CareFirst BlueChoice, Inc.

www.carefirst.com/fedhmo

(888) 789-9065

2015

A Health Maintenance Organization (high and standard option) and a high deductible health plan

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.

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

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 15 for requirements.

IMPORTANT
- Rates: Back Cover
- Changes for 2015: Page 16
- Summary of benefits: Page 142

Enrollment code for this Plan:

2G1 High Option Open Access - Self Only
2G2 High Option Open Access -Self and Family
2G4 Standard HealthyBlue - Self Only
2G5 Standard HealthyBlue - Self and Family
B61 HealthyBlue Advantage HDHP - Self Only
B62 HealthyBlue Advantage HDHP - Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

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

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 1-800-MEDICARE (1-800 633-4227), (TTY) 1-877-486-2048.

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Introduction

This brochure describes the benefits of CareFirst BlueChoice, Inc. under our contract (CS 2879) with the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. 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 oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, **2015**, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, **2015** and changes are summarized on page 16. 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 does meet 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 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 that 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 (toll free) (888) 789-9065 and explain the situation.

CALL - THE HEALTH CARE FRAUD HOTLINE

(877) 499-7295 OR go to www.opm.gov/oig

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.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you may be responsible for all benefits paid during the period in which premiums were not paid. You may be billed directly by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage **that** you take, including non-prescription (over-the-counter) medicines 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 medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

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

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

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

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

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

  - "Exactly what will you be doing?"

  - "About how long will it take?"

  - "What will happen after surgery?"

  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

-www.ahrg.gov/consumer/. 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.npsf.org. The National council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

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

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

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

Never Events

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

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

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events, if you use CareFirst BlueChoice preferred providers. This policy helps to protect you from preventable medical errors and improve the quality if care you receive.

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/insure/health for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies 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 a *Guide to Federal Benefits* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

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

  Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children 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 and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event.

The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

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

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

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

You can find additional information at www.opm.gov/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 and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

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

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

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2015 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 2014 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC).

- **Upon divorce**

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

- **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, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from **www.opm.gov/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 FEHBP 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 apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

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

In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. 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 Affordable Care Act'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). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory. 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-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

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

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

General features of our High Open Access and Standard HealthyBlue Options

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

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

We have Open Access benefits

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

We have Point of Service (POS) benefits

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

How we pay providers

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

General Features of our High Deductible Health Plan (HDHP)

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHBP plans. FEHBP 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 from a network provider.

Annual deductible

There is no deductible under our High Option. Under Standard HealthyBlue, 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, 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 or Indian Health Services (IHS) benefits within the last three 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. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed $6,450 for Self Only enrollment, or $12,900 Self and family coverage.

- For the High Option, your catastrophic limit is $1,900 per individual and $5,500 per family.
- For the Standard HealthyBlue, the catastrophic limit is $1,900 for self only enrollment and $5,500 per family in-network services. For out-of-network services, the limit is $3,600 per self only enrollment and $7,200 per self and family enrollment.
- For the HealthyBlue Advantage HDHP, the catastrophic limit is $4,000 for self only enrollment and $8,000 for self and family enrollment for in-network services. For out-of-network services, the limit is $6,000 for self only enrollment and $12,000 for self and family enrollment.

Refer to page 24 for more information on the catastrophic limit.

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 HDHP Section 5(i)

Your Rights

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

- We are in compliance with Federal and State licensing and certification requirements
- We have been in existence since 1984
- We are a for profit corporation
- CareFirst BlueChoice, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. Registered trademark of the Blue Cross and Blue Shield Association. Registered trademark of CareFirst of Maryland, Inc.

If you want more information about us, call (toll free) (888) 789-9065 or write to Mail Administrator., P.O. Box 14114, Lexington, KY 40512-4114. You may also contact us by visiting our website at www.carefirst.com/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 CareFirst BlueChoice Open Access, you must ordinarily get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval. Under HealthyBlue, if you elect to receive care outside of our service area, the care will be treated as out-of-network.

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

Section 2. Changes for 2015

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 this Plan for all Options:

- Your share of the non-Postal premium will increase for all options. See Page 149
- Coverage of the following Preventive services with no copay:
  - BRCA testing
  - Lung cancer screening
  - HIV screening
- In-network copays and deductibles will be waived for Medicare eligible members and dependents who enroll in Medicare parts A & B. For additional information and details please see section 9.
- Coverage of weight loss drugs at the appropriate tier copay
- Coverage for preventive breast cancer drugs with no deductible or copays
- An enhanced formulary which will limit/restrict, but still cover, open formulary drugs that are:
  - Less efficacious than other available drugs for the same indication
  - Less safe than other available drugs for the same indication
  - Provide little to no incremental clinical value at substantial cost when compared to other available drugs
- Specialty Drugs Tier four may have one or more of the following characteristics:
  - Typically higher in cost
  - Injectable, infused, inhaled, or oral therapeutic agents, or products of biotechnology (excluding insulin)
  - 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

Changes to High Option only:

- Your share of the non-Postal premium will increase for Self Only and Family. The new premium for Self Only is $107.38 and for Family is $247.44. See page 149

Changes to Standard Option only:

- Your share of the non-Postal premium will increase for Self Only and Family. The new premium for Self Only is $74.56 and for Family is $173.61. See page 149

Changes to HDHP Option only:

- Your share of the non-Postal premium will increase for Self Only and Family. The new premium for Self Only is $66.96 and for Family is $149.36. See page 149

Changes for Standard Option and HDHP Option only:

- For urgent/emergent services within our service area and provided by a non-participating provider, the member is not responsible for amounts in excess of the allowed benefit.

- In place of deductible credits, members will now receive a debit card to help pay for qualified medical expenses. It is important to note that members with a Health Savings Account (HSA) plan will only receive their medical expense debit card after meeting the $1,400 individual deductible or the $2,800 family deductible. Please refer to Section 5(h) for the standard option, and Section 5(h) for the HDHP option for more details.
- For 2015 we now have a benefit for meeting biometric based goals.

Changes for the HDHP Option Only:

- The HDHP in-network deductible has been decreased to $1,400 per self only enrollment and $2,800 for family enrollment. Currently members can choose between a HSA or HRA option.
- For 2015, 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.

Section 3. How you get care

Identification cards

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

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

Where you get covered care

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

- **Plan providers**

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

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

- **Plan facilities**

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

What you must do to get covered care

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

- **Primary care**

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

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

- **Specialty care**

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

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

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

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

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

- **Hospital care**

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

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

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

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

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

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

You need prior Plan approval for certain services

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

- **Inpatient hospital admission**

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

- 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 authorization for:

  - Dialysis in a hospital setting
  - Growth hormone therapy
  - 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.

- **Non-urgent care claims**

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

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

- **Urgent care claims**

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

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) to 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 2 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, then 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 business days following the day of the emergency admission, even if you have been discharged from the hospital.

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

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

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

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

Under our Standard HealthyBlue option, certain services can be obtained from out-of-network providers. For services requiring prior authorization or pre-certification, refer to the "You need prior Plan approval for certain services" section on page 19.

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 yo 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 High BlueChoice Open Access HMO has no in-network deductible.

The Standard HealthyBlue Option has a calendar year in-network deductible of $500 per self only enrollment and $1,000 for self and family contract, and an out-of-network deductible of $1,000 per self only enrollment and $2,000 for self and family coverage. The in-network deductible is included in the out-of-network total.

Under the self and family contract, services for any or all members contribute to the deductible. Those services subject to the deductible are indicated in Sections 5 (a) through 5 (g).

The HealthyBlue Advantage HDHP has a deductible of $1,400 per self-enrollment or $2,800 per family enrollment for in-network services and $3,000 per self enrollment and $6,000 per family enrollment for out-of-network care each calendar year. The 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 (c) in the High Deductible section of this brochure.

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 copay or coinsurance. Please check the Hearing Aid benefit for detail for when network providers may bill for balances (see pages 39 and 94).

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

Your catastrophic protection out-of-pocket maximum

Under the BlueChoice Open Access plan, once your expenses (copayments and coinsurance) total $1,900 for self only or $5,500 per family in any calendar year, you do not have to pay anymore for covered services. Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

Under HealthyBlue, once your expenses for in-network care (copayments and deductible) total $1,900 for self only contract or $5,500 per 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 $3,600 for self only contract and $7,200 per family in any calendar year, and only expenses up to our allowed benefit contribute; any balances in excess of our allowed benefit do not contribute to the catastrophic limit and remain your liability.

Under the HealthyBlue Advantage HDHP option, once your expenses for in-network services (copayments and deductible total $4,000 for self only contract or $8,000 per family in any calendar year, you do not have to pay anymore 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 family in any calendar year, and only expenses up to our allowed benefit contribute; any balances in excess of our allowed benefit do not contribute to the catastrophic limit and remain your liability.

Carryover

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

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

When Government facilities bill us

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

Section 5. Benefits - High and Standard Option

See page 16 on how our benefits changed this year. Pages 142 to 144 contain the benefit summaries for both the High Open Access and the Standard HealthyBlue.

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. High and Standard Option Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard 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 High and Standard Option benefits, contact us at (888) 789-9065 or on our website at www.carefirst.com/fedhmo.

