \$50 <p>Out-of-network:</p> <ul style="list-style-type: none"> • Deductible, then \$80

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	Standard HealthyBlue Option
<ul style="list-style-type: none"> Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home. 	<p>In-network:</p> <ul style="list-style-type: none"> Deductible, then \$50 <p>Out-of-network:</p> <ul style="list-style-type: none"> Deductible, then \$80
<p>HOSPITALIZATION (Members are responsible for both physician and facility fees)</p>	<p>Ambulatory Surgical Center Physician \$0 PCP / \$40 Specialist</p> <p>Outpatient Hospital Surgical Services Physician PCP Deductible, then no copay Specialist - Deductible, then \$40</p> <p>Inpatient Hospital Services (Includes Mental Health & Substance Use Disorder and IP Maternity) Physician PCP Deductible, then no copay Specialist - Deductible, then \$40</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Custodial care</i> <i>Non-covered facilities, such as nursing homes, schools</i> <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> <i>Private nursing care, except when medically necessary</i> 	<p><i>All Charges</i></p>
Outpatient hospital or ambulatory surgical center	Standard HealthyBlue Option
<ul style="list-style-type: none"> Operating, recovery, and other treatment rooms Prescribed drugs and medications 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. <p><i>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.</i></p>	<p>In-network:</p> <ul style="list-style-type: none"> Outpatient Hospital (Non-Surgical): No deductible, then \$40 copay per visit Freestanding /Ambulatory Surgical Center: No Deductible, then \$100 copay Outpatient Hospital (Surgical): Deductible, then \$150 copay <p>Out-of-network:</p> <ul style="list-style-type: none"> Outpatient Hospital (Non-Surgical): Deductible, then \$80 copay per visit Freestanding /Ambulatory Surgical Center: Deductible, then \$80 Outpatient Hospital (Surgical): Deductible, then \$200 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.)	Standard HealthyBlue Option
<p>Outpatient Hospital Diagnostic Services such as laboratory tests and pathology services</p> <ul style="list-style-type: none"> • Non-surgical • not lab or X-ray • Includes but, not limited to EKG's and EEG's 	<p>In-Network:</p> <ol style="list-style-type: none"> 1) Labs: Deductible, then \$0 2) X-Rays: Deductible, then \$40 copay 3) Other diagnostic services: Deductible, then \$40 copay <p>Out-of-Network:</p> <ol style="list-style-type: none"> 1) Labs: Deductible, then 20% of allowed benefit 2) X-Rays: Deductible, then 20% of allowed benefit 3) Other diagnostic services: Deductible then 20% of allowed benefit
<p>Specialty Imaging:</p> <ul style="list-style-type: none"> • MRA/MRS • MRI • PET • CAT scans 	<p>In-Network:</p> <p>Deductible, then \$60 copay</p> <p>Out-of-Network:</p> <p>Deductible, then 20% of allowed benefit</p>
Extended care benefits/Skilled nursing care facility benefits	Standard HealthyBlue Option
<p>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.</p> <ul style="list-style-type: none"> • 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. 	<p>In-Network:</p> <ul style="list-style-type: none"> • Facility- 20% of allowed amount <p>Out-of-Network:</p> <ul style="list-style-type: none"> • Facility- 30% of allowed amount
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> 	<p><i>All charges</i></p>
Hospice care	Standard HealthyBlue Option
<p>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 (6) months or less, will direct these services.</p> <p>Respite Care is limited to three (3) periods of 48 hours during the Hospice Eligibility Period.</p> <p>Bereavement Services are provided for up to three (3) visits during the 90 days following the patient's death.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$40 copay per visit <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$80 per copay per visit
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay
Ambulance	Standard HealthyBlue Option
<ul style="list-style-type: none"> • Local professional ambulance service when medically appropriate • Air ambulance service when medically appropriate • Not covered: Air ambulance, unless medically necessary and no other transport is reasonably available. 	<p>In-network:</p> <ul style="list-style-type: none"> • Deductible, then \$50 <p>Out-of-network:</p> <ul style="list-style-type: none"> • Deductible, then \$100 • 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.
- The calendar year deductible under Standard HealthyBlue Option is \$500 for Self Only enrollment and \$1,000 per Self Plus One and Self and Family enrollment. The calendar year deductible applies to almost all benefits in this section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
- 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 a free nurse advice line available 24 hours a day, 7 days a week. Call 800-535-9700 to speak to a registered nurse who will discuss your symptoms and recommend the most appropriate care.

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
<p>Emergency Services</p> <ul style="list-style-type: none"> • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services <p>Note: We waive the ER copay if you are admitted to the hospital.</p> <p>Note: For services within the service area and provided by a nonparticipating provider, the member is not responsible for amounts in excess of the allowed benefits.</p> <p>Note: If emergency room and treating physician bill separately, both copays will apply</p>	<p>Standard HealthyBlue Option</p> <p>In-Network:</p> <ul style="list-style-type: none"> • Emergency Room - Deductible, then \$200 copay (waived if admitted) • Emergency Room Professional - Deductible, then \$40 • Urgent Care Center - No Deductible, then \$50 copay • Ambulance - Deductible, then \$50 copay <p>Out-of-Network:</p> <ul style="list-style-type: none"> • Emergency Room - In-network deductible then, \$200 copay (waived if admitted) • Emergency Room Professional - In-network deductible then, \$40 • Urgent Care Center - No Deductible, then \$80 copay • Ambulance - Deductible, then \$100
<p><i>Not covered: Elective care or non-emergency care</i></p>	<p><i>All charges</i></p>
<p>Ambulance</p> <p>Professional ambulance service when medically appropriate.</p> <p>Note: See 5(c) for non-emergency service.</p>	<p>Standard HealthyBlue Option</p> <p>In-network: Deductible, then \$50</p> <p>Out-of-network:</p> <ul style="list-style-type: none"> • Deductible, then \$100 • Non-participating providers may bill the member for the amount in excess of our allowed benefit
<p><i>Not covered: Air ambulance, unless medically necessary and no other transport is reasonably available.</i></p>	<p><i>All charges</i></p>

Section 5(e). Mental Health and Substance Use Disorder Benefit

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.
- If you think you need mental health or substance abuse services, call 800-245-7013 for helping finding a provider.
- Under Standard HealthyBlue, when you receive out-of-network care from providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay.
- Under Standard HealthyBlue, when you receive out-of-network care from 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.
- Standard HealthyBlue has a calendar year in-network deductible of \$500 per Self Only contract and \$1,000 per Self Plus One and Self and Family enrollment, and an out-of-network deductible of \$3,000 for Self Only enrollment and \$6,000 for Self Plus One and Self and Family enrollment. The in-network deductible is included in the out-of-network total.
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
- 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
<p>Professional services</p> <p>When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Services include:</p> <ul style="list-style-type: none"> • Outpatient and office medication management • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) 	<p>Standard HealthyBlue Option</p> <p>In-network:</p> <ul style="list-style-type: none"> • Inpatient professional - Deductible then \$30 copay • Office/Outpatient Professional - No deductible, no copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • Inpatient professional - Deductible, then \$80 copay • Office/Outpatient Professional - Deductible, then \$80 copay <p>Note: Any cost between our allowed amount and the provider's billed charges.</p>

Professional services - continued on next page

Benefit Description	You pay
<p>Professional services (cont.)</p> <ul style="list-style-type: none"> • Diagnosis and treatment of alcoholism and drug use, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider’s office or other professional setting • Electroconvulsive therapy 	<p>Standard HealthyBlue Option</p> <p>In-network:</p> <ul style="list-style-type: none"> • Inpatient professional - Deductible then \$30 copay • Office/Outpatient Professional - No deductible, no copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • Inpatient professional - Deductible, then \$80 copay • Office/Outpatient Professional - Deductible, then \$80 copay <p>Note: Any cost between our allowed amount and the provider's billed charges.</p>
<p>Inpatient hospital or other covered facility</p> <p>Inpatient services provided and billed by a hospital or other covered facility</p> <ul style="list-style-type: none"> • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services 	<p>Standard HealthyBlue Option</p> <p>In-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$300 per admission copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$500 per admission copay applies and any cost between our allowed amount and the facility's billed charges.
<p>Outpatient hospital or other covered facility</p> <ul style="list-style-type: none"> • Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment 	<p>Standard HealthyBlue Option</p> <p>In-network: \$50 copay</p> <p>Out-of-Network: \$80 copay</p>
<p>Not covered</p> <ul style="list-style-type: none"> • <i>Inpatient admissions not precertified through Case Management</i> • <i>Care determined not to meet medically accepted levels of care.</i> 	<p>Standard HealthyBlue Option</p> <p><i>All charges</i></p>
<p>CareFirst Addiction Program</p> <p>The goals of the Alcohol and Drug Addiction Community-Based Program are to:</p> <ol style="list-style-type: none"> 1) Provide Members with necessary treatments to deliver the best outcomes for their individual clinical circumstances. 2) Provide access to cost effective addiction treatment programs that offer the most up-to-date clinically appropriate standards. 3) Educate Members, PCPs and all stakeholders as to the causes, identification and treatments of addiction. 4) Provide appropriate care in a community setting outside of a hospital or residential setting to enhance sustainable outcomes and lower costs. 	<p>Standard HealthyBlue Option</p> <ul style="list-style-type: none"> • CareFirst Preferred Addiction Recovery center - No cost share for intensive outpatient treatment program • Other outpatient recovery centers - Standard out-of-pocket amounts (copay, deductible, coinsurance) will apply

Benefit Description	You pay
<p>CareFirst Addiction Program (cont.)</p>	<p>Standard HealthyBlue Option</p>
<p>Members may receive any of the following services as part of their treatment:</p> <ul style="list-style-type: none"> • Assessment • Intensive Outpatient Program • Outpatient Detox • Partial Hospital Program (PHP) • Individual Therapy • Group Therapy • Family Therapy • Medication Assisted Treatment (MAT) (includes psychiatrist assessment) <p>Preferred Recovery Centers can be located at www.member.carefirst.com/mos/#/fadpublic/search/standard</p>	<ul style="list-style-type: none"> • CareFirst Preferred Addiction Recovery center - No cost share for intensive outpatient treatment program • Other outpatient recovery centers - Standard out-of-pocket amounts (copay, deductible, coinsurance) will apply

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.
- Federal law prevents the pharmacy from accepting unused medications.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- A \$100 calendar year deductible applies to Tiers 2 - Tiers 5 prescription drugs under the Standard HealthyBlue Option.
- A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified "Dispense as Written" for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- Mandatory Generic Drug Substitution requires that the member is responsible for the price difference between the brand and its generic equivalents as well as the copay when a generic is available and a brand drug is dispensed.
- Out-of-Network: Members will be responsible for all charges for drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies

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 dentist, and in states allowing it, a licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy, or by mail. You may contact CVS Health at **(800) 241-3371** to get more information on the mail order service. We will now require members to fill certain specialty medications within a designated network. Currently the exclusive specialty pharmacy network consists of CVS/Caremark.
- **We use a formulary.** A formulary is a list of covered drugs. Our drug list is reviewed and approved by an independent national committee comprised of physicians, pharmacists and other health care professionals who make sure the drugs on the formulary are safe and clinically effective. Some drugs may be excluded from the formulary and others may require prior authorization from the plan before being filled. Members may request a medical necessity waiver from the Plan to obtain medications that require prior authorization or medications that are excluded from the formulary.
- **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 CVS Health 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, and will pay two (2) copays. Your copay will be \$0, \$35, \$65 or \$150 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. 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 **CVS Health at (800) 241-3371**.
- **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. Please check the detailed charts in this section to see what you would pay should you get the brand named drug when a generic equivalent is available. If a drug is not available in a generic form, the appropriate brand copay will apply.
- **When you do have to file a claim.** Call our preferred drug vendor, **CVS Health at (800) 241-3371** to order prescription drug claim forms. You will send the prescription drug claim form to: **CVS Health, P.O. Box 52136, Phoenix, AZ 85072**.

Benefit Description	You pay
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medications that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i> • Insulin • Diabetic supplies limited to: Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction <p>Note:</p> <ul style="list-style-type: none"> • Specialty Drugs are typically high in cost and have one or more of the following characteristics: <ul style="list-style-type: none"> - Injectable, infused, inhaled, or oral therapeutic agents, or products of biotechnology - Complex drug therapy for a chronic or complex condition, and/or high potential for drug adverse effects - Specialized patient training on the administration of the drug (including supplies and devices needed for administration) and coordination of care is required prior to drug therapy initiation and/or during therapy - Unique patient compliance and safety monitoring requirements - Unique requirements for handling, shipping, and storage 	<p>Standard HealthyBlue Option</p> <p>There is a \$100 deductible for Tiers 2 through Tiers 5.</p> <p>Retail: up to 34-day supply per copay:</p> <p>Tier 1 generics (no deductible), \$0 Tier 2 preferred brand - After deductible, \$35 copay Tier 3 non-preferred brand - After deductible, \$65 copay Tier 4 preferred specialty - After deductible, \$100 copay Tier 5 non-preferred specialty - After deductible, \$150</p> <p>Maintenance drugs up to 90-day supply per copay:</p> <p>Tier 1 generics (no deductible), \$0 Tier 2 preferred brand - After deductible, \$70 copay Tier 3 non-preferred brand - After deductible, \$130 copay Tier 4 preferred specialty - After deductible, \$200 copay Tier 5 non-preferred specialty - After deductible, \$300 copay</p> <p>Mandatory Generic Drug Substitution 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 when a generic substitute is available and a brand drug is dispensed.</p> <p>Out-of-Network: Members will be responsible for all charges for drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay
<p>Covered medications and supplies (cont.)</p> <ul style="list-style-type: none"> - 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 - Specialty drugs require pre-authorization and the use of preferred pharmacies - Glucometers are covered as Durable Medical Equipment under the Medical and Surgical Benefits. See page 49 	<p>Standard HealthyBlue Option</p> <p>There is a \$100 deductible for Tiers 2 through Tiers 5.</p> <p>Retail: up to 34-day supply per copay:</p> <p>Tier 1 generics (no deductible), \$0 Tier 2 preferred brand - After deductible, \$35 copay Tier 3 non-preferred brand - After deductible, \$65 copay Tier 4 preferred specialty - After deductible, \$100 copay Tier 5 non-preferred specialty - After deductible, \$150</p> <p>Maintenance drugs up to 90-day supply per copay:</p> <p>Tier 1 generics (no deductible), \$0 Tier 2 preferred brand - After deductible, \$70 copay Tier 3 non-preferred brand - After deductible, \$130 copay Tier 4 preferred specialty - After deductible, \$200 copay Tier 5 non-preferred specialty - After deductible, \$300 copay</p> <p>Mandatory Generic Drug Substitution 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 when a generic substitute is available and a brand drug is dispensed.</p> <p>Out-of-Network: Members will be responsible for all charges for drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</p>
<p>Preventive Care medications to promote better health as recommended by ACA.</p> <p>The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a health care professional and filled at a network pharmacy:</p> <ul style="list-style-type: none"> • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 mcg & 800 mcg • Liquid iron supplements for children age 0-1 year • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Pre-natal vitamins for pregnant women • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 	<p>No Copay</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay
<p>Covered medications and supplies (cont.)</p> <p>Preventive Care medications to promote better health as recommended by ACA includes the following:</p> <ul style="list-style-type: none"> • Men and women ages 40 through 75 years old • No quantity limit • No prior authorization • Low to moderate dose statins, generics only (no high dose or brand statins are included) <p>The following generic drugs are covered without cost-share as prescribed by a health care professional and filled at a network pharmacy and will be made available as follows:</p> <ul style="list-style-type: none"> • Atorvastatin 10 mg, 20 mg • Fluvastatin 20 mg, 40 mg • Fluvastatin ER 80 mg • Lovastatin 10 mg, 20 mg, 40 mg • Pravastatin 10 mg, 20 mg, 40 mg, 80 mg • Rosuvastatin 5 mg, 10 mg • Simvastatin 5 mg, 10 mg, 20 mg, 40 mg <p>Note: For statin prescriptions outside of these age ranges and/or strengths our standard plan benefits will apply.</p>	<p>No copay</p>
<p>The following prescription drugs are covered in full:</p> <ul style="list-style-type: none"> - Chemotherapy medications received through a pharmacy - Preventive Breast Cancer drugs for women who are at an increased risk for breast cancer, and at a low risk for adverse medication effects <p>Please refer to our website carefirst.com/fedhmo for any updates to this list and for additional information on how these items are covered.</p>	<p>No copay</p>
<p>Women's contraceptive drugs and devices</p>	<p>No copay</p>
<p>Smoking deterrents</p> <p>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.</p>	<p>Nothing, up to two (2) attempts per year</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> 	<p><i>All charges</i></p>

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	Standard HealthyBlue Option
<ul style="list-style-type: none"> • <i>Drugs to enhance athletic performance</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them, except as listed above</i> • <i>Nonprescription medications</i> • <i>Infertility drugs related to procedures excluded under this contract (see Section 5 (a) and Section 5 (f))</i> <p><i>Note: Drugs that do not require a prescription by Federal law (Over-the-counter medications) that are not part of the preventive drug benefit. Listed preventive care over-the-counter drugs can be submitted only if the member presents a prescription form completed by an authorized provider.</i></p>	<p><i>All charges</i></p>

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 FEHB Plan will be First Primary payor of any benefit payment and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- Under Standard HealthyBlue, when you receive out-of-network care from providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate deductible and copay.
- Under Standard HealthyBlue, when you receive out-of-network care from 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.
- Standard HealthyBlue has a calendar year in-network deductible of \$500 per Self Only enrollment and \$1,000 per Self Plus One and Self and Family enrollment, and an out-of-network deductible of \$3,000 for Self Only enrollment and \$6,000 for Self Plus One and Self and Family enrollment. The in-network deductible is included in the out-of-network total.
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
- 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	Standard HealthyBlue Option
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.	<p>In-network:</p> <ul style="list-style-type: none"> • No deductible • No copay for primary care physician • \$40 per visit to a specialist <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$80 copay per visit
We have no other dental benefits	<i>All charges</i>

Section 5(h). Wellness and Other Special Features

Feature	Description
<p>Flexible benefits for the Standard Option</p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • 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 dispute our regular contract benefits decision under the OPM disputed claim process. (See Section 8).
<p>24-hour nurse line for the Standard Option</p>	<p>If your PCP is unavailable, call FirstHelp a free nurse advice line available 24 hours a day, 7 days a week. Call 800-535-9700 to speak to a registered nurse who will discuss your symptoms and recommend the most appropriate care.</p>
<p>Services for deaf and hearing impaired for the Standard Option</p>	<p>Our TTY number for Customer Service is (202) 479-3546</p>
<p>Care Team Program for the Standard Option</p>	<p>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:</p> <ul style="list-style-type: none"> • 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 <p>Please call us at (800) 783-4582 for more information about our Care Team Program</p>

Feature - continued on next page

Feature (cont.)	Description
	<p>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.</p>
<p>BlueRewards for Standard HealthyBlue Option</p>	<p>Financial incentives can effectively encourage Members to take an active role in their own health. Through Blue Rewards - the CareFirst Health and Wellness Incentive Program - Members can earn a reward for completing specific activities that increase the likelihood of success in their wellness efforts.</p> <p>For 2019, the Blue Rewards incentive program will be expanded to include Subscribers and Spouses for all CareFirst medical plans to encourage initial and ongoing engagement. Blue Rewards will feature three types of rewards 1) participation-based rewards, 2) ongoing rewards, and 3) coaching rewards:</p> <p>Participation Rewards – will be earned by members who complete one or both of the following activities within 120 days of their effective/renewal date:</p> <ol style="list-style-type: none"> 1. Choose a PCMH/PCMH Plus PCP AND complete their health screening with their PCP or at a CVS MinuteClinic to earn \$100 2. Complete a health assessment AND provide e-consent for wellness communications to earn \$50 <p>Ongoing Rewards – will become available once members complete the above step 2:</p> <ol style="list-style-type: none"> 1. Retaking their health assessment after a 6-month period to earn \$50 <p>Coaching Rewards – will become available if members are identified as coach-directed, rewards can be earned throughout the entire benefit period:</p> <ol style="list-style-type: none"> 1. Consenting and completing coaching calls (one session per month, maximum three sessions) to earn \$30 session 1, \$70 session 2, \$100 session 3 (maximum of \$200 per benefit period). 2. Members will receive their incentive in the form of a medical expense debit card to help pay for deductibles, copays, and coinsurance for CareFirst health, pharmacy, vision, and dental costs. The debit card reduces barriers to care and is preloaded with Merchant Category Codes (MCC) for eligible medical expenses that dictate whether the card will work at a specific location. If the member tries to use the card at a location where the MCC is not loaded, the card will reject the charge.

Feature - continued on next page

Feature (cont.)	Description
	<p>To get started, visit carefirst.com/sharecare. You'll need to enter your CareFirst account username and password and complete the one-time registration with Sharecare to link your CareFirst account information. This will help personalize your experience.</p>
<p>Cost Share Waiver</p>	<p>Members currently enrolled in a CareFirst care plan are eligible for the waiver of cost sharing for certain services. Patients in these care coordination programs have their copayments, coinsurance, deductibles, and visit limits waived for certain services. However, these waivers are only applied when a member is actively working to achieve stable health by complying with their care plan. When the member cost sharing waiver is applied, CareFirst pays the provider the amount of the member's cost share in addition to the agreed upon negotiated benefit amount.</p> <p>Members participating in the following TCCI Programs are eligible for a waiver of cost sharing on a majority of the services needed outside of the hospital. The programs include:</p> <ul style="list-style-type: none"> • Chronic care coordination • Complex case management <p>Behavioral health and substance use case management</p> <p>CareFirst will waive cost sharing for all in-network professional claims:</p> <ul style="list-style-type: none"> • Specialist office visits • Home health visits • Primary care visits • Physical therapy • Durable medical equipment or DME • Radiology (not in a hospital) • CareFirst Addiction Program Centers of Excellence <p>The following claims are not eligible for cost share waiver:</p> <ul style="list-style-type: none"> • Out-of-network claims • Institutional claims • Drug claims, regardless of their benefit coverage (Medical or Pharmacy)

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Section 5. HealthyBlue Advantage HDHP Overview

This Plan offers a High Deductible Health Plan (HDHP). The HealthyBlue Advantage HDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

The HealthyBlue Advantage HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read **important things you should keep in mind about these benefits** at the beginning of each subsection. Also read the general exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HealthyBlue Advantage HDHP benefits, contact us at (888) 789-9065 or on our website at www.carefirst.com/fedhmo.

Our HealthyBlue Advantage HDHP option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your health care benefits.

When you enroll in HealthyBlue Advantage HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment. If the member does not open an account within 30 days of receiving the HSA application/forms, their funds will automatically be defaulted into an HRA account. **As a reminder, once you are enrolled into your plan year benefits, you cannot change your HRA to an HSA election until the next annual Open Enrollment period.**

With this Plan, preventive care is covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described on page 100. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

HealthyBlue Advantage HDHP includes five (5) key components: Preventive care; traditional medical coverage health care that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

- **Preventive care** The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity/weight loss programs, disease management and wellness programs. These services are covered at 100% if you use a network provider and the services are described in Section 5, *Preventive care*. You do not have to meet the deductible before using these services.
- **Traditional medical coverage** After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in Section 5. The Plan typically pays a higher copay after the deductible for out-of-network care that applies to in-network services.

Covered services include:

 - Medical services and supplies provided by physicians and other health care professionals
 - Surgical and anesthesia services provided by physicians and other health care professionals
 - Hospital services; other facility or ambulance services
 - Emergency services/accidents
 - Mental health and substance abuse benefits
 - Prescription drug benefits
 - Dental benefits
- **Savings** Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses.

- **Health Savings Accounts (HSAs)**

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA (except for veterans with a service-connected disability) and/or Indian Health Service (IHS) benefits within the last three months or do not have other health insurance coverage other than another High Deductible Health Plan. In 2019, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$75 per month for a Self Only or \$150 per month for a Self Plus One or a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is \$3,500 for an individual and \$7,000 for a family. See maximum contribution information on page 88. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

HSA features include:

- Your contributions to the HSA are tax deductible
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses)
- Your unused HSA funds and interest accumulate from year to year
- It is portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in HealthyBlue Advantage HDHP with a Health Savings Account (HSA), and start or become covered by a HCFSA health care flexible spending account (such as FSAFEDS offers – see Section 11), HealthyBlue Advantage HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you. **Forms are available on our website, www.carefirst.com/fedhmo, and may be submitted directly to us at the same time you complete your enrollment forms.**

- **Health Reimbursement Arrangement (HRA)**

If you are not eligible for an HSA, for example, you are enrolled in Medicare or have another health plan; we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA as soon as possible. Forms are available on our website, www.carefirst.com/fedhmo, and may be submitted directly to us at the same time you complete your enrollment forms.

In 2019, we will give you an HRA credit of \$900 per year for a Self Only enrollment, or \$1,800 per year for a Self Plus One enrollment, or \$1,800 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that do not count toward the deductible.

HRA features include:

- For HealthyBlue Advantage HDHP, the HRA is administered by Blue Fund Administrator
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by HealthyBlue Advantage HDHP
- Unused credits carryover from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFA). However, you must meet FSAFEDS eligibility requirements

- **Catastrophic protection for out-of-pocket expenses**

When you use in-network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to \$3,500 per person or \$7,000 per Self Plus One, or Self and Family enrollment, and out-of-network care is limited to \$6,750 per person and \$13,500 per Self Plus One or Self and Family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4, *Your catastrophic protection out-of-pocket maximum* and HealthyBlue Advantage HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

Please note that the out-of-pocket maximums will be combined for both in-network and out-of-network services.

- **Health education resources and account management tools**

HealthyBlue Advantage HDHP Section 5(i) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

Section 5. Savings - HSAs and HRAs

Feature comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) <i>Provided when you are ineligible for an HSA</i>
Administrator	The Plan will establish an HSA for you with Blue Fund Administrator and Further, HealthyBlue Advantage HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.)	Blue Fund Administrator is the HRA fiduciary for this Plan.
Fees	Set-up fee is paid by the HealthyBlue Advantage HDHP. No per month administrative fee charged by the fiduciary and taken out of the account balance as long as you are enrolled in the plan.	None
Eligibility	You must: <ul style="list-style-type: none"> • Enroll in HealthyBlue Advantage HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not have received VA (except for veterans with a service-connected disability) and/or Indian Health Service (IHS) benefits in the last three (3) months • Complete and return all banking paperwork • If you do not open an account with Bank of New York Mellon (BBY Mellon) within 30 days of receiving HSA application/forms, you will automatically be defaulted into an HRA account 	You must enroll in HealthyBlue Advantage HDHP. Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.
Funding	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HealthyBlue Advantage HDHP.	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.

	<p>Note: If your effective date in the HDHP is after the 1st of the month, the earliest your HSA will be established is the 1st of the following month.</p> <p>In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).</p>	
Self Only enrollment	For 2019, a monthly premium pass through of \$75 will be made by the HealthyBlue Advantage HDHP directly into your HSA each month.	For 2019, your HRA annual credit is \$900 (prorated for mid-year enrollment).
Self Plus One enrollment	For 2019, a monthly premium pass through of \$150 will be made by the HealthyBlue Advantage HDHP directly into your HSA each month	For 2019, your HRA annual credit is \$1,800 (prorated for mid-year enrollment).
Self and Family enrollment	For 2019, a monthly premium pass through of \$150 will be made by the HealthyBlue Advantage HDHP directly into your HSA each month.	For 2019, your HRA annual credit is \$1,800 (prorated for mid-year enrollment).
Contributions/credits	<p>The maximum that can be contributed to your HSA is an annual combination of the HealthyBlue Advantage HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of \$3,500 for an individual \$7,000 for a family.</p> <p>If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution.</p> <p>You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HealthyBlue Advantage HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year.</p>	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.