High Option

- Open Access Plan does not require referrals to see a specialist
- Preventive care and Women's health are covered with no copay
- $25 PCP copay and $35 specialist copay
- No copay for lab and x-ray at preferred network providers
- $200 per admission copay for inpatient hospitalization
- $50 facility copay for surgery in an Ambulatory Surgical Center and $100 facility fee for outpatient hospital
- Prescriptions:
  - For up to a 34 day supply - $0 copay for generic drugs, $35 for tier 2 brand named drugs and $65 for tier 3 brand named drugs and $150 for Trier 4 specialty drug
  - For a 35 through 90-day supply: two copays

Standard HealthyBlue Option

The benefits listed for the high option with the exception that 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 of-of-network care. The deductible can apply to both facility and professional care. Sections 5 (a) through 5 (h) indicated when the deductible applies.
- Under HealthyBlue, you have access to Blue Rewards and can earn up to $250 per individual contract or up to $700 on afamily contract. 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:
  - For up to a 34-day supply - $0 copay for generic drugs, $35 for tier 2 brand named drugs and $65 for tier 3 brand named drugs and $150 for Trier 4 specialty drug
  - For a 35-day through 90-day supply: two copays
  - Mandatory Generic benefit indicating that the member is responsible for the price difference between the brand name drug and its generic equivalent as well as the copay.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center of the outpatient department of a hospital.
- 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.
- HealthyBlue has a calendar year in-network deductible of $500 per self only contract and $1,000 per self and family contract, and an out-of-network deductible of $1,000 for self only contract and $2,000 for self and family coverage. 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.

Benefit Description	You pay	
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians In a physician's office • Office medical consultation • Second surgical opinion • Development and Maintenance of a Care Plan by a PCMH panel provider • At home care	$25 per visit to your primary care physician $35 per visit to a specialist	In network: • No deductible • No copay for primary care physician • $35 per visit to a specialist Out-of-network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per visit
In a Plan urgent care center (see Emergency care 5(d)) ***Note: Benefit is limited to emergency services or unexpected, urgently required services.***	$35 per visit	$35 per visit

Diagnostic and treatment services - continued on next page

Benefit Description	You pay	
Diagnostic and treatment services (cont.)	**High Option**	**Standard Option**
		When seeing providers who are not contracted with, or participating in, any CareFirst BlueCross Blue Shield network, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate copay.
Professional services received: - During a hospital inpatient stay - During a facility outpatient stay - In a skilled nursing facility	Nothing	In Network: • Calendar year deductible applies • No professional copay Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay for each professional provider per admission
Not covered: Test required for marriage, employment, attending schools or camp, foreign travel, or government licensing	*All charges*	*All charges*
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing	In network: No charge Out-of-network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Annual deductible applies • $70 copay

Benefit Description	You pay	
Preventive care, adult	**High Option**	**Standard Option**
Routine physical every year which includes routine screenings, such as: • 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 tests include: - Fecal occult blood test - Sigmoidoscopy screening - every five years starting at age 50 - Colonoscopy screening - every ten 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	Nothing	In Network: • No deductible • No copay Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • No office copay
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older in accordance with the most current American Cancer Society guidelines	Nothing	In Network: • No deductible • No copay Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • No copay
Well woman care - including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus	Nothing	In Network: • No deductible • No copay Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
• 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.	Nothing	In Network: • No deductible • No copay Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • No copay
Routine pap test - one annually Routine mammogram - covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40, one every calendar year	Nothing	In Network: • No deductible • No copay Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • No deductible • No copay
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC). **Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available online at www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.**	Nothing if you receive these services through a well-child visit or a complete physical.	In Network: • No deductible • No copay Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • No copay
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.*	*All charges*	*All charges*

Benefit Description	You pay	
Preventive care, children	**High Option**	**Standard Option**
Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	In Network: • No deductible • No copay Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • No copay
• Well-child care charges for routine examinations, immunizations and care in accordance with the most recent guidance from the American Academy of Pediatrics. • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Ear exams through age 17 to determine the need for hearing correction Note: A complete list of preventive care services recommended under the USPSTF is available online at www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	Nothing	In Network: • No deductible • No copay Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar Year deductible applies • No copay
Maternity Care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • Delivery • Postnatal care **See Section 5 (c) for information on outpatient facility services.**	No copay for routine maternity care	In Network: • No deductible for pre and post natal care • Calendar year deductible applies to **professional services** for delivery • No copay Out-of-Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • No copay

Maternity Care - continued on next page

Benefit Description	You pay	
Maternity Care (cont.)	**High Option**	**Standard Option**
		• ***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.***
Breastfeeding support, supplies and counseling for each birth Note: Benefit coverage for breastfeeding support, supplies and counseling for each birth begin immediately after delivery. 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.	Nothing	In -Network: Nothing Out-of-network: After deductible, no copay
Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 20 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Doulas are not covered		

Benefit Description	You pay	
Family planning	**High Option**	**Standard Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization - See Surgical procedures Section 5 (b) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms • Contraceptive counseling on an annual basis at no cost sharing. Note: We cover oral contraceptives under the prescription drug benefit.	Nothing	In-network: Nothing Out-of-network: After deductible, no copay
Contraceptive procedures for men	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible • No copay for primary care physician / $35 per visit to a specialist Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar Year deductible applies, then $70 copay per visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling* • *Fertility drugs for procedures excluded under this contract. See Section 5 (a) and Section 5 (f)*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - Intravaginal Insemination (IVI) - Intracervical Insemination (ICI) - Intrauterine Insemination (IUI) Note:	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • Calendar year deductible applies • 50% coinsurance Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • 50% coinsurance

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High Option**	**Standard Option**
• We cover drugs for the treatment of infertility, unless they are prescribed for procedures not covered under this plan. When covered, injectable drugs are medical benefits, and oral drugs are benefits under prescription drug coverage. See Section 5 (g). • Prior authorization for the treatment must be obtained from CareFirst BlueChoice. • Benefits are limited to six attempts per live birth. • The Member's Spouse's sperm is used. Any charges associated with the collection of the Member's Spouse's sperm will not be covered unless the Spouse is also a Member. • The Member is responsible for the copayment or coinsurance for 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 if the couple has a relationship under which the FEHB Program recognizes each partner as a spouse of the other.	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • Calendar year deductible applies • 50% coinsurance Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • 50% coinsurance
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg.*	*All charges*	*All charges*

Benefit Description	You pay	
Allergy care	**High Option**	**Standard Option**
• Testing and treatment • Allergy injections	$25 primary care physician office visit may apply $35 specialist office visit copay may apply	In Network: • No deductible • No copay for primary care physician • $35 per visit to a specialist Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per visit
Allergy serum	$25 primary care office visit copay may apply $35 specialist office visit copay may apply	In Network: • No deductible • No copay for primary care physician • $35 per visit to a specialist Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per visit
Not covered: Provocative food testing and Sublingual allergy desensitization	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on pages 49. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit.	$25 per visit to your primary care physician $35 per visit to a specialist Nothing if provided as part of home health services (see page 43)	In Network: • No deductible • No copay for primary care physician • $35 per visit to a specialist Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per visit

Treatment therapies - continued on next page

Benefit Description	You pay	
Treatment therapies (cont.)	**High Option**	**Standard Option**
See Section 5 (c) for information on outpatient facility services. *Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See "Other services" under "You need prior Plan approval for certain services" on page 19.*	$25 per visit to your primary care physician $35 per visit to a specialist Nothing if provided as part of home health services (see page 43)	In Network: • No deductible • No copay for primary care physician • $35 per visit to a specialist Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per visit
Physical, Occupational, and Speech therapies	**High Option**	**Standard Option**
Up to 60 visits (combined physical, occupational and/or speech therapy) per condition per benefit period for the services of the following qualified providers: • Physical therapists • Occupational therapists • Speech therapists Note: Coverage shall include Physical Therapy, Occupational Therapy and Speech Therapy for the treatment of individuals who have sustained an illness or injury that CareFirst BlueChoice determines to be subject to improvement Note: Occupational Therapy is limited to the use of purposeful activity or interventions designed to achieve functional outcomes that promote health, prevent injury or disability, and that develop, improve, sustain or restore the highest possible level of independence of an individual. Brochure language also states under member liability: • Other than any applicable inpatient or outpatient facility copay, member has no copay or coinsurance during an approved inpatient stay. **See Section 5 (c) for information on outpatient facility services.**	$35 per visit to a specialist Nothing during a covered inpatient admission	In Network: • No deductible • $35 per visit to a specialist Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per visit
Not covered: • *Long-term rehabilitative therapy*	*All charges*	*All charges*

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

Benefit Description	You pay	
Physical, Occupational, and Speech therapies (cont.)	**High Option**	**Standard Option**
• *Exercise programs* • *Maintenance therapy*	*All charges*	*All charges*
Habilitative therapy	**High Option**	**Standard Option**
• 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 co-payment, but are not counted toward any visit maximum for therapy services • See Section 5 (c) for outpatient facility services	$35 per visit to a specialist Nothing during a covered inpatient admission	In Network: • No deductible • $35 per visit to a specialist Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 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.***
Benefits are not covered for Habilitative Services delivered through early intervention or school services. Prior authorization is required.	*All charges*	*All charges*
Cardiac Rehabilitation	**High Option**	**Standard Option**
• Up to 90 visits per condition per benefit period Note: Cardiac Rehabilitation benefits are provided to Members who: • have been diagnosed with significant cardiac disease • suffered a myocardial infarction • undergone invasive cardiac treatment immediately preceding referral See section 5 (c) for outpatient facility services.	$35 per visit to a specialist Nothing during a covered inpatient admission	In Network: • No deductible • $35 per visit to a specialist Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per visit
Note: Benefits are not provided for maintenance cardiac rehabilitation	*All charges*	*All charges*