	<p>If you do not meet the 12-month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.</p> <p>You may rollover funds you have in other HSAs to the HealthyBlue Advantage HDHP HSA (rollover funds do not affect your annual maximum contribution under HealthyBlue Advantage HDHP).</p> <p>HSAs earn tax-free interest (does not affect your annual maximum contribution).</p>	
Self Only enrollment	In addition to the pass through contribution, you may make an annual maximum contribution of \$3,000.	You cannot contribute to the HRA.
Self Plus One enrollment	In addition to the pass through contribution, you may make an annual maximum contribution of \$6,000.	You cannot contribute to the HRA.
Self and Family enrollment	In addition to the pass through contribution, you may make an annual maximum contribution of \$6,000.	You cannot contribute to the HRA.
Access funds	<p>You can access your HSA by the following methods:</p> <ul style="list-style-type: none"> • Debit card • Withdrawal form • Checks 	For qualified medical expenses under your HealthyBlue Advantage HDHP, you will be automatically reimbursed when claims are submitted through the HDHP. For expenses not covered by the HealthyBlue Advantage HDHP, such as orthodontia, a reimbursement form will be sent to you upon your request.
Distributions/ withdrawals <ul style="list-style-type: none"> • Medical 	<p>You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HealthyBlue Advantage HDHP) from the funds available in your HSA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses.</p>	<p>You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HealthyBlue Advantage HDHP.</p> <p>Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan.</p> <p>See <i>Availability of funds</i> below for information on when funds are available in the HRA.</p> <p>Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.</p>
<ul style="list-style-type: none"> • Non-medical 		Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.

	<p>If you are under age 65, distributions/ withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds.</p> <p>When you turn age 65, distributions/ withdrawal can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.</p>	
Availability of funds	<p>Funds are not available for withdrawal until all the following steps are completed:</p> <ul style="list-style-type: none"> • Your enrollment in HealthyBlue Advantage HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change) • The HealthyBlue Advantage HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA • The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you 	<p>The entire amount of your HRA will be available to you upon your enrollment in the HealthyBlue Advantage HDHP.</p>
Account owner	FEHB enrollee	HealthyBlue Advantage HDHP
Portable	<p>You can take this account with you when you change plans, separate or retire.</p> <p>If you do not enroll in another HDHP, you can no longer contribute to your HSA.</p>	<p>If you retire and remain in HealthyBlue Advantage HDHP, you may continue to use and accumulate credits in your HRA.</p> <p>If you terminate employment or change health plans, only eligible expenses incurred while covered under HealthyBlue Advantage HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.</p>
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If you have an HSA

• **Contributions**

All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

If you newly enroll in HealthyBlue Advantage HDHP during Open Season and your effective date is after January 1st, or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

• **Catch-up contributions**

If you are age 55 or older, the IRS permits you to make additional “catch-up” contributions to your HSA. The allowable catch-up contribution is \$1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury website at www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx.

• **If you die**

If you have not named beneficiary, and you are married, your HSA becomes your spouse’s; otherwise, your HSA becomes part of your taxable estate.

• **Qualified expenses**

You can pay for “qualified medical expenses;” as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, physician prescribed over-the-counter drugs, LASIK surgery, and some nursing services.

When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling (800) 829-3676, or visit the IRS website at www.irs.gov and click on “Forms and Publications”. Note: although physician prescribed over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

• **Non-qualified expenses**

You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

• **Tracking your HSA balance**

You will receive a periodic statement that shows the “premium pass through”, withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.

• **Minimum reimbursements from your HSA**

You can request reimbursement in any amount. However, funds will not be disbursed until your reimbursement totals at least \$25.

If you have an HRA

- **Why an HRA is established**

If you do not qualify for an HSA when you enroll in HealthyBlue Advantage HDHP, or later become ineligible for an HSA, we will establish an HRA for you. Also, if you do not open an account within 30 days of receiving the HSA application/forms, your funds will be automatically defaulted into an HRA account. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.

- **How an HRA differs**

Please review the chart on page 89 which details the differences between HRA and an HSA. The major differences are:

- you cannot make contributions to an HRA
- funds are forfeited if you leave the HDHP
- an HRA does not earn interest
- HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HealthyBlue Advantage HDHP. FEHB law does not permit qualified medical expenses to include 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.

Section 5. Preventive Care

Important things you should keep in mind about these benefits:

- In-network preventive care services listed in this Section are not subject to the deductible.
- You must use providers that are part of our network.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible.*
- When seeing providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.

Benefit Description	You pay
Preventive care, adult	
<p>Routine physical every year which includes screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal cancer screenings 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: <ul style="list-style-type: none"> • Fecal occult blood test • Sigmoidoscopy screening - every five (5) years starting at age 50 • Colonoscopy screening - every ten (10) years starting at age 50 • Lung Cancer screenings - adults age 55 to 80 who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years • Screening will be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery • HIV screenings starting at age 15 to 65 • Individual counseling on prevention and reducing health risks • Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC), based on the Advisory Committee on Immunization Practices (ACIP) schedule 	<p>In-network:</p> <ul style="list-style-type: none"> • No Copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • No Copay • All costs between the plan allowance and the provider billed charges

Preventive care, adult - continued on next page

Benefit Description	You pay
<p>Preventive care, adult (cont.)</p> <ul style="list-style-type: none"> Routine Prostate Specific Antigen (PSA) test - one (1) annually for men age 40 and older in accordance with the most current American Cancer Society guidelines <p>Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/</p> <p>And HHS at:</p> <p>http://www.healthcare.gov/preventive-care-benefits/For additional information: healthfinder.gov/myhealthfinder/default.aspx</p> <p>Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.</p>	<p>In-network:</p> <ul style="list-style-type: none"> No Copay <p>Out-of-network:</p> <ul style="list-style-type: none"> Calendar year deductible applies No Copay All costs between the plan allowance and the provider billed charges
<p>Well woman care - including, but not limited to:</p> <ul style="list-style-type: none"> Cervical cancer screening (Pap smear) Human Papillomavirus (HPV) testing Chlamydia/gonorrhea screening Osteoporosis screening Breast cancer screening Counseling for sexually transmitted infections Counseling and screening for human immune-deficiency virus (HIV) Contraceptive methods and counseling Screening and counseling for interpersonal and domestic violence. Screening for women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (<i>BRCA1</i> or <i>BRCA2</i>). Women with positive screening results are eligible to receive genetic counseling and testing, if indicated after counseling <p>Note: Women's preventive services: Please refer to the specific link to women's preventive services. https://www.healthcare.gov/preventive-care-women/.</p>	<p>In-network:</p> <ul style="list-style-type: none"> No copay <p>Out-of-network:</p> <ul style="list-style-type: none"> Calendar year deductible applies No copay When seeing providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
<ul style="list-style-type: none"> Routine mammogram — covered for women 	<p>In-network:</p> <ul style="list-style-type: none"> No copay <p>Out-of-network:</p> <ul style="list-style-type: none"> No copay When seeing providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay
<ul style="list-style-type: none"> Routine exams limited to: <ul style="list-style-type: none"> One (1) routine eye exam every 12 months One (1) routine OB/GYN exam every 12 months including one (1) Pap smear and related services One (1) routine hearing exam every 24 months 	<p>In-network:</p> <ul style="list-style-type: none"> No copay <p>Out-of-network:</p> <ul style="list-style-type: none"> Calendar year deductible applies No copay When seeing providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel. Immunizations, boosters, and medications for travel or work-related exposure 	<p><i>All charges</i></p>
Preventive care, children	
<ul style="list-style-type: none"> Well-child visits examinations, and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics <p>Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org/Pages/default.aspx</p> <p>Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/</p> <p>HHS: www.healthcare.gov/preventive-care-benefits/.</p> <p>For additional information: healthfinder.gov/myhealthfinder/default.aspx</p>	<p>In-network:</p> <ul style="list-style-type: none"> No copay <p>Out-of-network:</p> <ul style="list-style-type: none"> Calendar year deductible applies No copay When seeing providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	
<p>Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • No copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • No copay • When seeing providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel</i> • <i>Immunizations, boosters, and medications for travel</i> 	<p><i>All charges</i></p>
Dental Preventive Care	
<p>Preventive care limited to:</p> <ul style="list-style-type: none"> • Prophylaxis (cleaning of teeth) – limited to two (2) treatments per calendar year • Fluoride applications (limited to one (1) treatment per calendar year and for children under age 16) • Sealants – (once every three (3) years, from the last date of service, on permanent molars for children under age 16) • Space maintainer (primary teeth only) • Bitewing X-rays (one (1) set per calendar year) • Complete series X-rays (one (1) complete series every three (3) years) • Periapical X-rays • Routine oral evaluations (limited to two (2) per calendar year) 	<p>All charges</p>

Section 5. Traditional Medical Coverage Subject to the Deductible

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.
- In-network preventive care is covered at 100% and is not subject to the calendar year deductible
- The deductible is \$1,400 per Self Only enrollment, \$2,800 per Self Plus One and Family enrollment for in-network services. The deductible is \$3,000 per Self Only enrollment, or \$6,000 per Self Plus One and Self and Family enrollment for out-of-network care. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under traditional medical coverage, you are responsible for your coinsurance and copayments for covered expenses.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total \$4,000 per Self Only enrollment and \$6,500 per Self Plus One and Self and Family enrollment in any calendar year for in-network services and \$6,000 for Self Only enrollment and \$12,000 for Self Plus One and Self and Family enrollment for out-of-network services, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).
- In-network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits apply.
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
- 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 After the calendar year deductible
Deductible before Traditional medical coverage begins	
The deductible applies to almost all benefits in this Section. In the You pay column, we say “No deductible” when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of \$1,400 per Self Only enrollment, \$2,800 per Self Plus One enrollment and Self and Family enrollment for in-network services and \$3,000 per Self Only, and \$6,000 per Self Plus One and Self and Family for out-of-network care.
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	<p>In-network: After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket.</p> <p>Out-of-network: After you meet the deductible, you pay the indicated coinsurance based on our Plan allowance and any difference between our allowance and the billed amount.</p>

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.
- The calendar year deductible is \$1,400 per Self Only enrollment or \$2,800 per Self Plus One and Self and Family enrollment for in-network services and \$3,000 per Self Only enrollment and \$6,000 per Self Plus One and Self and Family enrollment for out-of-network care each calendar year. The Self and Family deductible can be satisfied by one (1) or more family members. The deductible applies to all benefits in this Section unless we indicate differently. Durable medical equipment (DME), including orthopedic and prosthetic devices, are subject to the calendar year deductibles mentioned above.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- 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.
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.

Benefit Description	You pay After the calendar year deductible
Diagnostic and treatment services	
Professional services of physicians: <ul style="list-style-type: none"> • In physician’s office • Inpatient/Skilled nursing Professional (Non-Surgical) • Outpatient Professional (Non-Surgical) • Office medical consultations • Second surgical opinion 	<p>Office/Outpatient Hospital</p> <p>In-network:</p> <ul style="list-style-type: none"> • PCP - No copay • Specialist - \$35 copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay <p>Inpatient Hospital/Skilled Nursing</p> <p>In-network:</p> <ul style="list-style-type: none"> • PCP - No copay • Specialist - \$35 copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay

Diagnostic and treatment services - continued on next page

Benefit Description	You pay After the calendar year deductible
Diagnostic and treatment services (cont.)	
<p>Convenience care (Retail health clinic):</p> <p>While primary care providers should be the first line of defense for members, there are tiered care alternatives members can access when their PCP is not available such as CVS MinuteClinic, Walgreens TakeCare and Target Clinic who can serve as the immediate backup to PCPs (after hours).</p>	<p>In-network: Deductible, then \$0 copay</p> <p>Out-of-network: Deductible, then \$80 copay</p>
Telehealth Services	
<p>Telemedicine visits – video visits – are fully covered by CareFirst BlueChoice Inc. and are reimbursed at the same level as an in-office Evaluation and Management (E&M) visit.</p> <p>Pathway to Telemedicine Services:</p> <p>Pathway #1</p> <p>Members seeking treatment advice for common conditions (e.g., allergies, bronchitis, strep throat, eye or ear infections, etc.) have 24/7 access to on-demand video consultations with board certified physicians through the CareFirst BlueChoice website www.CareFirstBlueChoiceVideoVisit.com.</p>	<p>Deductible, then \$0 copay for video visit with a PCP</p>
Diagnostic Services (Professional)	
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG 	<p><u>Office/Freestanding Setting</u></p> <p>In-Network:</p> <ol style="list-style-type: none"> 1) Labs: Deductible then, no copay 2) X-Rays: Deductible then, \$35 3) Other diagnostic services: Deductible then, \$35 <p>Out-of-Network:</p> <ol style="list-style-type: none"> 1) Labs: Deductible then, 20% of allowed amount 2) X-Rays: Deductible then, 20% of allowed amount 3) Other diagnostic services: Deductible then, 20% of allowed amount
<p>Specialty Imaging:</p> <ul style="list-style-type: none"> •MRA/MRS •MRI •PET •CAT scans 	<p>In-Network:</p> <p>Deductible then, \$50</p> <p>Out-of-Network:</p> <p>Deductible then, 20% of allowed amount</p>

Benefit Description	You pay After the calendar year deductible
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Screening for gestational diabetes for pregnant women after 24 weeks gestation • Delivery • Postnatal care <p>Members are responsible for both physician and facility fees. Please refer to section 5(c) for outpatient or inpatient facility fees.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • No copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay
<p>Breastfeeding support, supplies and counseling for each birth</p> <p>Note: Benefit coverage for breastfeeding support, supplies and counseling for each birth begins immediately after delivery.</p> <p>Note: Breastfeeding support benefits include but are not limited to the following: comprehensive lactation support, lactation counseling, and rental or purchase of a breast pump and related supplies in conjunction with each birth.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • No copay, deductible does not apply <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay
<p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your vaginal delivery; see page 23 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal 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 Plus One or 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. <p>Note: When a newborn requires definitive treatment during or after the mother’s confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Doulas</i> 	

Benefit Description	You pay After the calendar year deductible
Family planning	
<p>Contraceptive counseling on an annual basis</p>	<p>In-network:</p> <ul style="list-style-type: none"> • No copay, deductible does not apply <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization for a woman • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit</p>	<p>In-network:</p> <ul style="list-style-type: none"> • No copay – deductible does not apply <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay
<p>Voluntary sterilization for a male:</p> <p>Hospital services are covered under Section 5(c). Surgical benefits are covered under Section 5(b).</p>	<p>Deductible applies:</p> <p>In-network:</p> <ul style="list-style-type: none"> • Professional copay of \$35 <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay <p>Note: Facility copays are in Section 5(c).</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic testing and counseling</i> • <i>Elective Abortion</i> 	<p><i>All charges</i></p>
Infertility services	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Fertility drugs for covered procedures <p>Note:</p> <ul style="list-style-type: none"> • 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). 	<p>In-network:</p> <ul style="list-style-type: none"> • \$35 office copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay

Benefit Description	You pay After the calendar year deductible
Infertility services (cont.)	
<ul style="list-style-type: none"> • Prior authorization for the treatment must be obtained from CareFirst BlueChoice. • Benefits are limited to six (6) attempts per live birth. • Any charges associated with the collection of the sperm will not be covered unless the partner is also a member. • The member is responsible for the copayment or coinsurance for artificial insemination 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 regardless of whether the couple has a relationship under which the FEHB Program recognizes each partner as a spouse of the other. • Members are responsible for both physician and facility fees. Please refer to Section 5(c) for outpatient or inpatient facility fees. 	<p>In-network:</p> <ul style="list-style-type: none"> • \$35 office copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>In vitro fertilization (IVF)</i> • <i>Embryo transfer and gamete intra-fallopian transfer (GIFT)</i> • <i>Zygote intra-fallopian transfer (ZIFT)</i> • <i>Intrauterine and Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>Services and supplies related to ART procedures</i> - <i>Cost of donor sperm</i> - <i>Cost of donor egg</i> - <i>Drugs for non-covered procedure</i> 	<p><i>All charges</i></p>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections <p>Note: If there is a charge for the injection and not the office visit, the office copay will still apply.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • \$35 office copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay
Allergy serum	No charge

Benefit Description	You pay After the calendar year deductible
Treatment therapies	
<ul style="list-style-type: none"> • Radiation therapy • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Growth hormone therapy (GHT) • Applied Behavior Analysis (ABA)-Children with autism spectrum disorder <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>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.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • \$35 office copay <p>Out-of network:</p> <ul style="list-style-type: none"> • \$80 copay <p>Note: Members are responsible for both physician and facility fees. Please refer to section 5(c) for outpatient or inpatient facility fees.</p>
<ul style="list-style-type: none"> • Chemotherapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 117.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • \$35 office copay <p>Out-of network:</p> <ul style="list-style-type: none"> • \$80 copay <p>Note: Members are responsible for both physician and facility fees. Please refer to section 5(c) for outpatient or inpatient facility fees.</p>
Physical and occupational and speech therapies	
<p>Up to 60 visits (combined physical, occupational and/or speech therapy) per condition per benefit period for the services of the following qualified providers:</p> <ul style="list-style-type: none"> • Physical therapists • Occupational therapists • Speech therapists <p>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</p> <p>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.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • \$35 office copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay

Physical and occupational and speech therapies - continued on next page

Benefit Description	You pay After the calendar year deductible
Physical and occupational and speech therapies (cont.)	
<p>Note: Other than any applicable inpatient or outpatient facility copay, member has no copay or coinsurance during an approved inpatient stay.</p> <p>Note: Members are responsible for both physician and facility fees. Please refer to section 5(c) for outpatient or inpatient facility fees.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • \$35 office copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> • <i>Maintenance therapy</i> 	<p><i>All charges</i></p>
Cardiac Rehabilitation	
<p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 90 sessions per condition per benefit period.</p> <ul style="list-style-type: none"> • Cardiac rehabilitation benefits are provided to members who: <ul style="list-style-type: none"> - have been diagnosed with a significant cardiac disease - suffered a myocardial infarction - undergone invasive cardiac treatment immediately preceding referral <p>Note: Members are responsible for both physician and facility fees. Please refer to section 5(c) for outpatient or inpatient facility fees.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • \$35 office copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay
<p><i>Not Covered:</i></p> <ul style="list-style-type: none"> • <i>Benefits are not provided for maintenance cardiac rehabilitation.</i> 	<p><i>All charges</i></p>
Pulmonary Rehabilitation	
<p>Pulmonary Rehabilitation</p> <ul style="list-style-type: none"> • 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. • <i>Benefits are not provided for maintenance programs</i> <p>Note: Members are responsible for both physician and facility fees. Please refer to section 5(c) for outpatient or inpatient facility fees.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • \$35 office copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay

Benefit Description	You pay After the calendar year deductible
Habilitative therapy	
<ul style="list-style-type: none"> 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 are subject to the applicable occupational therapy, physical therapy, and speech therapy copay, but are not counted toward any visit maximum for Applied Behavioral Analysis (ABA) coverage for Autism Spectrum Disorder, verbal behavior therapy, occupational therapy, Physical Therapy and Speech Therapy from 18 months to 19 years of age. There will be no visit maximums and preauthorization will be required therapy services. 	<p>In-network:</p> <ul style="list-style-type: none"> Deductible, then \$35 <p>Out-of-network:</p> <ul style="list-style-type: none"> Deductible, then \$80 copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Benefits delivered through early intervention or school services 	<p><i>All charges</i></p>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Member is responsible for getting approval for all out-of-network services <p>Note: For routine hearing screening performed during a child's preventive care visit, see Section 5 (a), <i>Preventive care, children.</i></p>	<p>In-network:</p> <ul style="list-style-type: none"> \$35 per visit <p>Out-of-network:</p> <ul style="list-style-type: none"> \$80 copay
<ul style="list-style-type: none"> External hearing aids Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants <p>Note:</p> <ul style="list-style-type: none"> For more information on benefits, see Section 5(a) <i>Orthopedic and prosthetic devices.</i> 	<p>In-network:</p> <ul style="list-style-type: none"> \$35 copay <p>Out-of-network:</p> <ul style="list-style-type: none"> \$80 copay <p>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.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Hearing services that are not shown as covered 	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Annual eye refractions 	<p>In-network:</p> <ul style="list-style-type: none"> • \$10 at Davis providers for routine eye exams • Medical Eye exams - \$35 specialist copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses (except as listed above)</i> • <i>Eye exercises and orthoptics</i> • <i>Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses</i> • <i>Deluxe eyeglass frames or lens features for eyeglasses or contact lenses such as special coating, polarization, UV treatment, etc.</i> • <i>Multifocal, accommodating, toric, or other premium intraocular lenses (IOLs) including Crystalens, ReStor, and ReZoom</i> • <i>Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described above</i> • <i>LASIK, INTACS, radial keratotomy, and other refractive surgery and/or other refractive surgical services</i> • <i>Refractions, including those performed during an eye examination related to a specific medical condition</i> 	<p><i>All charges</i></p>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • \$35 copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible
<p>Orthopedic and prosthetic devices</p> <ul style="list-style-type: none"> • Artificial limbs and eyes • Prosthetic sleeve or sock • 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 (1) hair prosthesis per benefit period. • External hearing aids (See Hearing services in this section for additional information) • 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. • Medically Necessary molded foot orthotics <p>Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) <i>Surgical and anesthesia services</i>. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) <i>Services provided by a hospital or other facility, and ambulance services</i>.</p> <p>Note: Externally worn prosthetics and devices are treated as Durable medical Equipment (DME). See page 111.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • \$35 copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Prosthetic replacements provided less than 3 years after the last one we covered</i> • <i>Over-the-counter orthotics</i> 	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible
<p>Durable medical equipment (DME)</p> <p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors • Insulin pumps • Canes • Diabetic shoes • Commodes • Suction machines • Medical supplies (i.e. ostomy and catheter supplies, dialysis supplies, medical foods for inherited metabolic diseases and disorders 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 fitted compression stockings <p>Note: Call us at (888) 789-9065 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>In-Network:</p> <ul style="list-style-type: none"> • Deductible, then 25% of allowed amount <p>Out-of-network:</p> <ul style="list-style-type: none"> • Deductible, then 25% of allowed amount
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eye glasses and contact lenses (except as listed under Vision Services)</i> • <i>Dental prosthetics (except as listed under Orthopedic and Prosthetics above)</i> • <i>Foot orthotics (except as listed above)</i> • <i>Environment control products</i> • <i>Over-the-counter compression stockings</i> 	<p><i>All Charges</i></p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible
Durable medical equipment (DME) (cont.)	
<ul style="list-style-type: none"> • Medical equipment of an expendable nature (i.e. ace bandages, incontinent pads) • 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
Home health services	
<ul style="list-style-type: none"> • 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. • Home Health Services-Postpartum visits are limited to two (2) per plan year. • Home Health Services-Post Mastectomy/Testicle Removal visits are limited to four (4) per plan year. 	<p>In-network:</p> <ul style="list-style-type: none"> • \$35 copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • 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 • Private duty nursing 	All charges
Chiropractic	
<p>Chiropractic services are limited to spinal manipulation, evaluation and treatment up to a maximum of 20 visits per calendar year when performed by a Plan chiropractor.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • \$35 copay <p>Out-of-network</p> <ul style="list-style-type: none"> • \$80 copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Services other than for musculoskeletal conditions of the spine. 	All charges

Benefit Description	You pay After the calendar year deductible
Alternative treatments	
<p>Acupuncture, limited to 20 visits per benefit period.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • \$35 copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Naturopathic services • Hypnotherapy • Biofeedback • Acupuncture except as listed above 	<p><i>All charges</i></p>
Educational classes and programs	
<p>Coverage is provided for:</p> <ul style="list-style-type: none"> • Tobacco Cessation programs, including individual/group/telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. 	<p>In-network:</p> <ul style="list-style-type: none"> • No deductible applies • Nothing for counseling for up to two (2) quit attempts per year. • Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence. <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay
<ul style="list-style-type: none"> • Diabetes self-management • Childhood obesity education • Medically necessary nutrition therapy • Medically necessary professional nutritional counseling 	<p>In-network:</p> <ul style="list-style-type: none"> • No deductible applies • No copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 copay
Sleep Studies	
<p>CareFirst BlueChoice has created a network of providers that have agreed to oversee this program. The main objective of this approach is diligent monitoring of sleep apnea patients to ensure compliance with their treatment and reducing any further medical complications arising from sleep disorders. CareFirst BlueChoice has also removed barriers, such as prior authorizations, to acquiring sleep apnea equipment such as CPAP machines.</p>	<p>In-Network:</p> <p>Home - Deductible, then No Charge Office/Freestanding - Deductible, then \$35 Outpatient Hospital - Deductible, then \$200</p> <p>Out-of-network:</p> <p>Home - Deductible, then \$50 Office/Freestanding - Deductible, then \$80 Outpatient Hospital - Deductible, then \$500</p>

Benefit Description	You pay After the calendar year deductible
Infusion Services	
<p>Infusion Services: Prior Authorization required for Specialty drugs.</p>	<p>In-Network: Home/Office/Freestanding - Deductible, then \$20 OP Hospital (attended) - Deductible, then \$200</p> <p>Out-of-network: Home/Office/Freestanding - Deductible, then \$80 OP Hospital - Deductible, then \$500</p>

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.
- The calendar year deductible is \$1,400 per Self Only enrollment or \$2,800 per Self Plus One and Self and Family enrollment for in-network services and \$3,000 per Self Only enrollment and \$6,000 per Self Plus One and Self and Family enrollment for out-of-network care each calendar year. The Self Only, Self Plus One, and Self and Family deductible can be satisfied by one(1) or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, your traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
- Surgical procedures may involve the services of a co-surgeon, surgical assistant or assistant-at surgeon who may bill separately from the primary surgeon.

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • 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 <i>Reconstructive surgery</i>) • Surgical treatment of morbid obesity (bariatric surgery) • Insertion of internal prosthetic devices. See 5(a) <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., vasectomy) 	<p>In-network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – No copay • Specialist – \$35 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • No copay for professional services <p>Out-of-Network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital/Inpatient Hospital:</p> <ul style="list-style-type: none"> • \$80 copay

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible
Surgical procedures (cont.)	
<ul style="list-style-type: none"> Treatment of burns <p>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.</p>	<p>In-network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:</p> <ul style="list-style-type: none"> PCP – No copay Specialist – \$35 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> No copay for professional services <p>Out-of-Network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital/Inpatient Hospital:</p> <ul style="list-style-type: none"> \$80 copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Reversal of voluntary sterilization Routine treatment of conditions of the foot (see Foot care) 	<p><i>All charges</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> Surgery to correct a functional defect Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> 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; birthmarks; and webbed fingers and toes. All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> 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) <p>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.</p>	<p>In-network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:</p> <ul style="list-style-type: none"> PCP – No copay Specialist – \$35 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> No copay for professional services <p>Out-of-Network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital/Inpatient Hospital:</p> <ul style="list-style-type: none"> \$80 copay

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible
Reconstructive surgery (cont.)	
<p>Transgender Benefits -</p> <p>We will cover medically necessary care including where appropriate gender reassignment surgery, hormone therapy, and psychotherapy. Transgender services include, but are not limited to, medical counseling, behavioral health services, hormonal therapy, reconstructive surgery and cosmetic surgery. Please note some cosmetic surgery may be specifically excluded. Prior authorization for transgender services is required. The provider must submit a request for services and clinical information prior to the anticipated date of service through the CareFirst BlueChoice authorization portal or by fax. The clinical information is reviewed for persistent, well-documented gender dysphoria, the capacity to make a fully informed decision and to consent for treatment, age of majority in a given state, documentation to support any significant medical or mental health concerns are reasonably well controlled, and a history of hormone therapy for certain procedures. The request is reviewed according to the member’s contract, CareFirst BlueChoice’s Operating Procedure for Transgender Services, and CareFirst BlueChoice’s Medical Policy for Cosmetic and Reconstructive Surgery. The request is then reviewed by a Medical Director for final determination.</p>	<p>In-network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – No copay • Specialist – \$35 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • No copay for professional services <p>Out-of-Network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital/Inpatient Hospital:</p> <ul style="list-style-type: none"> • \$80 copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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.</i> 	<p><i>All charges</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • 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. 	<p>In-network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – No copay • Specialist – \$35 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • No copay for professional services <p>Out-of-Network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital/Inpatient Hospital:</p> <ul style="list-style-type: none"> • \$80 copay

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay After the calendar year deductible
<p>Oral and maxillofacial surgery (cont.)</p> <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Oral implants and transplants • Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) 	<p><i>All charges</i></p>
<p>Organ/tissue transplants</p> <p>These solid organ transplants are covered. Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants <ul style="list-style-type: none"> - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas <p>These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to <i>Other services</i> in Section 3 for prior authorization procedures.</p> <ul style="list-style-type: none"> • Autologous tandem transplants for <ul style="list-style-type: none"> - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) 	<p>In-network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – No copay • Specialist – \$35 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • No copay for professional services <p>Out-of-Network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital/Inpatient Hospital:</p> <ul style="list-style-type: none"> • \$80 copay
<p>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.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia 	<p>In-network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – No copay • Specialist – \$35 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • No copay for professional services