Benefit Description	You pay	
Pulmonary Rehabilitation	**High Option**	**Standard Option**
Pulmonary Rehabilitation • For those who have significant pulmonary disease or who have undergone certain surgical procedures of the lung. • Limited to one (1) pulmonary rehabilitation program per lifetime. • *Benefits are not provided for maintenance programs* See Section 5 (c) for outpatient facility services.	$25 primary care copay $35 specialist copay $50 hospital outpatient facility copay	In Network: • No deductible • $35 per visit to a specialist Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per visit
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O. or audiologist *Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) Preventive care.*	$35 specialist copay per visit	In Network: • No deductible • $35 per visit to a specialist Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per visit
Hearing Aids • *One Medically Necessary Hearing aid per ear is covered up to our allowed amount each 36 months.* Medical devices, such as bone anchored hearing aids (BAHA) and cochlear implants, (that 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. **More detail is available under the Orthopedic and prosthetic supplies portion of this section.**	Providers may bill for services related to external hearing aids for an amount in excess of our allowance if they provide written advance notice.	In Network: • Calendar year deductible applies • Paid up to our allowed benefit with no copay • Provider may bill for services in excess of our allowance with written advance notice Out of Network: • Calendar year deductible applies • Paid up to our allowed benefit with no copay • Provider may bill any amount in excess of our allowance. Participating providers will advise you in writing in advance if you will have a balance
Not covered:	*All charges*	*All charges*

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

Benefit Description	You pay	
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**
• *Hearing services that are not shown as covered.*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly related to intraocular surgery (such as for cataracts) Note: This is a medical benefit not a vision benefit.	$25 per visit to your primary care physician $35 per visit to a specialist Nothing for the eyeglasses for the first pair after covered surgery for medical condition.	In Network: • No deductible • No copay for primary care physician • $35 per visit to a specialist Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per visit
Routine eye exams Note: See Preventive care, children for eye exams for children Note: Eye care and exams related to medical conditions are subject to the specialist copay	• $10 per visit at Davis Vision Providers only	In Network: • No deductible • $10 per visit at Davis Vision Providers • $35 per visit to a specialist Out of Network: • Plan pay $33 dollars and member pays the balance.
Not covered: • *Eyeglasses or contact lenses (except as listed above)* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible • No copay for primary care physician • $35 per visit to a specialist

Foot care - continued on next page

Benefit Description	You pay	
Foot care (cont.)	**High Option**	**Standard Option**
		Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per visit
Not covered: • *Other routine palliative or cosmetic care of the feet including flat foot conditions, supportive devices for the foot, treatment of sublaxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, week feet, chronic foot strain, and symptomatic complaints of the feet.*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
- Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy. - Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. - Hair Prosthesis (wig) is covered when prescribed by a treating oncologist and the hair loss is the result of chemotherapy. The Plan will cover up to $350 for one hair prosthesis per benefit period. - Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants. - Internal prosthetic devices such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Notes: For information on the professional charges for the surgery to insert an implant. See Section 5(b) Surgical procedures. For information on the hospital and or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance service. Note: Externally worn prosthetics and devices are treated as Durable Medical Equipment (DME). See page 42.	$25 per visit to your primary care physician $35 per visit to a specialist Nothing for hair prostheses for hair loss due to chemotherapy up to the specified limit. Note: Copays apply to professional services not to the devices.	In Network: • No deductible • $35 per device Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 per device
Not covered:	*All charges*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
• *Orthopedic and corrective shoes* • *Arch supports, heel pads, and heel cups (except as listed under Durable Medical Equipment)* • *Foot orthotics (except as listed under Durable Medical Equipment).* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Wigs, including cranial prostheses, unless otherwise specified* • *Prosthetic replacements provided less than 3 years after the last one we covered* • *Prosthetic devices such as artificial limbs and lenses following cataract removal unless covered under the DME benefit (see Durable Medical Equipment below)* • *Prosthetic replacements provided less than 3 years after the last one we covered.*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Canes • Diabetic shoes • Commodes • Glucometers • Suction machines • Medical supplies (i.e. ostomy and catheter supplies, dialysis supplies, medical foods for inherited metabolic diseases and inborn deficiencies of amino acid metabolism)	25% coinsurance up to allowed benefit.	In Network: • Deductible applies • $35 copay per device Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per device • *Note: Services do contribute to the catastrophic limit.*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
• Externally worn non-surgical durable devices which replace a body part or assist a patient in performing a bodily function (unless otherwise described in the "orthopedic and prosthetic devices" section above) • Externally worn braces which improve the function of a limb • Medically Necessary molded foot orthotics • Medically Necessary fitted compression stockings *Note:*	25% coinsurance up to allowed benefit.	In Network: • Deductible applies • $35 copay per device Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per device • *Note: Services do contribute to the catastrophic limit.*
Not covered: • *Eye glasses and contact lenses (except as listed under Vision Services)* • *Dental prosthetics (except as listed under Orthopedic and Prosthetics above)* • *Environment control products* • *Over the counter orthotics* • *Over the counter compression stockings* • *Medical equipment of an expendable nature (i.e. ace bandages, incontinent pads)* • *Replacement of DME equipment not due to normal wear and tear* • *Comfort and convenience items* • *Over the counter items, except as listed above* • *Exercise equipment* • *Equipment that can be used for non-medical purposes*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	Nothing	In Network: • Calendar year deductible applies • $35 per visit copay Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per visit

Home health services - continued on next page

Benefit Description	You pay	
Home health services (cont.)	**High Option**	**Standard Option**
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Private duty nursing*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
Chiropractic services, limited to spinal manipulation, evaluation, and treatment up to a maximum of 20 visits per calendar year benefit period when provided by a Plan chiropractor. *Benefits are limited to those who are age 13 or older.*	$35 per visit to a specialist	In Network: • No deductible • $35 per visit to a specialist Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per visit
Not covered: *Services other than for musculoskeletal conditions of the spine.*	*All charges*	*All charges*
Alternative treatments	**High Option**	**Standard Option**
Acupuncture for: • anesthesia • pain relief	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible • $35 per visit to a specialist Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per visit
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback*	*All charges*	*All charges*

Benefit Description	You pay	
Educational classes and programs	**High Option**	**Standard Option**
Coverage is provided for: • Diabetes self-management (Sponsored by the Plan's Health Education Department) • Tobacco programs, including individual group telephone counseling, drugs approved by the FDA to treat tobacco dependence. 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 70.. • Childhood obesity as part of routine child care visit • Birthing classes	Nothing	In Network: • No deductible • No copay Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • No copay
Other Education Classes conducted by approved providers for: • Diabetes self-management • Childhood obesity education • Medically necessary nutrition therapy • Medically necessary professional nutritional counseling	$25 primary care copay $35 specialist copay $50 hospital outpatient facility copay	In Network: • No deductible • No copay for Primary Care • $35 copayment outpatient facility copay Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay for Professional or Facility Care
Note: 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.	*All charges.*	*All charges*

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- 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.
- We do not have a calendar year deductible under the BlueChoice Open Access program. HealthyBlue has a calendar year in network deductible of $500 per self only enrollment and $1,000 per self and family contract, and an out-of-network deductible of $1,000 per self only enrollment and $2,000 for self and family coverage. 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.).
- **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.

Benefit Description	You pay	
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*)	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• Surgical treatment of morbid obesity (bariatric surgery) Note: You must meet certain criteria to be eligible for bariatric surgery. They include: • A body mass index that is greater than 40 kilograms per meter squared; or • Equal to or greater than 35 kilograms per meter squared with a co-morbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes. Please contact Member Services at 888/789-9065 for more details on bariatric surgery. • Insertion of internal prosthetic devices. See 5 (a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. No additional copay is required for internal prostheses (devices). Note: See Section 5(c) about possible outpatient facility or inpatient hospital admission copayment	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per office visit • $70 physician copay while an inpatient or outpatient in a facility if the physician's services are not billed as part of the facility bill.
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Note: See Section 5(c) about possible outpatient facility or inpatient hospital admission copayment	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per office visit • $70 per physician per admission while an inpatient or outpatient in a facility if the physician's services are not billed as part of the facility bill.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay	
Oral and maxillofacial surgery (cont.)	**High Option**	**Standard Option**
Note: See Section 5(c) about possible outpatient facility or inpatient hospital admission copayment	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per office visit • $70 per physician per admission while an inpatient or outpatient in a facility if the physician's services are not billed as part of the facility bill.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Removal of impacted teeth* • *Any other dental surgery not listed or the result of traumatic injury or treatment of cleft pallet*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
These **solid organ transplants** are subject to medical necessity and experimental/ investigational review by the plan. Refer to Other services in Section 3 for prior authorization procedures. • Cornea • Heart • Heart/lung	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Intestinal transplant - 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 • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis. These **tandem blood or marrow stem cell transplants** for covered transplants are subject to medical necessity review by the Plan. Refer to other services in Section 3 for prior authorization procedure. • Autologous tandem transplant for - AL Amyloidosis - Multiple myeloma (de movo and treated) - Recurrent germ cell tumors (including testicular cancer) Note: See Section 5(c) about possible outpatient facility or inpatient hospital admission copayment	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per office visit • $70 per physician per admission while an inpatient or outpatient in a facility if the physician's services are not billed as part of the facility bill.
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • Allogeneic transplants for	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)*

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- 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) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myclodysplasia/Myclodysplastic 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 - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed)	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per office visit • $70 per physician per admission while an inpatient or outpatient in a facility if the physician's services are not billed as part of the facility bill.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer (limited to clinical trials) - Childhood rhabdomyosarcoma - Ependymoblastoma - Epithelial ovarian cancer (limited to clinical trials) - Ewing's sarcoma - Mantle Cell (Non-Hodgkin Lymphoma) - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular Mediastinal, Retroperitoneal, and ovarian germ cell tumors **Mini-transplants performed in a clinical trial setting** (non-myeloblative reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan Refer to *Other Services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with 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 Noctumal Hemoglobimuria	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per office visit • $70 per physician per admission while an inpatient or outpatient in a facility if the physician's services are not billed as part of the facility bill.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Severe combined immunodeficiency - Sever or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i. e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma Note: See Section 5c about possible outpatient facility or inpatient hospital admission copayment	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per office visit • $70 per physician per admission while an inpatient or outpatient in a facility if the physician's services are not billed as part of the facility bill.
These blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for: - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per office visit

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Chronic inflammatory demyelination poluneuropathy (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 - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small cell lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MSDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle Cell anemia • Autologous Transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per office visit • $70 per physician per admission while an inpatient or outpatient in a facility if the physician's services are not billed as part of the facility bill.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- 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) Note: We cover related medical and hospital expenses of the donor when we cover the recipient who is not covered by other insurance. We cover donor testing for the actual solid organ donor or up to four bone marrow/ stem cell transplant donors in addition to the testing of family member. Note: See Section 5c about possible outpatient facility or inpatient hospital admission copayment	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per office visit • $70 per physician per admission while an inpatient or outpatient in a facility if the physician's services are not billed as part of the facility bill.
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	In Network: • No deductible for office care • Deductible applies to care received while an outpatient or inpatient in a facility • No copay for primary care physician in the office • $35 per office visit to a specialist • No professional copay while an inpatient or outpatient in a facility

Anesthesia - continued on next page

Benefit Description	You pay	
Anesthesia (cont.)	**High Option**	**Standard Option**
		Out of Network: *(See notation in the introduction to this section on how we process claims from out-of-network providers)* • Calendar year deductible applies • $70 copay per office visit • $70 per physician per admission while an inpatient or outpatient in a facility if the physician's services are not billed as part of the facility bill.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We do not have a calendar year deductible under the BlueChoice Open Access program. HealthyBlue has a calendar year in-network deductible of $500 per self only enrollment and $1,000 per self and family contract, and an out-of-network deductible of $1,000 per self only enrollment and $2,000 for self and family coverage. 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 in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

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

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Acute Inpatient Rehabilitation • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home. *Note: Hospitalization solely for Acute Rehabilitation is limited to 90 days per calendar year.*	Nothing	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care, except when medically necessary*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Professional services, such as those listed in sections 5 (a), that are the sole service and billed by the hospital. Examples include, but are not limited to, covered education classes, physical therapy and cardiac rehabilitation.	$50 per outpatient visit for medical care $50 per Ambulatory Surgical Center visit involving a surgical procedure $100 per hospital outpatient visit involving a surgical procedure	In Network: • Calendar year deductible applies • $35 copay per visit copay for medical care • $35 copay for Ambulatory Surgical Center for surgical services • $100 copay for Outpatient Hospital for surgical services Out-of-network: • Calendar year deductible applies • $70 per admission copay for medical services • $70 per Ambulatory Surgical Center visit involving a surgical procedure • $140 per hospital outpatient visit involving a surgical procedure

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay	
Outpatient hospital or ambulatory surgical center (cont.)	**High Option**	**Standard Option**
Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$50 per outpatient visit for medical care $50 per Ambulatory Surgical Center visit involving a surgical procedure $100 per hospital outpatient visit involving a surgical procedure	In Network: • Calendar year deductible applies • $35 copay per visit copay for medical care • $35 copay for Ambulatory Surgical Center for surgical services • $100 copay for Outpatient Hospital for surgical services Out-of-network: • Calendar year deductible applies • $70 per admission copay for medical services • $70 per Ambulatory Surgical Center visit involving a surgical procedure • $140 per hospital outpatient visit involving a surgical procedure • Non-participating facilities may bill the member for any amount in excess of our allowed benefit.
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
If a Plan doctor determines that you need full-time skilled nursing care or need to stay in a skilled nursing facility, and we approve that decision, we will give you the comprehensive range of benefits with no dollar or day limit. • Bed, board, and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	Nothing	In Network: • Calendar year deductible applies • No per admission copay Out-of-network: • Calendar year deductible applies • $70 per admission copay • If member chooses an out-of-network facility without prior approval, the member will be responsible for any amount in excess of our allowed benefit. If the admission is urgent or a medical emergency, the member will only be responsible for the per admission copay.
Not covered: Custodial care	*All charges*	*All charges*

Benefit Description	You pay	
Hospice care	**High Option**	**Standard Option**
If terminally ill, you are covered for supportive and palliative care in your home or at a hospice. This includes inpatient and outpatient care and family counseling. A Plan doctor, who certifies that you are in the terminal stages of illness, with a life expectancy of approximately six months or less, will direct these services. Respite Care is limited to 3 periods of 48 hours during the Hospice Eligibility Period. Bereavement Services are provided for up to 3 visits during the 90 days following the patient's death.	Nothing	In Network: • Calendar year deductible applies • $35 copay per visit Out-of-network: • Calendar year deductible applies • $70 per copay per visit • If member chooses an out-of-network facility without prior approval, the member will be responsible for any amount in excess of our allowed benefit. If the admission is urgent or a medical emergency, the member will only be responsible for the per admission copay.
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
• Local professional ambulance service when medically appropriate • Air Ambulance Service when medically appropriate	Nothing	In Network • Calendar year deductible does not apply • $50 per trip Out-of-Network • Calendar year deductible does not apply • $50 per trip • Non-participating providers may bill the member for the amount in excess of our allowed benefit

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

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

What is a medical emergency?

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

What to do in case of emergency:

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

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

Urgent Care

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

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

Emergencies inside our service area:

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

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

Emergencies outside our service area:

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

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

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

Emergency outside our service area - continued on next page

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

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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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.
- We do not have a calendar year deductible under the BlueChoice Open Access program. HealthyBlue has a calendar year in-network deductible of $500 per self only contract and $1,000 per self and family contract, and an out-of-network deductible of $1,000 for self only contract and $2,000 for self and family coverage. 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.
- YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS. Please refer to Section 3 for more information about precertification.
- We administer mental health and substance abuse benefits under a contract with Magellan Behavioral Health (or another vendor we determine). If you think you need mental health or substance abuse services you must first call Magellan at (800) 245-7013to obtain a Magellan provider. Magellan must coordinate all mental health and substance services, not your primary care doctor.

Benefit Description	You pay	
Professional services	**High Option**	**Standard Option**
Outpatient and office Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers for the diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • 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	$25 professional office copay	In Network: • Calendar year deductible does not apply • No office copay Out-of-network: • Calendar year deductible applies • $70 copay • Non-participating providers will bill the member for any charges in excess of our allowed amount.

Professional services - continued on next page

Benefit Description	You pay	
Professional services (cont.)	**High Option**	**Standard Option**
• Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$25 professional office copay	In Network: • Calendar year deductible does not apply • No office copay Out-of-network: • Calendar year deductible applies • $70 copay • Non-participating providers will bill the member for any charges in excess of our allowed amount.
Diagnostics	**High Option**	**Standard Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing	Nothing
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	$200 per admission copayment	In Network • Calendar year deductible applies • $200 per admission copay Out-of-network • Calendar year deductible applies • $500 per admission copay apples • Non-participating facilities may bill the member for any charges in excess of our allowed benefit.

Benefit Description	You pay	
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
Not covered	**High Option**	**Standard Option**
• *Inpatient admissions not precertified through Case Management* • *Care determined not to meet medically accepted levels of care.*	*All charges*	*All charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

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

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

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

- **Who can write your prescription**. A licensed physician or 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 use a formulary**. A formulary is a preferred list of drugs that we selected to meet patient needs at a lower cost. The formulary includes both generic and brand name drugs. You will be responsible for higher charges if your doctor prescribes a drug not on our formulary list. However, non-formulary drugs will be covered when prescribed by a Plan doctor.
- **We have an open formulary**. If your provider believes a name brand product is necessary or there is no generic available, a name brand drug from a formulary list may be prescribed. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 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 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	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (Subject to dosage limitations. Contact us for these limitations.) • Diabetic supplies including insulin syringes, needles, glucose test strips, lancets, and alcohol swabs • Allergy serum • Vitamin D is covered for adults 65 and older • Weight loss drugs - The disposal of these drugs will be subject to utilization management protocols, including prior approval, duration of therapy limits, and medical necessity review Notes: • Intravenous fluids and medications for home use, implantable drugs (such as Norplant), some injectable drugs (such as Depo Provera), and IUDs are covered under the Medical and Surgical Benefits • Speciality drugs require pre-authorization and the use of preferred pharmacies • Glometers are covered as Durable Medical Equipment under the Medical and Surgical Benefits. See page 42.	Up to 34-day supply • Tier 1 -$0 per unit or refill for generic prescriptions • Tier 2 - $35 per unit or refill for brand name prescriptions on our preferred drug list • Tier 3 - $65 per unit or refill for brand name prescriptions not on our preferred drug list • Tier 4 - $150 per unit or refill for Specialty Drugs Maintenance Drugs: 35-day through 90-day supply: • Tier 1 - $0 for generic prescriptions • Tier 2 - $70per unit or refill for brand name prescriptions on our preferred drug list • Tier 3 - $130for brand name prescriptions not on our preferred drug list • Tier 4 - $300 for Specialty Drugs Notes: • If there is no generic equivalent available, you will still have to pay the brand name copay • If a drug is available in generic, and your physician has not indicated "Do not substitute" or "Dispense as written on the prescription, you will be responsible for the price difference between brand named drugs and their generic equivalent as well as the tier 2 or tier 3 copay • Specialty Drugs are typically high in cost and have one or more of the following characteristics: - Injectable, infused, inhaled, or oral therapeutic agents, or products of biotechnology	Up to 34-day supply • Tier 1 -$0 per unit or refill for generic prescriptions • Tier 2 - $35 per unit or refill for brand name prescriptions on our preferred drug list • Tier 3 - $65 per unit or refill for all other prescriptions • Tier 4 - $150 per unit or refill for Specialty Drugs Maintenance Drugs: 35-day through 90-day supply: • Tier 1 - $0 for generic prescriptions • Tier 2 - $70 for brand name prescriptions on our preferred drug list • Tier 3 - $130 for brand named prescriptions not on our preferred list • Tier 4 - $300 for Specialty Drugs Notes: • If there is no generic equivalent available, you will still have to pay the brand name copay • If a drug is available in generic, you will be responsible for the price difference between brand named drugs and their generic equivalent as well as the tier 2 or tier 3 copay • Specialty Drugs are typically high in cost and have one or more of the following characteristics: - 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