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> - Advanced Hodgkin’s lymphoma with reoccurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin’s lymphoma with reoccurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic - Hemoglobinopathy - lymphoma (CLL/SLL) - Infantile malignant osteoporosis - Kostmann’s syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi’s, PNH, Pure Red Cell Aplasia) - Mucopolysaccharidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfillippo’s syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with reoccurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymblastoma - Epithelial ovarian cancer - Ewing’s sarcoma - Multiple myeloma 	<p>In-network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – No copay • Specialist – \$35 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • No copay for professional services <p>Out-of-Network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital/Inpatient Hospital:</p> <ul style="list-style-type: none"> • \$80 copay

Organ/tissue transplants - continued on next page
 HealthyBlue Advantage HDHP Section 5(b)

Benefit Description	You pay After the calendar year deductible
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors 	<p>In-network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – No copay • Specialist – \$35 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • No copay for professional services <p>Out-of-Network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital/Inpatient Hospital:</p> <ul style="list-style-type: none"> • \$80 copay
<p>Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan.</p> <p>Refer to <i>Other services</i> in Section 3 for prior authorization procedures:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - 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 (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi’s, Paroxysmal nocturnal hemoglobinuria (PNH), Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for 	<p>In-network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – No copay • Specialist – \$35 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • No copay for professional services <p>Out-of-Network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital/Inpatient Hospital:</p> <ul style="list-style-type: none"> • \$80 copay

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with reoccurrence (relapsed) - Amyloidosis - Breast Cancer - Epithelial ovarian cancer - Neuroblastoma 	<p>In-network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – No copay • Specialist – \$35 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • No copay for professional services <p>Out-of-Network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital/Inpatient Hospital:</p> <ul style="list-style-type: none"> • \$80 copay
<p>These blood or marrow stem cell transplants are 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.</p> <p>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.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for: <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma 	<p>In-network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – No copay • Specialist – \$35 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • No copay for professional services <p>Out-of-Network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital/Inpatient Hospital:</p> <ul style="list-style-type: none"> • \$80 copay

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> - Advanced non-Hodgkin’s lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MPDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for <ul style="list-style-type: none"> - 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 lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis 	<p>In-network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – No copay • Specialist – \$35 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • No copay for professional services <p>Out-of-Network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital/Inpatient Hospital:</p> <ul style="list-style-type: none"> • \$80 copay
<ul style="list-style-type: none"> • National Transplant Program (NTP) 	<p>In-network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – No copay

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible
Organ/tissue transplants (cont.)	
	<ul style="list-style-type: none"> • Specialist – \$35 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • No copay for professional services <p>Out-of-Network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital/Inpatient Hospital:</p> <ul style="list-style-type: none"> • \$80 copay
<p><i>Note: We cover related medical and hospital expenses of the donor when we cover the recipient. 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 members.</i></p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except as shown above • Implants of artificial organs • Transplants not listed as covered 	<p><i>All charges</i></p>
Anesthesia	
<p>Professional services provided in – Hospital (inpatient)</p>	<p>In-network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – No copay • Specialist – \$35 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • No copay for professional services <p>Out-of-Network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital/Inpatient Hospital:</p> <ul style="list-style-type: none"> • \$80 copay
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>In-network</p> <p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:</p> <ul style="list-style-type: none"> • PCP – No copay • Specialist – \$35 copay <p>Inpatient Hospital:</p> <ul style="list-style-type: none"> • No copay for professional services <p>Out-of-Network</p>

Anesthesia - continued on next page

Benefit Description	You pay After the calendar year deductible
Anesthesia (cont.)	
	<p>Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital/Inpatient Hospital:</p> <ul style="list-style-type: none"> • \$80 copay for professional services

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.
- The deductible is \$1,400 per Self Only enrollment or \$2,800 per Self Plus One and Self and Family enrollment for in-network services and \$3,000 per Self Only enrollment and \$6,000 per Self Plus One and Self and Family enrollment for out-of-network care each calendar year. The Self Plus One and Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, your traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- 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).
- If a 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.

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay After the calendar year deductible
Inpatient hospital	
Room and board, such as <ul style="list-style-type: none"> • 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.	In-network: <ul style="list-style-type: none"> • Deductible, then 20% of allowed amount Out-of-network: <ul style="list-style-type: none"> • Deductible, then 30% of allowed amount
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services 	In-network: <ul style="list-style-type: none"> • Deductible, then \$100 copay Out-of-network: <ul style="list-style-type: none"> • Deductible, then \$500 copay

Benefit Description	You pay After the calendar year deductible
Inpatient hospital (cont.)	
<ul style="list-style-type: none"> • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) <p>Note: Hospitalization solely for Acute Rehabilitation is limited to 90 days per calendar year.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • Deductible, then \$100 copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • Deductible, then \$500 copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • 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 	<p><i>All charges</i></p>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>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.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$100 copay at an ambulatory surgical center • \$300 copay in the outpatient department of a hospital for surgical procedures • \$200 for non-surgical hospital outpatient admissions <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$500 copay at an ambulatory surgical center • \$500 copay in the outpatient department of a hospital
<p>Outpatient Hospital Diagnostic laboratory tests, X-rays, and pathology services</p> <ul style="list-style-type: none"> • Non-surgical • Not lab or x-ray • Includes but, not limited to EKG's and EEG's • Specialty Imaging 	<p>In-Network:</p> <p>Deductible, then 20% of allowed amount</p> <p>Out-of-Network:</p> <p>Deductible, then 20% of allowed amount</p>
<p><i>Not covered: Blood and blood derivatives not replaced by the member</i></p>	<p><i>All Charges</i></p>

Benefit Description	You pay After the calendar year deductible
Extended care benefits/Skilled nursing care facility benefits	
<p>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 cover the comprehensive range of benefits with no dollar or day limit.</p> <ul style="list-style-type: none"> • 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. 	<p>In-Network:</p> <p>Facility- 20% of allowed amount</p> <p>Out of Network:</p> <p>Facility- 30% of allowed amount</p>
<i>Not covered: Custodial care</i>	<i>All charges</i>
Hospice care	
<p>If terminally ill, you are covered for a 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 (6) months or less, will be direct these services.</p> <p>Respite Care is limited to three (3) periods of 48 hours during the Hospice Eligibility Period.</p> <p>Bereavement Services are provided for up to three (3) visits during the 90 days following the patient's death.</p> <p>Note: Hospice services must be pre-approved</p>	<p>In-network:</p> <ul style="list-style-type: none"> • Deductible applies • \$35 copay <p>Out-of-network</p> <ul style="list-style-type: none"> • Deductible applies • \$80 copay
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>
Ambulance	
<p>Local professional ambulance service when medically appropriate</p>	<p>In-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$50 per trip <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$50 per trip • Non-participating provider may charge you for the amount in excess of our allowed benefit.
<p>Not covered: Air Ambulance unless medically necessary and no other transport is reasonably available.</p>	<i>All Charges</i>

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.
- Under the HealthyBlue Advantage Option, the calendar year deductible is \$1,400 per Self Only enrollment or \$2,800 per Self Plus One and Self and Family enrollment for in-network services and \$3,000 per Self Only enrollment and \$6,000 per Self Plus One and Self and Family enrollment for out-of-network care each calendar year. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, your traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- Please remember that when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
- 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 a free nurse advice line available 24 hours a day, 7 days a week. Call 800-535-9700 to speak to a registered nurse who will discuss your symptoms and recommend the most appropriate care.

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 After the calendar year deductible
Emergency Services	
<ul style="list-style-type: none"> • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services <p><i>Note: We waive the ER copay if you are admitted to the hospital.</i></p> <p><i>Note: For services within the service area and provided by a non-participating provider, the member is not responsible for amounts in excess of the allowed benefits.</i></p>	<p>In-network:</p> <ul style="list-style-type: none"> • Emergency Room - \$300 copay (waived if admitted) • Emergency Room-Professional Services - No copay • Urgent care center - \$50 copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • Emergency Room - \$300 copay (waived if admitted) • Emergency Room-Professional Services - No copay • Urgent care center - \$50 copay
<p>Not covered:</p> <ul style="list-style-type: none"> • Elective care or non-emergency care 	<p><i>All charges</i></p>
Ambulance	
<p>Professional ambulance service when medically appropriate.</p> <p>Note: See 5(c) for non-emergency service.</p>	<p>In-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$50 per trip <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$50 per trip • Non-participating provider may charge you for the amount in excess of our allowed benefit. <p>Not covered: Air Ambulance unless medically necessary and no other transport is reasonably available.</p>

Ambulance - continued on next page

Benefit Description	You pay After the calendar year deductible
Ambulance (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Air Ambulance unless medically necessary and no other transport is reasonably available.</i> 	<p><i>All charges</i></p>

Section 5(e). Mental Health and Substance Use Disorder 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.
- The calendar year deductible is \$1,400 per Self Only enrollment or \$2,800 per Self Plus One and Self and Family enrollment for in-network services and \$3,000 per Self Only enrollment and \$6,000 per Self Plus One and Self and Family enrollment for out-of-network care each calendar year. The Self Plus One and Self and Family deductible can be satisfied by one (1) or more family members. The deductible applies to all benefits in this Section unless we indicate differently. We added "No deductible" to show when a deductible does not apply.
- For facility care, the inpatient deductible applies to almost all benefits in this Section. We added "No deductible" to show when a 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 will provide medical review criteria or reason for treatment plan denial to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
- Members will be responsible for all costs between the plan allowance and provider billed charges.

Note: Inpatient professional services are paid the same as medical inpatient professional services.

Benefit Description	You pay After the calendar year deductible
Professional services	
<p>When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists</p>	<p>Your cost-sharing responsibilities are no greater than for other illnesses or conditions.</p>
<p>Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:</p> <ul style="list-style-type: none"> • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) 	<p>In-network:</p> <ul style="list-style-type: none"> • Inpatient professional - \$35 copay • Office - \$35 copay • Outpatient Professional Services- No copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • Inpatient professional - \$80 copay • Office/Outpatient Professional Services - \$80 copay <p>Note: Member is responsible for any cost between our allowed amount and the provider's billed charges.</p>

Professional services - continued on next page

Benefit Description	You pay After the calendar year deductible
<p>Professional services (cont.)</p> <ul style="list-style-type: none"> • Diagnosis and treatment of alcoholism and drug use, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider’s office or other professional setting • Tests, such as <ul style="list-style-type: none"> - Blood tests - Urinalysis - Non-routine Pap tests - Pathology - X-rays - Non-routine mammograms - CAT Scans/MRI - Ultrasound - Electrocardiogram and EEG 	<p>In-network:</p> <ul style="list-style-type: none"> • Inpatient professional - \$35 copay • Office - \$35 copay • Outpatient Professional Services- No copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • Inpatient professional - \$80 copay • Office/Outpatient Professional Services - \$80 copay <p>Note: Member is responsible for any cost between our allowed amount and the provider’s billed charges.</p> <p><u>Office/Freestanding Setting</u></p> <p>In-Network:</p> <ol style="list-style-type: none"> 1) Labs: Deductible then, no copay 2) X-Rays: Deductible then, \$35 3) Other diagnostic services: Deductible then, \$35 <p>Out-of-Network:</p> <ol style="list-style-type: none"> 1) Labs: Deductible then, 20% of allowed amount 2) X-Rays: Deductible then, 20% of allowed amount 3) Other diagnostic services: Deductible then, 20% of allowed amount
<p>Inpatient hospital or other covered facility</p> <p>Inpatient services provided and billed by a hospital or other covered facility</p> <p>Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services</p>	<p>In-network:</p> <ul style="list-style-type: none"> • Deductible, then 20% of allowed amount <p>Out-of-network:</p> <ul style="list-style-type: none"> • Deductible, then 30% of allowed amount
<p>Outpatient hospital or other covered facility</p> <ul style="list-style-type: none"> • Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment 	<p>In-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$100 copay at an ambulatory surgical center • \$300 copay in the outpatient department of a hospital for surgical procedures • \$200 for non-surgical hospital outpatient admissions <p>Out-of-network:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$500 copay at an ambulatory surgical center • \$500 copay in the outpatient department of a hospital

Benefit Description	You pay After the calendar year deductible
Not covered Services	
Services that are not part of a preauthorized approved treatment plan.	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible
<p>CareFirst Addiction Program</p> <p>The goals of the Alcohol and Drug Addiction Community-Based Program are to:</p> <ol style="list-style-type: none"> 1) Provide Members with necessary treatments to deliver the best outcomes for their individual clinical circumstances. 2) Provide access to cost effective addiction treatment programs that offer the most up-to-date clinically appropriate standards. 3) Educate Members, PCPs and all stakeholders as to the causes, identification and treatments of addiction. 4) Provide appropriate care in a community setting outside of a hospital or residential setting to enhance sustainable outcomes and lower costs. <p>Members may receive any of the following services as part of their treatment:</p> <ul style="list-style-type: none"> • Assessment • Intensive outpatient program • Outpatient detox • Partial hospital program (PHP) • Individual therapy • Group therapy • Family therapy • Medication assisted treatment (MAT) (includes psychiatrist assessment) <p>Preferred Recovery Centers can be located at www.member.carefirst.com/mos/#!/fadpublic/search/standard.</p>	<ul style="list-style-type: none"> • CareFirst Preferred Addiction Recovery center - No cost share for intensive outpatient treatment program • Other outpatient recovery centers - standard out-of-pocket amounts (copay, deductible, coinsurance) will apply.

Section 5(f). Prescription Drug Benefits

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.
- Federal law prevents the pharmacy from accepting unused medications.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- The calendar year deductible is \$1,400 per Self Only enrollment or \$2,800 per Self Plus One and Self and Family enrollment for in-network services and \$3,000 per Self Only enrollment and \$6,000 per Self Plus One and Self and Family enrollment for out-of-network care each calendar year. The Self Plus One and Self and Family deductible can be satisfied by one (1) or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, your traditional medical coverage begins.
- The deductible is waived for preferred generic drugs to treat asthma, blood pressure, cholesterol, depression and diabetes.
- Under your traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions.
- A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified "Dispense as Written" for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- Out-of-Network: Members will be responsible for all charges for drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies.