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
	- 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	- 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
Women's contraceptive drugs and devices Note: Over-the-counter contraceptives drugs and devices approved by the FDA require a written prescription by an approved provider	Nothing	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Medical supplies such as dressings and antiseptics* • *Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies* • *Vitamins, nutrients and food supplements, even if a physician prescribes or administers them, except as listed above* • *Nonprescription medicines* • *Infertility drugs related to procedures excluded under this contract (see Section 5 (a) and Section 5 (f)*	*All charges*	*All charges*
Smoking deterrents Note: Medications approved by the FDA to treat tobacco dependence are covered under the tobacco cessation benefits and dispensed under our pharmacy program. To be covered, the medications must be prescribed by a physician, even if it is available over-the-counter. See page 45.	Nothing up to two attempts per year	Nothing up to two attempts per year

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
The following prescription drugs are covered in full: • Folic acid supplements containing 0.4 to 0.8 milligrams of folic acid for women planning to become, or capable of becoming pregnant, are covered in full • Fluoride will be paid for children older than 6 months of age whose primary water source is deficient in fluoride. • Iron supplements for asymptomatic children aged 6 to 12 months who are at increased risk of iron deficiency anemia • Chemotherapy medications received through a pharmacy • Preventive Breast Cancer drugs for women who are at an increased risk for breast cancer, and at a low risk for adverse medication effects Please refer to our website *carefirst.com/fedhmo* for any updates to this list and for additional information on how these items are covered.	Nothing	Nothing

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHBP Plan will be First Primary payor of any Benefit payment and your FEDVIP Plan is secondary to your FEHBP Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- 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.
- We do not have a calendar year deductible under the BlueChoice Open Access program. HealthyBlue has a calendar year in-network deductible of $500 per self only contract and $1,000 per self and family contract, and an out-of-network deductible of $1,000 for self only contract and $2,000 for self and family coverage. 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.

Benefit Description	You Pay	
Accidental injury benefit	**High Option**	**Standard 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.	$25 per visit to your primary care physician $35 per visit to a specialist	In Network: • No deductible • No copay for primary care physician • $35 per visit to a specialist Out of Network: *(See notation in the introduction to this section for information on how we process claims from out-of-network providers.* • Calendar year deductible applies • $70 copay per visit
We have no other dental benefits	*All charges*	*All charges*

Section 5(h). Special features

Feature	Description
Flexible benefits for High and Standard options	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process. (See Section 8).
24-hour nurse line for High and Standard options	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.
Services for deaf and hearing impaired for High and Standard options	Our TTY number for Customer Service is (202) 479-3546
Care Team Program for High and Standard options	We provide programs for members diagnosed with coronary artery disease, congestive heart failure, diabetes, cancer, asthma and other chronic conditions. These programs are designed to help you better understand and manage your condition. Our Care Team Program benefits may include: • Educational materials, such as self-monitoring charts, resource listings, self-care tips, and a quarterly newsletter • A health assessment and nurse consultation • Access to a 24-hour Nurse Advisor help line Please call us at (800) 783-4582 for more information about our Care Team Program

Feature - continued on next page

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

Feature - continued on next page

Feature (cont.)	Description
Healthy Reward for Standard HealthyBlue option	Under HealthyBlue you can earn a Healthy Reward $300 per individual contract or up to $700 on a family contract. In place of deductible credits, members will now receive a debit card to help pay for qualified medical expenses. To earn the Healthy Reward you must complete the following steps: • Choose a PCP who participates in our PCMH Program • Complete the online Health Assessment (Adults 18+ only) • Follow the steps to complete the electronic signature on the Consent Authorization form included with the Health Assessment (Adults 18+ only) • Work with your PCMH PCP to complete the Health and Wellness Evaluation Form • Return the Health and Wellness Evaluation Form to CareFirst • Complete all steps within 180 days of your effective date Under the Standard Option: Healthy Rewards are accumulated at the rate of $300 per adult member and $25 per minor dependent aged 2 to 17 up to a family maximum of $700. In addition, adult members can earn $100 and minor dependents aged 2 to 17 can earn $25 for meeting Biometric results-based goals - up to a total family maximum of $250. The Health and Wellness Evaluation Form can be returned to us in any of the following ways: • Upload the information in the My Account section of CareFirst.com/fedhmo on the Manage My Health tab. • Scan as a JPG, PDF or TIFF form and upload through the Manage My Health tab. • Fax to (800) 354-8205 • Mail to: Mail Administrator P.O. Box 14116 Lexington, KY 40512-4116

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Section 5. High Deductible Health Plan Overview

This Plan offers a High Deductible Health Plan (HDHP). The 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.

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 HDHP benefits, contact us at (888) 789-9065 or on our website at www.carefirst.com/fedhmo.

Our 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 this 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.

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 85. 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.

This HDHP includes five 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 and/or Indian Health Services (IHS) benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In 2015, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $37.50 per month for a Self-Only enrollment or $75.00 per month for 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 $3,350 for an individual and $6,650 for a family. See maximum contribution information on page 81. 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 HSA is administered by Blue Fund Administrator, in conjunction with **the Bank of New York Mellon (BNY Mellon)**
- 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.
- As long as you are enrolled in this plan, you incur no administrative fees. If you leave the plan, you will be responsible for administrative fees.
- When you need it, funds up to the actual HSA balance are available.
- 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.

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this 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), this 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, 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 2015, we will give you an HRA credit of **$450** per year for a Self-Only enrollment and **$900** 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 our HDHP option, 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 this 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 (HCFSA). However, you must meet FSAFEDS eligibility requirements.

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

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to **$4,000** per **individual enrollment** or **$8,000** per family enrollment, and out-of network care is limited to **$6,000 per individual enrollment and $12,000 per 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 HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

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

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) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA for you with Blue Fund Administrator and the **Bank of New York Mellon (BNY Mellon),** this 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 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: • Enroll in this 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 and/or Indian Health Services (IHS) benefits in the last three 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 this 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 HDHP. 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.).	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.

Self Only enrollment	For 2015, a monthly premium pass through of **$37.50** will be made by the HDHP directly into your HSA each month.	For 2015, your HRA annual credit is **$450** (prorated for mid-year enrollment).
Self and Family enrollment	For 2015, a monthly premium pass through of **$75** will be made by the HDHP directly into your HSA each month.	For 2015, your HRA annual credit is **$900** (prorated for mid-year enrollment).
Contributions/ credits	The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $3,350 for an individual $6,650 for a family. 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. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your 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. 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. You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). HSAs earn tax-free interest (does not affect your annual maximum contribution). Catch-up contribution discussed on page 83.	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.
Self Only enrollment	In addition to the pass through contribution, you may make an annual maximum contribution of $2,850.	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 $5,650.	You cannot contribute to the HRA.

Access funds	You can access your HSA by the following methods: • Debit card • Withdrawal form • Checks	For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through the HDHP. For expenses not covered by the HDHP, such as orthodontia, a reimbursement form will be sent to you upon your request.
Distributions/ withdrawals • **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA. See IRS Publication 502 for a list of eligible medical expenses.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds* below for information on when funds are available in the HRA. Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable
• **Non-medical**	If you are under age 65, 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. When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The 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.	The entire amount of your HRA will be available to you upon your enrollment in the HDHP.
Account owner	FEHB enrollee	HDHP
Portable	You can take this account with you when you change plans, separate or retire.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA.

	If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 80 for HSA eligibility.	If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
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 an HDHP during Open Season and your effective data 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.ustreas.gov/offices/public-affairs/hsa/

- **If you die**

  If you have not named beneficiary, and you are married, you 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 this 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 80, which details the differences between an 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 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*.