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 dentist, and in states allowing it, licensed or certified physician assistant, nurse practitioner and psychologist must prescribe your medication.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy, or by mail. You may contact **CVS Health** at **(800) 241-3371** to get more information on the mail order service. We will now require members to fill certain specialty medications within a designated network. Currently the exclusive specialty pharmacy network consists of **CVS/Caremark**.
- **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. This structure will require prior authorizations for a total of 90+ formulary medications. Members and physicians will receive a letter 60 days in advance stating that the drug (or particular brand of affected diabetic test strips) requires a prior authorization effective January 1, 2019. The provider has 60 days to complete the prior authorization paperwork or prescribe a preferred product. Any member attempting to obtain a new prescription or refill on or after January 1, 2019 will receive a notice at the pharmacy stating that the prescription requires a prior authorization. In such cases, the pharmacist or member must notify the prescriber that the prescription requires a prior authorization and obtain said authorization, as appropriate.

- **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 **CVS Health 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, and will pay two (2) copays. Your copay will be \$0, \$30, \$60 or \$150 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. 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 **CVS Health at (800) 241-3371**.
- **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. Please check the detailed charts in this section to see what you would pay should you get the brand named drug when a generic equivalent is available. If a drug is not available in a generic form, the appropriate brand copay will apply. This plan has a Mandatory Generic Drug Substitution. This means that a Member is responsible for the price difference between the brand and its generic equivalents as well as the copay.
- **When you do have to file a claim.** Call our preferred drug vendor, **CVS Health at (800) 241-3371** to order prescription drug claim forms. You will send the prescription drug claim form to: **CVS Health, P.O. Box 52136, Phoenix, AZ 85072**.

Benefit Description	You pay After the calendar year deductible
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medications that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i> • Insulin • Diabetic supplies limited to: Disposable needles and syringes for administration of covered medications. • Drugs for sexual dysfunction (Subject to dosage limitations) <p>Note:</p> <ul style="list-style-type: none"> • Specialty drugs are typically high in cost and have one or more of the following characteristics: <ul style="list-style-type: none"> - Injectable, infused, inhaled, or oral therapeutic agents, or products of biotechnology - Complex drug therapy for a chronic or complex condition, and/or high potential for drug adverse effects 	<p>Retail up to 34-day supply per copay: Select Generics - No deductible and \$0 Tier 1 generics - Deductible, then \$0 Tier 2 preferred brand - Deductible, then \$30 Tier 3 non-preferred brand - Deductible, then \$60 Tier 4 preferred specialty - Deductible, then \$100 Tier 5 non-preferred specialty - Deductible, then \$150</p> <p>Maintenance Drugs up to 90-day supply per copay: Select Generics - No deductible and \$0 Tier 1 generics - Deductible, then \$0 Tier 2 preferred brand - Deductible, then \$60 Tier 3 non-preferred brand - Deductible, then \$120 Tier 4 preferred specialty - Deductible, then \$200 Tier 5 non-preferred specialty - Deductible, then \$300</p> <p>Mandatory Generic Drug Substitution A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. Member is responsible for the price difference between the brand and its generic equivalents as well as the copay.</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible
Covered medications and supplies (cont.)	
<ul style="list-style-type: none"> - Specialized patient training on the administration of the drug (including supplies and devices needed for administration) and coordination of care is required prior to drug therapy initiation and/or during therapy - Unique patient compliance and safety monitoring requirements - Unique requirements for handling, shipping, and storage - 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 - Specialty drugs require pre-authorization and the use of preferred pharmacies - Glucometers are covered as Durable Medical Equipment under the Medical and Surgical Benefits. See page 110 - No deductible for select generic drugs for treatment of asthma, blood pressure, cholesterol, depression and diabetes 	<p>Retail up to 34-day supply per copay: Select Generics - No deductible and \$0 Tier 1 generics - Deductible, then \$0 Tier 2 preferred brand - Deductible, then \$30 Tier 3 non-preferred brand - Deductible, then \$60 Tier 4 preferred specialty - Deductible, then \$100 Tier 5 non-preferred specialty - Deductible, then \$150</p> <p>Maintenance Drugs up to 90-day supply per copay: Select Generics - No deductible and \$0 Tier 1 generics - Deductible, then \$0 Tier 2 preferred brand - Deductible, then \$60 Tier 3 non-preferred brand - Deductible, then \$120 Tier 4 preferred specialty - Deductible, then \$200 Tier 5 non-preferred specialty - Deductible, then \$300</p> <p>Mandatory Generic Drug Substitution A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. Member is responsible for the price difference between the brand and its generic equivalents as well as the copay.</p>
<p>Preventive Care medications to promote better health as recommended by ACA</p> <p>The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a health care professional and filled at a network pharmacy.</p> <ul style="list-style-type: none"> • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age (400 mcg & 800 mcg) • Liquid iron supplements for children age 0-1 year • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Pre-natal vitamins for pregnant women • Fluoride tablets, solution (rinses, not toothpaste) for children age 0-6 <p>Note: To receive this benefit a prescription from a doctor must be presented to pharmacy.</p>	<p>No copay</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible
<p>Covered medications and supplies (cont.)</p> <p>Preventive Care medications to promote better health as recommended by ACA includes the following:</p> <ul style="list-style-type: none"> • Men and women ages 40 through 75 years old • No quantity limit • No prior authorization • Low to moderate dose statins, generics only (no high dose or brand statins are included) <p>The following generic drugs are covered without cost-share as prescribed by a health care professional and filled at a network pharmacy and will be made available as follows:</p> <ul style="list-style-type: none"> • Atorvastatin 10 mg, 20 mg • Fluvastatin 20 mg, 40 mg • Fluvastatin ER 80 mg • Lovastatin 10 mg, 20 mg, 40 mg • Pravastatin 10 mg, 20 mg, 40 mg, 80 mg • Rosuvastatin 5 mg, 10 mg • Simvastatin 5 mg, 10 mg, 20 mg, 40 mg <p>Note: For statin prescriptions outside of these age ranges and/or strengths our standard plan benefits will apply.</p>	<p>No copay</p>
<p>The following prescription drugs are covered in full:</p> <ul style="list-style-type: none"> - Chemotherapy medications received through a pharmacy - Preventive breast cancer drugs for women who are at an increased risk for breast cancer, and at a low risk for adverse medication effects <p>Please refer to our website www.carefirst.com/fedhmo for any updates to this list and for additional information on how these items are covered.</p>	<p>No copay</p>
<p>Smoking deterrents</p> <p>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.</p>	<p>Nothing, up to two (2) attempts per year</p>
<p>Women's contraceptive drugs and devices</p>	<p>No copay</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Medical supplies such as dressings and antiseptics</i> 	<p><i>All Charges</i></p>

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible
Covered medications and supplies (cont.)	
<ul style="list-style-type: none"> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them, except as listed above</i> • <i>Nonprescription medications</i> • <i>Infertility drugs related to procedures excluded under this contract</i> <p>Note: Drugs that do not require a prescription by Federal law (Over-the-counter medications) that are not part of the preventive drug benefit. Listed preventive care over-the-counter drugs can be submitted only if the member presents a prescription form completed by an authorized provider.</p>	<p><i>All Charges</i></p>

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 FEHB Plan will be first/primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See *Section 9*, Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- The calendar year deductible is \$1,400 per Self Only enrollment or \$2,800 per Self Plus One and Self and Family enrollment for in-network services and \$3,000 per Self Only enrollment and \$6,000 per Self Plus One and Self and Family enrollment for out-of-network care each calendar year. The Self Plus One and Family deductible can be satisfied by one (1) or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, your traditional medical coverage begins.
- Under your traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- 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.
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
- 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 After the calendar year deductible
Accidental injury benefit	
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.	<p>In-network:</p> <ul style="list-style-type: none"> • \$35 visit copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$80 visit copay
Dental benefits	
We have no other benefits	<i>All charges</i>

Section 5(h). Wellness and Other Special Features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • 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 of 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 dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
24 hour nurse line	<p>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.</p>
Services for deaf and hearing impaired	<p>Our TTY number for Customer Service is (202) 479-3546.</p>
Care Team Program	<p>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:</p> <ul style="list-style-type: none"> • 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 <p>Please call us at (800) 783-4582 for more information about our Care Team Program.</p>
Guest membership	<p>If you, or one of your covered family members, 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.</p>

<p>HealthyBlue Rewards</p>	<p>Financial incentives can effectively encourage Members to take an active role in their own health. Through Blue Rewards - the CareFirst Health and Wellness Incentive Program - Members can earn a reward for completing specific activities that increase the likelihood of success in their wellness efforts.</p> <p>For 2019, the Blue Rewards incentive program will be expanded to include Subscribers and Spouses for all CareFirst medical plans to encourage initial and ongoing engagement. Blue Rewards will feature three types of rewards 1) participation-based rewards, 2) ongoing rewards, and 3) coaching rewards:</p> <p>Participation Rewards – will be earned by members who complete one or both of the following activities within 120 days of their effective/renewal date:</p> <ol style="list-style-type: none"> 1. Choose a PCMH/PCMH Plus PCP AND complete their health screening with their PCP or at a CVS MinuteClinic to earn \$100 2. Complete a health assessment AND provide e-consent for wellness communications to earn \$50 <p>Ongoing Rewards – will become available once members complete the above step 2:</p> <ol style="list-style-type: none"> 1. Retaking their health assessment after a 6-month period to earn \$50 <p>Coaching Rewards – will become available if members are identified as coach-directed, rewards can be earned throughout the entire benefit period:</p> <ol style="list-style-type: none"> 1. Consenting and completing coaching calls (one session per month, maximum three sessions) to earn \$30 for session 1, \$70 for session 2 and \$100 for session 3 (maximum of \$200 per benefit period). 2. Members will receive their incentive in the form of a medical expense debit card to help pay for deductibles, copays, and coinsurance for CareFirst health, pharmacy, vision, and dental costs. The debit card reduces barriers to care and is preloaded with Merchant Category Codes (MCC) for eligible medical expenses that dictate whether the card will work at a specific location. If the member tries to use the card at a location where the MCC is not loaded, the card will reject the charge. Members who choose the high-deductible health plan option, and choose to fund their account, are not allowed to use their card funds for eligible medical and/or prescription expenses until first satisfying their IRS minimum deductible. However, these members can use the card funds for eligible dental and or vision expenses that are part of the benefit plan. <p>To get started, visit carefirst.com/sharecare. You'll need to enter your CareFirst account username and password and complete the one-time registration with Sharecare to link your CareFirst account information. This will help personalize your experience.</p>
<ul style="list-style-type: none"> • Cost Share Waiver 	<p>Members currently enrolled in a CareFirst BlueChoice plan are eligible for the waiver of cost sharing for certain services. Patients in these care coordination programs have their copayments, coinsurance, deductibles, and visit limits waived for certain services. However, these waivers are only applied when a member is actively working to achieve stable health by complying with their care plan. When the member cost sharing waiver is applied, CareFirst pays the provider the amount of the member's cost share in addition to the agreed upon negotiated benefit amount.</p> <p>Note: For members in an HSA-compatible health plan who are contributing to an HSA, the waiver of cost sharing only begins after the IRS-mandated deductible is met.</p> <p>Members participating in the following Total Care and Cost Improvement (TCCI) Programs are eligible for a waiver of cost sharing on a majority of the services needed outside of the hospital. The programs include:</p> <ul style="list-style-type: none"> • Chronic care coordination

	<ul style="list-style-type: none">• Complex case management• Behavioral health and substance use case management <p>CareFirst will waive cost sharing for all in-network professional claims:</p> <ul style="list-style-type: none">• Specialist office visits• Home health visits• Primary care visits• Physical therapy• Durable medical equipment (DME)• Radiology (not in a hospital)• CareFirst Addiction Recovery Program Centers of Excellence <p>The following claims are not eligible for cost share waiver:</p> <ul style="list-style-type: none">• Out-of-network claims• Institutional claims• Drug claims, regardless of their benefit coverage (Medical or Pharmacy)
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Section 5(i). Health Education Resources and Account Management Tools

Special features	Description
<p>Health education resources</p> <p>www.carefirst.com/fedhmo</p> <p>Visit our expanded web option</p>	<p><i>My Account</i></p> <p>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:</p> <ul style="list-style-type: none"> • View who is covered under their contract • Current and historical claims status • Order a new ID card <p>Additional features include:</p> <ul style="list-style-type: none"> • Drug pricing tool • Hospital comparison tool • Treatment cost estimator • Provider Directory with special information • Health Risk Assessment <p><i>My CareFirst</i></p> <p>This is our member health and wellness section. Here you can find:</p> <ul style="list-style-type: none"> • Health Library of Medical Conditions • Health Lifestyle Section: Nutrition, Fitness, etc. • Personal Health page, with tracking tools and assistance setting health and wellness goals <p><i>Telephonic Health Coaching</i></p> <p>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.</p> <ul style="list-style-type: none"> • 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.
<p>Account management tools</p>	<p>For each HSA and HRA account holder, we maintain a complete claims payment history online through www.carefirst.com/fedhmo</p> <p>Your balance will also be shown on your explanation of benefits (EOB) form. You will receive an EOB after every claim.</p> <p>If you have an HSA:</p> <ul style="list-style-type: none"> • Once your account is activated, periodic accounts statements will be available • There is a \$0.75 fee charged for each paper statement • To receive electronic statements and avoid this fee:

	<ul style="list-style-type: none"> - Log on on to www.carefirst.com/fedhmo to complete initial registration and gain entry to "My Account" - You have two options - either click on tab to "Manage My Plan" or "Manage My Money" - to gain access to the "Blue Fund Administrator" link - Follow the prompts to be routed to Bank of New York Mellon's HSA website, BenefitWallet. Click on "Update Account Profile" - Edit "Your Statement Delivery Options" to electronic notices <ul style="list-style-type: none"> • You may also access your account on-line at www.carefirst.com/fedhmo <p>If you have an HRA:</p> <ul style="list-style-type: none"> • Your balance will also be shown on your EOB form. • Your HRA balance will be available online through www.carefirst.com/fedhmo
<p>Consumer choice information</p>	<p>As a member of HealthyBlue Advantage HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Directories are available online at www.carefirst.com/fedhmo.</p> <p>Pricing information for medical care and prescription drugs is available at www.carefirst.com/fedhmo.</p> <p>Link to online pharmacy through www.carefirst.com/fedhmo.</p> <p>Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.carefirst.com/fedhmo.</p>
<p>Care support</p>	<p>Patient safety information is available online at www.carefirst.com/fedhmo/html/health-wellness.</p>

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/fedhmo

Options/Blue365 Discount Programs

As a member, you have access to fitness centers, acupuncture, spas, chiropractic care, nutritional counseling, laser vision correction, hearing aids and more. Visit www.carefirst.com/options to learn more.