Benefit Description	You pay
Preventive care, adult	**High Option**
• Routine screenings, such as: • Blood tests • Urinalysis • Total Blood Cholesterol • Routine Prostate Specific Antigen (PSA) test — one annually for men age 50 and older • Colorectal Cancer Screening, including: • Fecal occult blood test yearly starting at age 50 • Sigmoidoscopy screening - every five years starting at age 50 • Colonoscopy screening - every 10 years starting at age 50 • Routine annual digital rectal exam (DRE) for men age 40 and older • 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	In Network: Nothing Out of network: 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.
• Well woman care - including, but not limited to: - Routine Pap test - Human papillomavirus testing for women age 30 and up once every three years - Annual counseling for sexually transmitted infections - Annual counseling and screening for human immune-deficiency virus - Contraceptive methods and counseling on an annual basis - Screening and counseling for interpersonal and domestic violence.	In Network: Nothing Out of network: 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.)	**High Option**
- 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.	In Network: Nothing Out of network: 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.
• Routine mammogram — covered for women age 35 and older, as follows: - From age 35 through 39, one during this five year period - From age 40 through 64, one every calendar year - At age 65 and older, one every two consecutive calendar years - Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC). 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/adultrec.htm	In Network: Nothing Out of network: Nothing 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.
• Routine physicals which include: - One exam every 24 months up to age 65 - One exam every 12 months age 65 and older • Routine exams limited to: - One routine eye exam every 12 months - One routine OB/GYN exam every 12 months including 1 Pap smear and related services - One routine hearing exam every 24 months	In Network: Nothing Out of network: 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
Not covered: *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*	*All charges*

Benefit Description	You pay
Preventive care, children	**High Option**
• Professional services, such as: • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Childhood immunizations recommended by the American Academy of Pediatrics • Examinations, such as: • Eye exam through age 17 to determine the need for vision correction • Hearing exams through age 17 to determine the need for hearing correction Note: A complete list of preventive care services recommended under the USPSTF is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	In Network: Nothing Out of network: 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.
Not covered: *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel* *Immunizations, boosters, and medications for travel.*	*All charges*
Dental Preventive Care	**High Option**
Preventive care limited to: • Prophylaxis (cleaning of teeth) – limited to 2 treatments per calendar year • Fluoride applications (limited to 1 treatment per calendar year and for children under age 16) • Sealants – (once every 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 set per calendar year) • Complete series x-rays (one complete series every 3 years) • Periapical x-rays • Routine oral evaluations (limited to 2 per calendar year)	All charges

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% (see page 85) and is not subject to the calendar year deductible
- The deductible is $1,400 per self-enrollment or $2,800 per family enrollment for in-network services and $3,000 per self-enrollment and $6,000 per 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 enrollment and $8,000 per family enrollment in any calendar year for in-network services and $6,000 for self enrollment and $12,000 for 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.
- 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	**High Option**
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-enrollment or $2,800 per family enrollment for in-network services and $3,000 per self-enrollment and $6,000 per family enrollment 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.	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. 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.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The deductible is $1,400 per self-enrollment or $2,800 per family enrollment for in-network services and $3,000 per self-enrollment and $6,000 per family enrollment for out-of-network care each calendar year. The 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, 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	**High Option**
Professional services of physicians • In physician's office • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion	In network PCP- No charge for office consultations Specialist - $35 copay for office consultation Professional Provider care in a facility – No charge Out of network *(See notation in the introduction to this section on how we process out-of-network claims)* $70 copay
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	In network PCP- No charge for office consultations Specialist - $35 copay for office consultation Professional Provider care in a facility – No charge Out of network *(See notation in the introduction to this section on how we process claims for out-of-network providers)* $70 copay

Benefit Description	You pay After the calendar year deductible
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • Delivery • Postnatal care Facility Services are listed in Section 5(c) and the copay would apply to delivery	In network – No charge. ***Note: The calendar year deductible only applies to professional charges related to delivery*** Out of network *(See the notation in the introduction to this section on how we process claims from non-participating providers)* $70 copay
Breastfeeding support, supplies and counseling for each birth Note: Benefit coverage for breastfeeding support, supplies and counseling for each birth begin immediately after delivery. 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.	In network – No charge, Deductible does not apply Out of network *(See the notation in the introduction to this section on how we process claims from out-of-network providers)* $70 copay
Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 19 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury • Doulas are not covered	

Benefit Description	You pay After the calendar year deductible
Family planning	**High Option**
Contraceptive counseling on an annual basis	In Network Nothing – Deductible does not apply Out of network *(See the notation in the introduction to this section on how we process claims from out-of-network providers)* $70 copay
A range of voluntary family planning services, limited to: • Voluntary sterilization for a woman (See Surgical procedures Section 5 (b) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit	In Network Nothing – Deductible does not apply Out of network (*See the notation in the introduction to this section on how we process claims from out-of-network providers*) $70 copay
Voluntary sterilization for a male	Deductible applies: In network: Professional copay of $35 Out of network (*See the notation in the introduction to this section on how we process claims from out-of-network providers*) $70 copay Note: Facility copays are in Section 5(c).
Not covered: *Reversal of voluntary surgical sterilization* *Genetic counseling*	*All charges*
Infertility services	**High Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Fertility drugs for covered procedures Note: We cover Injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	In network – $35 office copay Out of network (*See the notation in the introduction to this section on how we process claims from out-of-network providers*) $70 copay
Not covered:	*All charges*

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible
Infertility services (cont.)	**High Option**
Assisted reproductive technology (ART) procedures, such as: • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Drugs for non-covered procedures*	*All charges*
Allergy care	**High Option**
• Testing and treatment • Allergy injections Note: If there is a charge for the injection and not the office visit, the office copay will still apply.	In network – $35 office copay Out of network (*See the notation in the introduction to this section on how we process claims from out-of-network providers*) $70 copay
Allergy serum	No charge unless through the pharmacy program (Section 5 (g).
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 101. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* on page 19.	In network – $35 office copay Out of network *(See the notation in the introduction to this section on how we process claims from out-of-network providers)* $70 copay Note: Facility charges are discussed in Section 5(c)

Benefit Description	You pay After the calendar year deductible
Physical and occupational and speech therapies	**High Option**
Up to 60 visits (combined physical, occupational and/or speech therapy) per condition per benefit period for the services of the following qualified providers: • Physical therapists • Occupational therapists • Speech therapists Note: Coverage shall include Physical Therapy, Occupational Therapy and Speech Therapy for the treatment of individuals who have sustained an illness or injury that CareFirst BlueChoice determines to be subject to improvement Note: Occupational Therapy is limited to the use of purposeful activity or interventions designed to achieve functional outcomes that promote health, prevent injury or disability, and that develop, improve, sustain or restore the highest possible level of independence of an individual. Brochure language also states under member liability: • Other than any applicable inpatient or outpatient facility copay, member has no copay or coinsurance during an approved inpatient stay. **See Section 5 (c) for information on outpatient facility services.**	In network – $35 office copay Out of network *(See the notation in the introduction to this section on how we process claims from out-of-network providers)* $70 copay
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Maintenance therapy*	*All charges*
Cardiac Rehabilitation	**High Option**
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 90 sessions per condition per benefit period. • Cardiac rehabilitation benefits are provider to member who: - have been diagnosed with a significant cardiac disease, - suffered a myocardial infraction - undergone invasive cardiac treatment immediately preceding referral See section 5 (c) for outpatient facility services	In network – $35 office copay Out of network *(See the notation in the introduction to this section on how we process claims from out-of-network providers)* $70 copay
Note: Benefits are not provided for maintenance cardiac rehabilitation.	*All charges*

Benefit Description	You pay After the calendar year deductible
Pulmonary Rehabilitation	**High Option**
Pulmonary Rehabilitation • For those who have significant pulmonary disease or who have undergone certain surgical procedures of the lung. • Limited to one (1) pulmonary rehabilitation program per lifetime. • *Benefits are not provided for maintenance programs* See section 5 (c) for outpatient facility services.	In network – $35 office copay Out of network *(See the notation in the introduction to this section on how we process claims from out-of-network providers)* $70 copay
Habilitative therapy	**High Option**
• 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 co-payment, but are not counted toward any visit maximum for therapy services • See section 5 (c) for outpatient facility services	In network – $35 office copay Out of network *(See the notation in the introduction to this section on how we process claims from out-of-network providers)* $70 copay
Benefits are not covered for Habilitative Services delivered through early intervention or school services. Prior authorization is required.	*All charges*
Hearing services (testing, treatment, and supplies)	**High Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist • Note: For routine hearing screening performed during a child's preventive care visit, see Section 5 (a) *Preventive care, children.* • Member is responsible for getting approval for all out-of-network services.	In network – $35 per visit Out of network Out of network *(See notation in the introduction to this section for information on how we process claims from out-of-network providers)* $70 copay
• **External hearing aids** • **Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants** **Note:** • **Hearing aid providers may bill for balances for services beyond our allowed amount with prior notification** • **For more information on benefits, see Section 5 (a) *Orthopedic and prosthetic devices***	In network – $35 copay Out of network *(See notation in the introduction to this section for information on how we process claims from out-of-network providers)* $70 copay

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

Benefit Description	You pay After the calendar year deductible
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**
Not covered: *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
• 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	$10 at Davis providers for routine eye exams Medical Eye exams - $35 specialist copay Out of network *(See notation in the introduction to this section for information on how we process claims from out-of-network providers)* $70 copay
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	In network – $35 copay Out of network *(See notation in the introduction to this section for information on how we process claims from out-of-network providers)* $70 copay
Not covered: • *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* • *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)*	*All charges*
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes • Stump hose • 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.	In network – $35 copay Out of network *(See notation in the introduction to this section for information on how we process claims from out-of-network providers)* $70 copay

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible
Orthopedic and prosthetic devices (cont.)	**High Option**
• 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. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical and anesthesia services*. 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 services*. Note; Externally worn prosthetics and devices are treated as Durable medical Equipment (DME). See page 96.	In network – $35 copay Out of network *(See notation in the introduction to this section for information on how we process claims from out-of-network providers)* $70 copay
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors • Insulin pumps • **Canes** • **Diabetic shoes** • **Commodes** • **Suction machines**	In network – $35 copay Out of network *(See notation in the introduction to this section for information on how we process claims from out-of-network providers)* $70 copay

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible
Durable medical equipment (DME) (cont.)	**High Option**
• **Medical supplies (i.e. ostomy and catheter supplies, dialysis supplies, medical foods for inherited metabolic diseases and inborn deficiencies of amino acid metabolism)** • **Externally worn non-surgical durable devices which replace a body part or assist a patient in performing a bodily function (unless otherwise described in the "orthopedic and prosthetic devices" section above)** • **Externally worn braces which improve the function of a limb** • **Medically Necessary molded foot orthotics** • **Medically Necessary fitted compression stockings** Note: 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.	In network – $35 copay Out of network *(See notation in the introduction to this section for information on how we process claims from out-of-network providers)* $70 copay
Home health services	**High Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	In network – $35 copay Out of network *(See notation in the introduction to this section for information on how we process claims from out-of-network providers)* $70 copay
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Private duty nursing*	*All charges*
Chiropractic	**High Option**
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. *Benefits are limited to those who are age 13 or older.*	In network – $35 copay Out of network *(See notation in the introduction to this section for information on how we process claims from out-of-network providers)* $70 copay
Not covered: Services other than for musculosketal conditions of the spine.	*All charges*

Benefit Description	You pay After the calendar year deductible
Alternative treatments	**High Option**
Acupuncture for: • anesthesia, • pain relief	In network – $35 copay Out of network *(See notation in the introduction to this section for information on how we process claims from out-of-network providers)* $70 copay
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Acupuncture except as listed above*	*All charges*
Educational classes and programs	**High Option**
Coverage is provided for: • 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.	In Network Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence. Out of network *(See notation in the introduction to this section for information on how we process claims from out-of-network providers)* $70 copay
• Diabetes self-management • Childhood obesity education	In Network Nothing Out of network *(See notation in the introduction to this section for information on how we process claims from out-of-network providers)* $70 copay

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 deductible is $1,400 per self-enrollment or $2,800 per family enrollment for in-network services and $3,000 per self-enrollment and $6,000 per family enrollment for out-of-network care each calendar year. The 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.
- 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.).
- **Surgical procedures may involve the services of a co-surgeon, surgical assistant or assistant-at surgery 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	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery)* • Surgical treatment of morbid obesity (bariatric surgery) • Insertion of internal prosthetic devices . See 5(a) *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns	In network: No copay for primary care provider $35 copay for specialist office visit No copay for professional copay during a covered inpatient stay. Out of network *(See notation in the introduction to this section on how we process claims from out-of-network providers)* $70 copay

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible
Surgical procedures (cont.)	**High Option**
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.	In network: No copay for primary care provider $35 copay for specialist office visit No copay for professional copay during a covered inpatient stay. Out of network *(See notation in the introduction to this section on how we process claims from out-of-network providers)* $70 copay
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedemas - breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	In network: No copay for primary care provider $35 copay for specialist office visit No copay for professional copay during a covered inpatient stay. Out of network (See notation in the introduction to this section on how we process claims from out-of-network providers) $70 copay
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All charges*

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible
Reconstructive surgery (cont.)	**High Option**
• *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	In network: No copay for primary care provider $35 copay for specialist office visit No copay for professional copay during a covered inpatient stay. Out of network *(See notation in the introduction to this section on how we process claims from out-of-network providers)* $70 copay
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	**High Option**
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - 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 • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for	In network: No copay for primary care provider $35 copay for specialist office visit No copay for professional copay during a covered inpatient stay. Out of network (See notation in the introduction to this section on how we process claims from out-of-network providers) $70 copay

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible
Organ/tissue transplants (cont.)	**High Option**
- AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	In network: No copay for primary care provider $35 copay for specialist office visit No copay for professional copay during a covered inpatient stay. Out of network (See notation in the introduction to this section on how we process claims from out-of-network providers) $70 copay
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. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (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) - Mucolipidosis (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)	In network: No copay for primary care provider $35 copay for specialist office visit No copay for professional copay during a covered inpatient stay. Out of network (*See notation in the introduction to this section on how we process claims from out-of-network providers)* $70 copay

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible
Organ/tissue transplants (cont.)	**High Option**
- Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	In network: No copay for primary care provider $35 copay for specialist office visit No copay for professional copay during a covered inpatient stay. Out of network (*See notation in the introduction to this section on how we process claims from out-of-network providers)* $70 copay
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. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy	In network: No copay for primary care provider $35 copay for specialist office visit No copay for professional copay during a covered inpatient stay. Out of network (*See notation in the introduction to this section on how we process claims from out-of-network providers)* $70 copay

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible
Organ/tissue transplants (cont.)	**High Option**
- 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 - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Neuroblastoma	In network: No copay for primary care provider $35 copay for specialist office visit No copay for professional copay during a covered inpatient stay. Out of network (*See notation in the introduction to this section on how we process claims from out-of-network providers)* $70 copay
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. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - 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:	In network: No copay for primary care provider $35 copay for specialist office visit No copay for professional copay during a covered inpatient stay. Out of network (*See notation in the introduction to this section on how we process claims from out-of-network providers)* $70 copay

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible
Organ/tissue transplants (cont.)	**High Option**
- 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 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 - 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	In network: No copay for primary care provider $35 copay for specialist office visit No copay for professional copay during a covered inpatient stay. Out of network (*See notation in the introduction to this section on how we process claims from out-of-network providers)* $70 copay
• National Transplant Program (NTP)	In network:

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible
Organ/tissue transplants (cont.)	**High Option**
	No copay for primary care provider $35 copay for specialist office visit No copay for professional copay during a covered inpatient stay. Out of network (*See notation in the introduction to this section on how we process claims from out-of-network providers)* $70 copay
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.	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**High Option**
Professional services provided in – Hospital (inpatient)	In network: No copay for primary care provider $35 copay for specialist office visit No copay for professional copay during a covered inpatient stay. Out of network (*See notation in the introduction to this section on how we process claims from out-of-network providers)* $70 copay
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	In network: No copay for primary care provider $35 copay for specialist office visit, $35 copay for services rendered in the outpatient facility by professional providers other than those billing on the hospital bill, except those related directly to laboratory, x-ray or machine tests. No copay for professional services related to a covered inpatient facility admission. Out of network (*See notation in the introduction to this section on how we process claims from out-of-network providers)* $70 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.
- The deductible is $1,400 per self-enrollment or $2,800 per family enrollment for in-network services and $3,000 per self-enrollment and $6,000 per family enrollment for out-of-network care each calendar year. The 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).

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	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	In Network: • Calendar year deductible applies • $300 per admission copay Out of network: • Calendar year deductible applies • $500 per admission applies Non-participating facilities may bill the member for any amount in excess of our allowed benefit.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items	Nothing

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible
Inpatient hospital (cont.)	**High Option**
• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service 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.	In Network: • Calendar year deductible applies • $100 copay at an ambulatory surgical center • $300 copay in the outpatient department of a hospital for surgical procedures • $100 for other hospital outpatient admissions Out of network: • Calendar year deductible applies • $500 copay at an ambulatory surgical center • $500 copay in the outpatient department of a hospital Non-participating facilities may bill the member for any amount in excess of our allowed benefit.
Not covered: Blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Extended care benefit:	In Network: • Deductible applies • $35 copay Out of network • Deductible applies • $70 copay Non-participating facilities may bill the member for any amount in excess of our allowed benefit.
Skilled nursing facility (SNF):	In Network: • Deductible applies

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description	You pay After the calendar year deductible
Extended care benefits/Skilled nursing care facility benefits (cont.)	**High Option**
	• $35 copay Out of network • Deductible applies • $70 copay Non-participating facilities may bill the member for any amount in excess of our allowed benefit.
Not covered: Custodial care	*All charges*
Hospice care	**High Option**
Hospice services must be pre-approved	*In Network:* • *Deductible applies* • *$35 copay* *Out of network* • *Deductible applies* • *$70 copay* *Non-participating facilities may bill the member for any amount in excess of our allowed benefit.*
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	**High Option**
Local professional ambulance service when medically appropriate	In Network • Calendar year deductible applies • $50 per trip Out of network • Calendar year deductible applies • $50 per trip Non-participating facilities may bill the member for any 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 deductible is $1,400 per self-enrollment or $2,800 per family enrollment for in-network services and $3,000 per self-enrollment and $6,000 per family enrollment for out-of-network care each calendar year. The 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 and 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.

What is a medical emergency?

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

What to do in case of emergency:

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

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

Urgent Care

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

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

Emergencies inside our service area:

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

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

Emergencies outside our service area:

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

Benefit Description	You pay After the calendar year deductible
Emergency within our service area - Accident or Medical Emergency care	**High Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services *Note: We waive the ER copay if you are admitted to the hospital.* *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.*	In network and out of network • Emergency Room - $200 copay • Urgent care center - $50 copay • Primary care office – no copay • Specialist office - $35 copay
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area - Accident or Medical Emergency care	**High Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	In network and out of network • Emergency Room - $200 copay • Urgent care center - $50 copay • Primary care office – no copay • Specialist office - $35 copay Non-participating provider may charge you for the amount in excess of our allowed benefit
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*

Benefit Description	You pay After the calendar year deductible
Ambulance	**High Option**
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	In network and out of network • $50 copay • Non-participating provider may charge you for the amount in excess of our allowed benefit.
Not covered: Air Ambulance unless medically necessary and no other transport is reasonably available.	*All charges*

Section 5(e). Mental health and substance abuse 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-enrollment or $2,800 per family enrollment for in-network services and $3,000 per self-enrollment and $6,000 per family enrollment for out-of-network care each calendar year. The 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. 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.