Dental Savings Plan

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 www.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

To request more information, or to speak with a knowledgeable product consultant, contact us today at 1-800-544-8703 or visit www.carefirst.com/individual to browse our plans.

Medical Plans (For Maryland, District of Columbia and Northern Virginia residents)

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.

All fifteen (15) CareFirst consumer direct medical plans offer:

- A vast network of at least 28,000 providers
- No charge, no deductible for in-network:
- Adult physicals
- Well-child exams and immunizations
- OB/GYN visits
- X-rays and diagnostic/lab tests
- Cancer screenings including mammograms, pap tests, prostate and colorectal screenings
- Routine prenatal maternity visits
- No referrals needed to see a specialist
- Eligibility for Federal Subsidies that could reduce or eliminate your monthly premium (not applicable with BlueChoice Young Adult)
- Vision and dental coverage for kids under age 19
- A free adult eye exam every 12 months and discounted adult dental service
- A variety of deductibles and premiums to fit your budget

MediGap-65 and Supplement-65 Medicare Supplemental Plans (For Medicare-eligible individuals in Maryland, District of Columbia and Northern Virginia)

Choose from eight (8) CareFirst Medicare Supplemental plans to give you protection against the important costs Medicare doesn't cover—costs that can add up to thousands of dollars each year.

Dental Plans (For Maryland, District of Columbia and Northern Virginia residents) Regular, preventive dental care is an important part of staying healthy. That's why CareFirst brings you 4 dental plans:

- Dental HMO (Less than \$.35 a day) 580+ participating providers and predictable copayments for routine and major dental services (Administered by The Dental Network in MD and CareFirst BlueChoice, Inc. in DC and VA)
- Preferred Dental (Less than \$.50 a day) 3,600+ participating providers and 100% coverage for preventive and diagnostic care (Administered by Group Hospitalization and Medical Services, Inc. in DC and VA)
- BlueDental Preferred (Less than \$1.00 a day) and Preferred Dental Plus (Less than \$1.30 a day) - 63,000+ network providers, 100% coverage for preventive and diagnostic care and extensive benefits for major dental services (Administered by CareFirst of Maryland, Inc. in MD and by Group Hospitalization and Medical Services, Inc. in DC and VA)

Section 6. General Exclusions – Services, Drugs and Supplies We Do Not 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, *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 you receive from a provider or facility barred from the FEHB Program.
- 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 yourself, 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, exception being 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, doctor's charges exceeding the amount specified by the Department of Health Medicare limiting charge, 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. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

How to claim benefits

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

In most cases, providers and facilities file claims for you. Your physician must file the form CMS-1500, Health Insurance Claim Form. Your facility will file 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/or 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 filing 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 (3) three-year limitation on the reissuance of uncashed checks.

Post service claims procedure	<p>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.</p> <p>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.</p> <p>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.</p>
Records	<p>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.</p>
Overseas claims	<p>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:</p> <p>BlueCard Worldwide Service Center, P.O. Box 72017, Richmond, VA 23255-2017 USA. Obtain Overseas Claim Forms from our website, www.carefirst.com/fedhmo. If you have questions about the processing of overseas claims contact (800) 810-2583.</p>
When we need more information	<p>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.</p>
Authorized representative	<p>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.</p>
Notice requirement	<p>If you live in a county where at least 10 percent of the population is literate only in a non-english language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language service (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.</p> <p>Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.</p>

Section 8. The Disputed Claims Process

You may 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 call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

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. To make your request, please contact our Customer Service Department by writing to Mail Administrator, P.O. Box 14114, Lexington, KY 40512-4114 or calling (888) 789-9065.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to the initial benefit determination or whether the information was submitted or consideration the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person (or his/her subordinate) who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

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

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">a) Write to us within 6 months from the date of our decision; andb) Send your request to us at: Mail Administrator, P.O. Box 14114, Lexington, KY 40512-4114; andc) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andd) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) formse) 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. <p>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.</p>

Step	Description
2	<p>In the case of a post-service claim, we have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"> a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information <p>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.</p> <p>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.</p>
3	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"> • 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. <p>Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 3, 1900 E Street, NW, Washington, DC 20415-3650.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"> • 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; and/or • 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. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p> <p>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 healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.</p> <p>Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.</p>
4	<p>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.</p> <p>If you do not agree with OPM's decision, your only recourse is to file a lawsuit. 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.</p> <p>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.</p>

You may not file a lawsuit 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 expedite 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 also call OPM's FEHB 3 at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about Plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this Plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving workers' compensation benefits.

Section 9. Coordinating Benefits with Medicare and 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".

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' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.carefirst.com/fedhmo.org.

• 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 FEHB 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

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation. Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if we paid benefits for that injury or illness, you must agree to the provisions listed below. In addition, if you are injured and no other person or entity is responsible but you receive (or are entitled to) a recovery from another source, and if we paid benefits for that injury, you must agree to the provisions below. These provisions constitute a condition of and a limitation on the nature of benefits or benefit payments and the provision of benefits to you. These provisions apply to all situations where we provide benefits and you have a right to recover damages under any law or type of insurance, including but not limited to:

- Automobile liability, uninsured or underinsured coverage,
- No-fault insurance, regardless of whether that insurance is primary or secondary to other plans,
- Homeowners or property insurance,
- Business, personal or umbrella liability coverage,
- Workers' compensation,
- Payments made directly by responsible individuals,
- Trust funds or accounts established from the proceeds of settlements, judgments, or awards received paid by responsible parties or payors.

All of our benefit payments in these circumstances are conditional, and remain subject to our contractual benefit limitations, exclusions, and maximums. By accepting these conditional benefits, you agree to the following:

- All recoveries you or your representatives obtain (whether by lawsuit, settlement, insurance or benefit program claims, or otherwise), no matter how characterized, designated, or apportioned, must be used to reimburse us in full for benefits we paid. Our recovery must be effectuated first before any of the rights of other parties are effectuated. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or your representatives. For purposes of this provision, “you” includes your covered dependents, and “your representatives” include, if applicable, your heirs, administrators, legal representatives, parents (if you are a minor), successors, or assignees. This is our right of recovery.
- We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not “made whole” for all of your damages in the recoveries that you receive. Our right of recovery is not subject to reduction for attorney’s fees and costs under the “common fund” or any other doctrine.
- We will not reduce our share of any recovery unless, in the exercise of our discretion, we agree in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys’ fees.
- You must cooperate in doing what is reasonably necessary to assist us with our right of recovery. You must not take any action that may prejudice our right of recovery.
- If you do seek damages for your illness or injury, you must tell us promptly that you have made a claim against another party for a condition that we have paid or may pay benefits for, you must seek recovery of our benefit payments and liabilities, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a first priority lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay. Our lien will apply to any settlements, judgments, and/or recoveries that you obtain from any source, no matter how characterized (e.g., as “pain and suffering” or “non-medical”, or “other.”)

We may request that you sign a reimbursement agreement and/or assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the signed reimbursement agreement and/or assignment, and we may enforce our right of recovery by offsetting future benefits. To avoid any unnecessary delay in processing benefits, it is essential that you and any dependent covered by this plan cooperate with our investigation and recovery efforts. You or your legal representative can also avoid delays by notifying us in writing within 30 days of making a claim against any responsible party or payor for illness or injury that requires medical attention and to notify us at least 10 days prior to reaching agreement with any other responsible party or payor when we have provided benefits for your illness or injury.

Contact us if you need more information about our recovery rights.

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 and 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 at www.BENEFEDS.com or by phone at (877) 888-3337 (TTY 1-877-889-5680), 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

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

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. We encourage you to contact the plan to discuss specific services 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.

When you have Medicare

- **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 any time 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 (800)MEDICARE ((800)633-4227), (TTY (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. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources, extra help in paying for a Medicare prescription. For more information about this extra help, visit the Social Security Association online at www.socialsecurity.gov or call them at (800)-772-1213, (TTY (800)-325-0778).

- **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 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 do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you did not 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/fedhmo

We waive some costs if the Original Medicare Plan is your primary payor- we will waive some out-of-pocket costs as follows:

- In-network and Out-of-Network copays, coinsurance and deductibles pertaining to medical services and supplies provided by physicians and other Healthcare professionals.

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B
Deductible	<p>Standard HealthyBlue: \$500 Self Only /\$1,000 Self Plus One and Self and Family</p> <p>HealthyBlue Advantage HDHP: \$1,400 Self Only/\$2,800 Self Plus One and Self and Family</p>	<p>Standard HealthyBlue: None</p> <p>HealthyBlue Advantage HDHP: No deductible</p>
Out-of-Pocket Maximum	<p>Standard HealthyBlue: \$2,500 Self Only/\$5,000 per Self Plus One or Self and Family</p> <p>HealthyBlue Advantage HDHP: \$4,000 Self Only/\$6,500 per Self Plus One or Self and Family</p>	<p>Standard HealthyBlue: \$2,500 Self Only/\$5,000 per Self Plus One or Self and Family</p> <p>HealthyBlue Advantage HDHP: \$6,000 Self Only/\$12,000 per Self Plus One or Self and Family</p>
Outpatient Hospital	<p>Standard HealthyBlue:</p> <ul style="list-style-type: none"> • Outpatient Hospital (Non-Surgical): No deductible \$40 copay per visit • Free standing / Ambulatory Surgical Center: No Deductible \$100 copay • Outpatient Hospital (Surgical): Deductible then \$150 copay <p>HealthyBlue Advantage HDHP:</p> <ul style="list-style-type: none"> • Calendar year deductible applies • \$100 copay at an ambulatory surgical center • \$300 copay in the outpatient department of a hospital for surgical procedures • \$200 for non-surgical hospital outpatient admissions 	<p>Standard HealthyBlue: Nothing</p> <p>HealthyBlue Advantage HDHP: Nothing</p>

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B
RX	<p>Standard HealthyBlue Option:</p> <p>Prescription Drug Deductible: \$100</p> <ul style="list-style-type: none"> • Tier 1 - \$0 all generic • Tier 2 - \$35 preferred brand • Tier 3 - \$65 non-preferred brand • Tier 4 - \$100 preferred Specialty • Tier 5 - \$150 non-preferred Specialty <p>HealthyBlue Advantage HDHP:</p> <ul style="list-style-type: none"> • No deductible, then \$0 for Select Generics • Tier 1 - Deductible, then \$0 for all other generics • Tier 2 - Deductible, then \$30 preferred brand • Tier 3 - Deductible, then \$60 non-preferred brand • Tier 4 - Deductible, then \$100 preferred Specialty • Tier 5 - Deductible, then \$150 non-preferred Specialty 	<p>Standard HealthyBlue Option:</p> <p>Prescription Drug Deductible: \$100</p> <ul style="list-style-type: none"> • Tier 1 - \$0 all generic • Tier 2 - \$35 preferred brand • Tier 3 - \$65 non-preferred brand • Tier 4 - \$100 preferred Specialty • Tier 5 - \$150 non-preferred Specialty <p>HealthyBlue Advantage HDHP:</p> <ul style="list-style-type: none"> • No deductible, then \$0 for Select Generics • Tier 1 - Deductible, then \$0 for all other generics • Tier 2 - Deductible, then \$30 preferred brand • Tier 3 - Deductible, then \$60 non-preferred brand • Tier 4 - Deductible, then \$100 preferred Specialty • Tier 5 - Deductible, then \$150 non-preferred Specialty

RX - Mail Order (90 day supply)	Standard HealthyBlue Option: <ul style="list-style-type: none"> • Tier 1 - \$0 all generic • Tier 2 - \$70 preferred brand • Tier 3 - \$130 non-preferred brand • Tier 4 - \$200 preferred Specialty • Tier 5 - \$300 non-preferred Specialty HealthyBlue Advantage HDHP: <ul style="list-style-type: none"> • No deductible, then \$0 for Select Generics • Tier 1 - Deductible, then \$0 generics • Tier 2 - Deductible, then \$60 preferred brand • Tier 3 - Deductible, then \$120 non-preferred brand • Tier 4 - Deductible, then \$200 preferred Specialty • Tier 5 - Deductible, then \$300 non-preferred Specialty 	Standard HealthyBlue Option: <ul style="list-style-type: none"> • Tier 1 - \$0 all generic • Tier 2 - \$70 preferred brand • Tier 3 - \$130 non-preferred brand • Tier 4 - \$200 preferred Specialty • Tier 5 - \$300 non-preferred Specialty HealthyBlue Advantage HDHP: <ul style="list-style-type: none"> • No deductible, then \$0 for Select Generics • Tier 1 - Deductible, then \$0 generics • Tier 2 - Deductible, then \$60 preferred brand • Tier 3 - Deductible, then \$120 non-preferred brand • Tier 4 - Deductible, then \$200 preferred Specialty • Tier 5 - Deductible, then \$300 non-preferred Specialty
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You can find more information about how one plan coordinates benefits with Medicare in CareFirst BlueChoice at www.carefirst.com/fedhmo

• **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 member(s) may have as this coverage may affect the primary or 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 (800) 633-4227), (TTY (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). However, 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.

Section 10. Definitions of Terms We Use in This Brochure

Allowed benefit	<p>For a contracting physician or contracting provider, the allowed benefit is the lesser of:</p> <p>The actual charge; or the amount CareFirst BlueChoice allows for the service in effect on the date that the service is rendered.</p> <p>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 as stated in the Schedule of Benefits and the contracting physician or contracting provider may bill the member directly for such amounts.</p> <p>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.</p> <p>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.</p>
Calendar year	<p>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.</p>
Care Plan	<p>A plan of action developed and submitted to CareFirst by a Primary Care Provider (PCP) who is a member of a Patient-Centered Medical Home panel. This is a customized program designed for members who are at risk for, or suffering from, a chronic disease or illness.</p>
Clinical Trials Cost Categories	<p>An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.</p> <ul style="list-style-type: none">• 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 are generally covered by the clinical trials. This plan does not cover these costs.
Coinsurance	<p>Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 27.</p>
Copayment	<p>A copayment is a fixed amount of money you pay when you receive covered services. See page 27.</p>

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 27.
Experimental or investigational service	<p>We consider services experimental or investigational if they do not meet the following criteria:</p> <ul style="list-style-type: none"> • 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	<p>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:</p> <ol style="list-style-type: none"> 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; and 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. <p>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.</p> <p>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.</p>
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.

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

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 evaluate whether or not 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. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no Government contribution.

Important information about four Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program (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. Participating employees save an average of about 30% on products and services they 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.

Fourth, the **Federal Employees' Group Life Insurance Program (FEGLI)** can help protect your family from burdensome funeral costs and the unexpected loss of your income.

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 \$100. The maximum annual election for a health care flexible spending account (HCFSA) or limited expense health care flexible spending account (LEX HCFSA) is \$2,600 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is \$5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, 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).
- **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 out-of-pocket 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).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your children 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.
- FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- 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 (877) FSAFEDS, (877) 372-3337, TTY: (866) 353-8058, Monday through Friday, 9 a.m. until 9 p.m. Eastern time.

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. 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, retirees or annuitants, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis. Beginning in 2019, FEDVIP is also available to TRICARE eligible retirees and their families during the 2018 Federal Benefits Open Season. Active duty family members are eligible to enroll in FEDVIP vision insurance. Both retirees and active duty family members must be enrolled in a TRICARE health plan in order to enroll in a FEDVIP vision plan.

Dental insurance

All dental plans provide a comprehensive range of services, including :

- Class A (Basic) service, which includes oral examinations, prophylaxis, diagnostic evaluations, sealants, and X-rays.
- Class B (Intermediate) services, which includeS restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which includes 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 12-month waiting period. Most FEDVIP dental plans cover adult orthodontia but it may be limited. Review your FEDVIP dental plan's brochure for information on this benefit.

Vision insurance

All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for 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/dental and www.opm.gov/vision. 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 can enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call (877) 888-3337 ,TTY: (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. Long term care can be received in your home, in a nursing home, in an assisted living facility or in adult day care. You must apply, answer health questions (called underwriting) and be approved for enrollment. Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services are eligible to apply. Your qualified relatives can apply, even if you do not. 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 (800) LTC-FEDS(800) 582-3337, TTY: (800) 843-3557or visit www.ltcfeds.com.

The Federal Employees' Group Life Insurance Program (*FEGLI*)

Peace of mind for you and your family The Federal Employees' Group Life Insurance Program (FEGLI) can help protect your family from burdensome funeral costs and the unexpected loss of your income. You can get life insurance coverage starting at one (1) year's salary to more than six (6) times your salary and many options in between. You can also get coverage on the lives of your spouse and unmarried dependent children under age 22. You can continue your coverage into retirement if you meet certain requirements. For more information, visit www.opm.gov/life.

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Summary of Benefits - Standard HealthyBlue for 2019

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. You can obtain a copy of our Summary of Benefits and Coverage at <https://www.carefirst.com/fedhmo/attachments/standard-healthyblue-fehb-sbc.pdf>. On these pages 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.

- Standard HealthyBlue has a calendar year in-network deductible of \$500 per Self Only contract and \$1,000 per Self Plus One and Self and Family contract, and an out-of-network deductible of \$3,000 for Self Only contract and \$6,000 for Self Plus One and Self and Family contract. The in-network deductible is included in the out-of-network total. There is a \$100 deductible for Pharmacy Tiers 2 - Tiers 5.

- 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	<p>Preventive Care - No deductible or copay In-network: No deductible or copay for primary care provider and \$40 for a specialist</p> <p>Out-of-network: After calendar year deductible, \$80 copay Preventive Care - Deductible, then no copay</p>	35
Services provided in a hospital:		
<ul style="list-style-type: none"> • Inpatient 	<p>In-network: After calendar year deductible, 20% of plan allowance</p> <p>Out-of-network: After calendar year deductible, 30% of plan allowance</p>	65
<ul style="list-style-type: none"> • Outpatient 	<p>In-network:</p> <ul style="list-style-type: none"> • Outpatient Hospital (Non-Surgical): No deductible \$40 copay per visit • Freestanding /Ambulatory Surgical Center: No Deductible \$100 copay • Outpatient Hospital (Surgical): Deductible then \$150 copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • Outpatient Hospital (Non-Surgical): Deductible \$80 copay per visit • Freestanding /Ambulatory Surgical Center: Deductible then \$80 • Outpatient Hospital (Surgical): Deductible then \$200 copay 	66

	Non-participating facilities may bill the member for any amount in excess of our allowed benefit.	
Emergency Benefits:		
• In-area	In-Network: <ul style="list-style-type: none"> • Emergency Room -Deductible then \$200 copay (waived if admitted) • Emergency Room Professional - Deductible, then \$40 • Urgent Care Center – No Deductible then, \$50 copay • Ambulance- Deductible then, \$50 copay 	70
• Out-of-area	Out of Network: <ul style="list-style-type: none"> • Emergency Room- In-network deductible then, \$200 copay • Emergency Room Professional- In-network deductible then, \$40 • Urgent Care Center – No Deductible then, \$50 copay • Ambulance- Deductible then, \$100 	70
Mental health and substance use disorder treatment:	Regular cost sharing	71
Prescription drugs:	Prescription Drug Deductible: \$100 for Tiers 2 - Tiers 5 Mandatory Generic Drug Substitution benefit indicating that if the member gets a brand-name drug when a generic is available, the member is responsible for the price difference between the brand-name drug and its generic equivalent as well as the brand copay. <i>Out-of-Network: Members will be responsible for all charges for drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i>	75
• Retail	For up to a 34-day supply: <ul style="list-style-type: none"> • Tier 1 - No copay (generic drugs) • Tier 2 - \$35 preferred brand name drug copay • Tier 3 - \$65 copay for non-preferred brand name drug • Tier 4 - \$100 for preferred specialty drugs • Tier 5 - \$150 for non-preferred specialty drugs For 35-day through 90-day supply, two (2) copays apply for all tiers.	75
• Mail order	Maintenance Drugs: for up to a 34-day supply: <ul style="list-style-type: none"> • Tier 1 - No copay (generic drugs) 	75

	<ul style="list-style-type: none"> • Tier 2 - \$35 preferred brand name drug copay • Tier 3 - \$65 copay for non-preferred brand name drug • Tier 4 - \$100 for preferred specialty drugs • Tier 5 - \$150 for non-preferred specialty drugs <p>For 35-day through 90-day supply, two (2) copays apply for all tiers.</p>	
Dental care:	No benefit except for services related to an accidental injury	79
Vision care:	Davis network providers: \$10 per visit copay for routine eye exams.	108
Special features: 24-hour nurse line; Care team program; Guest membership. Care plans, Blue Rewards.	No additional cost	80
Protection against catastrophic costs (out-of-pocket maximum)	<p>In-network: Nothing after \$2,500 Self only, \$5,000 Self Plus One and \$5,000 for Self and Family for per year based on contract, not members</p> <p>Out-of-network: After \$4,500 Self only, \$9,000 Self Plus One and \$9,000 for Self and Family per year based on contract, the member is liable for charges in excess of our allowed benefit.</p> <p>Some costs do not count toward this protection</p>	28

Summary of Benefits - HealthyBlue Advantage HDHP for 2019

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. You can obtain a copy of our Summary of Benefits and Coverage at <https://www.carefirst.com/fedhmo/attachments/healthyblue-advantage-fehb-sbc.pdf>. On these pages 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.

In 2019, for each month you are eligible for the Health Savings Account, HealthyBlue Advantage HDHP will deposit \$75 per month for Self-Only enrollment, \$150 for Self Plus One enrollment, or \$150 per month for Self and Family enrollment to your HSA. For the HSA you may use your HSA or pay out of pocket to satisfy your calendar year deductible of \$1,400 in-network and \$2,800 out-of-network for Self-Only and \$3,000 in-network and \$6,000 out-of-network for Self Plus One and Self and Family. Once you satisfy your calendar year deductible, traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of \$75 per month for Self-Only enrollment and \$150 for Self Plus One and Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, traditional medical coverage begins.

The deductible is \$1,400 per Self Only enrollment or \$2,800 per Self Plus One and Self and Family enrollment for in-network services and \$3,000 per Self Only enrollment and \$6,000 per Self Plus One and Self and Family enrollment for out-of-network services each calendar year. The Self Plus One and Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits unless we indicate differently in Sections 5(a) through 5(g) of this brochure.

Under HealthyBlue Advantage, you may earn a medical expense debit card to help pay for qualified medical expenses of up to \$400 per Self Only enrollment and up to \$800 per Self Plus One and Self and Family enrollment.

HealthyBlue Advantage HDHP	You pay	Page
Medical services provider by a physician		
Diagnostic and treatment services provided in the office	<p>In-network: Preventive Care and Women's Health: No copay</p> <p>All other office care: After deductible, No copay for PCP and \$35 for a specialist</p> <p>Out-of-network: After deductible, \$80 copay</p>	100
Services provided in a hospital:		
<ul style="list-style-type: none"> • Inpatient 	<p>In-network: After deductible, 20% of plan allowance</p> <p>Out-of-network: After deductible, 30% of plan allowance</p>	124

HealthyBlue Advantage HDHP	You pay	Page
<ul style="list-style-type: none"> • Outpatient 	<p>In-network:</p> <ul style="list-style-type: none"> • Medical care: After deductible, \$200 per admission in hospital and ambulatory surgical center • Surgical care: After deductible, \$100 in an ambulatory surgical center and \$300 in the outpatient department of a hospital. <p>Out-of-network:</p> <ul style="list-style-type: none"> • Medical care: After deductible, \$500 per admission in hospital and ambulatory surgical center • Surgical care: After deductible, \$500 in an ambulatory surgical center and in the outpatient department of a hospital. 	125
Emergency Benefits:		
<ul style="list-style-type: none"> • In area 	<p>After the deductible:</p> <ul style="list-style-type: none"> • \$50 copay for Urgent care center • \$50 copay for Ambulance services • \$300 copay for Emergency room services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	128
<ul style="list-style-type: none"> • Out-of-area 	<p>After the deductible:</p> <ul style="list-style-type: none"> • \$50 copay for urgent care center • \$50 copay for ambulance services • \$300 copay for emergency room services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	128
Mental health and substance use disorder treatment:		
Prescription drugs:		
	<p>Mandatory Generic Drug Substitution benefit indicating that if the member gets a brand-name drug when a generic is available, the member is responsible for the price difference between the brand-name drug and its generic equivalent as well as the brand copay</p> <p><i>Out-of-Network: Members will be responsible for all charges for drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i></p>	135
<ul style="list-style-type: none"> • Retail 	<p>No deductible for select generic drugs for the treatment of asthma, blood pressure, cholesterol, depression and diabetes</p> <p>After deductible:</p>	135

	<ul style="list-style-type: none"> • Tier 1 - Generic drugs - \$0 copay • Tier 2 - Preferred brand named drugs - \$30 copay for up to 34-day supply; \$60 for 35-day to 90-day supply • Tier 3 - Other brand named drugs - \$60 copay for up to 34-day supply; \$120 copay for 35-day to 90-day supply • Tier 4 - Preferred Specialty Drugs- \$100 copay for up to 34-day-supply; \$200 copay for 35-day to 90-day supply • Tier 5 - Non-Preferred Specialty Drugs- \$150 copay for up to 34-day-supply; \$300 copay for 35-day to 90-day supply 	
<ul style="list-style-type: none"> • Mail order 	<p>Benefit is designed for maintenance drugs only</p> <p>No Deductible for selected generic drugs for the treatment of asthma, blood pressure, cholesterol, depression and diabetes</p> <p>After deductible:</p> <ul style="list-style-type: none"> • Tier 1 - Generic drugs - \$0 copay • Tier 2 - Preferred brand named drugs - \$30 copay for up to 34-day supply; \$60 for 35-day to 90-day supply • Tier 3 - Other brand named drugs - \$60 copay for up to 34-day supply; \$120 copay for 35-day to 90-day supply • Tier 4 - Preferred Specialty Drugs - \$100 copay for up to 34-day-supply; \$200 copay for 35-day to 90-day supply • Tier 5 - Non-Preferred Specialty Drugs - \$150 copay for up to 34-day-supply; \$300 copay for 35-day to 90-day supply 	135
Dental care:	No benefit except for services related to an accidental injury	139
Vision Care	<p>In-network: \$10 for routine eye exams</p> <p>Out-of-network: You pay all charges</p> <p>Discount program is available for lenses, frames and contacts</p>	108
Special features: 24 nurse line; Care team program; Guest membership; Care plans; Blue Rewards	No additional costs	140
Protection against catastrophic costs (out-of-pocket maximum):	In-network: Nothing after \$4,000 under a Self-Only enrollment, \$6,500 for Self Plus One and \$6,500 for Self and Family enrollment per year.	28

	<p>Out-of-network: After \$6,000 on a Self-Only enrollment, \$12,000 for Self Plus One and \$12,000 for Self and Family enrollment. The member remains liable for charges in excess of our allowed benefit.</p> <p>Some costs do not count toward this protection.</p>	
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2019 Rate Information for CareFirst BlueChoice, Inc.

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, contact the agency that maintains your health benefits enrollment.

Postal rates apply to certain United States Postal Service employees as follows:

- **Postal Category 1** rates apply to career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NALC, NPMHU, and NRLCA.
- If you are a career bargaining unit employee represented by the agreement with NPPN, you will find your premium rates on <https://liteblue.usps.gov/fehb>.
- **Postal Category 2** rates apply to career bargaining unit employees who are represented by the following agreement: PPOA.

Non-Postal rates apply to all career non-bargaining unit Postal Service employees. Postal rates do not apply to non-career Postal employees, Postal retirees, and associate members of any Postal employee organization who are not career Postal employees.

If you are a Postal Service employee and have questions or require assistance, please contact:

USPS Human Resources Shared Service Center: 877-477-3273, option 5, Federal Relay Service 800-877-8339

Premiums for Tribal employees are shown under the monthly non-Postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

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
Standard Option Self Only	2G4	\$230.18	\$137.98	\$498.72	\$298.96	\$134.78	\$125.19
Standard Option Self Plus One	2G6	\$492.27	\$244.04	\$1,066.59	\$528.75	\$237.20	\$216.69
Standard Option Self and Family	2G5	\$525.32	\$349.41	\$1,138.19	\$757.06	\$342.11	\$320.23
HDHP Option Self Only	B61	\$179.40	\$59.80	\$388.70	\$129.57	\$57.41	\$49.63
HDHP Option Self Plus One	B63	\$358.79	\$119.60	\$777.38	\$259.13	\$114.81	\$99.27
HDHP Option Self and Family	B62	\$426.25	\$142.08	\$923.54	\$307.84	\$136.40	\$117.93