Benefit Description	You pay After the calendar year deductible
Professional services	**High Option**
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • 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) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling	In Network: • No charge Out of network *(See notation in the introduction of this section regarding claims from out-of-network providers)* • $70 copay

Professional services - continued on next page

Benefit Description	You pay After the calendar year deductible
Professional services (cont.)	**High Option**
• Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	In Network: • No charge Out of network *(See notation in the introduction of this section regarding claims from out-of-network providers)* • $70 copay
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	In Network: • No charge Out of network *(See notation in the introduction of this section regarding claims from out-of-network providers)* • $70 copay
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	In Network: • $300 per admission Out of network *(See notation in the introduction of this section regarding claims from out-of-network providers)* • $500 per admission
Outpatient hospital or other covered facility	**High Option**
• 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	In Network: • No charge Out of network In Network: • No charge Out of network *(See notation in the introduction of this section regarding claims from out-of-network providers)* • $70 copay
Not Covered Services	**High Option**
Services that are not part of a preauthorized approved treatment plan.	All charges

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.
- 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 deductible is $1,400 per self-enrollment or $2,800 per family enrollment for in-network services and $3,000 per self-enrollment and $6,000 per family enrollment for out-of-network care each calendar year. The 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 for eligible medical expenses or copayments for eligible 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.

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 **(800) 241-3371**to get more information on the mail order service.
- **We use a formulary**. A formulary is a preferred list of drugs that we selected to meet patient needs at a lower cost. The formulary includes both generic and brand name drugs. You will be responsible for higher charges if your doctor prescribes a drug not on our formulary list. However, non-formulary drugs will be covered when prescribed by a Plan doctor.
- **We have an open formulary**. If your provider believes a name brand product is necessary or there is no generic available, a name brand drug from a formulary list may be prescribed. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 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 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.
- **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
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • Speciality drugs require pre-authorization and the use of preferred pharmacies • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction • Vitamin D is covered for adults 65 and older • Weight loss drugs - The disposal of these drugs will be subject to utilization management protocols, including prior approval, duration of therapy limits, and medical necessity review	Up to 34-day supply • Tier 1 -$0 per unit or refill for generic prescriptions • Tier 2 - $30 per unit or refill for brand name prescriptions on our preferred drug list • Tier 3 - $60 per unit or refill for brand name prescriptions not on our preferred drug list • Tier 4 - $150 per unit or refill for Specialty Drugs Maintenance Drugs: 35-day through 90-day supply: • Tier 1 - $0 for generic prescriptions • Tier 2 - $60 per unit or refill for brand name prescriptions on our preferred drug list • Tier 3 - $120 for brand name prescriptions not on our preferred drug list • Tier 4 - $300 for Specialty Drugs Notes: • The deductible is waived for preferred generic drugs to treat asthma, blood pressure, cholesterol, depression and diabetes. • If there is a generic equivalent to a brand named drug, and the prescriber has not indicated "dispense as written', you will have to pay the difference between the brand named drug and the generic drug as well as the appropriate copay. • If there is no generic equivalent available, you will still pay the name brand copay only • Specialty Drugs are typically high in cost and have one or more of the following characteristics: - 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 - Secialized 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
• Women's contraceptive drugs and devices • Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (98). The following prescription drugs are covered in full:	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible
Covered medications and supplies (cont.)	**High Option**
- Folic acid supplements containing 0.4 to 0.8 milligrams of folic acid for women planning to become, or capable of becoming pregnant, are covered in full. - Fluoride will be paid for children older than 6 months of age whose primary water source is deficient in fluoride. - Iron supplements for asymptomatic children aged 6 to 12 months who are at increased risk of iron deficiency anemia - Chemotherapy medications received through a pharmacy - Preventive Breast Cancer drugs for women who are at an increased risk for breast cancer, and at a low risk for adverse medication effects Please refer to our website *carefirst.com/fedhmo* for any updates to this list and for additional information on how these items are covered.	Nothing
Not covered: *Drugs and supplies for cosmetic purposes* *Drugs to enhance athletic performance* *Fertility drugs not related to a covered assisted reproduction method.* *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* *Vitamins, nutrients and food supplements even if a physician prescribes or administers them, except as listed above.* *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.*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your 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 deductible is $1,400 per self-enrollment or $2,800 per family enrollment for in-network services and $3,000 per self-enrollment and $6,000 per family enrollment for out-of-network care each calendar year. The 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 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.
- 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	**High 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.	In Network: • $35 visit copay Out of network • $70 visit 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.
Dental benefits	**High Option**
We have no other benefits	*All charges*

Section 5 (h). Special Features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all 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	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.
Services for deaf and hearing impaired	Our TTY number for Customer Service is (202) 479-3546
Care Team Program	We provide programs for members diagnosed with coronary artery disease, congestive heart failure, diabetes, cancer, asthma and other chronic conditions. These programs are designed to help you better understand and manage your condition. Our Care Team Program benefits may include: • Educational materials, such as self-monitoring charts, resource listings, self-care tips, and a quarterly newsletter • A health assessment and nurse consultation • Access to a 24-hour Nurse Advisor help line Please call us at (800) 783-4582 for more information about our Care Team Program
Guest membership	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.

Healthy Reward	Under HealthyBlue Advantage you can earn a Healthy Reward of $250 per individual contract or up to $500 on a family contract. In place of deductible credits, members will now receive a debit card to help pay for qualified medical expenses. To earn the Healthy Reward you must complete the following steps: • Choose a PCP who participates in our PCMH Program • Complete the online Health Assessment (Adults 18+ only) • Follow the steps to complete the electronic signature on the Consent Authorization form included with the Health Assessment (Adults 18+ only) • Work with your PCMH PCP to complete the Health and Wellness Evaluation Form • Return the Health and Wellness Evaluation Form to CareFirst • Complete all steps within 180 days of your effective date Under the HDHP Option: Healthy Rewards are accumulated at the rate of $250 per adult member and $25 per minor dependent aged 2 to 17 - up to a family maximum of $500. In addition, adult members can earn $100 and minor dependents ages 2 to 17 can earn $25 for meeting Biometric results-based goals- up to a total family maximum of $250. The Health and Wellness Evaluation Form can be returned to us in any of the following ways: • Upload the information in the My Account section of CareFirst. com/fedhmo on the Manage My Health tab. • Scan as a JPG, PDF or TIFF form and upload through the Manage My Health tab. • Fax to (800) 354-8205 • Mail to: Mail Administrator P.O. Box 14116 Lexington, KY 40512-4116

Section 5(i). Health education resources and account management tools

Special features	Description
Health education resources www.carefirst.com/fedhmo Visit our expanded web option	My Account at www.carefirst.com/fedhmo This tool gives members access to their claims and benefit eligibility information when they log in to the secure, password- protected site. Each covered member over the age of 14 may create his or her own user ID and password. After creating a password, members can: • View who is covered under their contract • Current and historical claims status • Order a new ID card Additional features include: • Drug pricing tool • Hospital comparison tool • Treatment cost estimator • Provider Directory with special information • Health Risk Assessment • My CareFirst This is our member health and wellness section. Here you can find: • Health Library of Medical Conditions • Health Lifestyle Section-Nutrition, Fitness, etc. • Personal Health page, with tracking tools and assistance setting health and wellness goals. The healthy lifestyle-coaching program fills a void between healthy employees and those who suffer from chronic diseases. Employees who are at high risk for future disease as identified by MyHealthProfile are invited to participate in healthy lifestyle coaching sessions. • These are scheduled phone conversations where employees develop a relationship with a clinician (health coach) trained in Motivational Interviewing and in Behavior Change Theory. The health coach identifies a number of factors including the employee's existing barriers to change and their readiness to change. The health coach then helps the employee set achievable short-term and long-term goals so they can make a permanent change in health behavior
Account management tools	For each HSA and HRA account holder, we maintain a complete claims payment history online through **www.carefirst.com/fedhmo** Your balance will also be shown on your explanation of benefits (EOB) form. You will receive an EOB after every claim. If you have an **HSA**: • 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: - 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 • You may also access your account on-line at www.carefirst.com/fedhmo If you have an **HRA**: • Your balance will also be shown on your EOB form. • Your HRA balance will be available online through **www.carefirst.com/fedhmo**
Consumer choice information	As a member of this 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 Pricing information for medical care is available at www.carefirst.com/fedhmo. Pricing information for prescription drugs is available at www.carefirst.com/fedhmo. Link to online pharmacy through www.carefirst.com/fedhmo. Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.carefirst.com/fedhmo.
Care support	Patient safety information is available online at www.carefirst.com/fedhmoCase Managers

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** ***When you need prior approval for certain services.***

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan
- Services, drugs, or supplies not medically necessary
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies related to sex transformations.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Applied Behavior Analysis (ABA)
- 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, except that medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to plan limits
- Charges which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 130), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under the Medicare limiting charge, (see page 130), 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 at our website at www.carefirst.com/fedhmo.

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

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

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

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

In addition:

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

Deadline for filling your claim

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

Post service claims procedure

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

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

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

Records

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

Overseas claims

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

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

When we need more information

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

Authorized Representative

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

Notice Requirement

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.

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.

Section 8. The disputed claims process

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

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. 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 whether such 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 decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of the individual.

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

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

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

You may not 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 call OPM's Health Insurance Group 2 at (202) 606-3818 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 the NAIC website at www.NAIC.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 FEHBP coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

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

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

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Note: CareFirst uses vendors for this purpose. For 2015 they are The Rawlings Company (Kentucky) and Seidel Subrogation Associates. All information collected will be kept confidential, as this is a necessary industry standard. If these vendors change at any time during the 2015 calendar year, any updates will be reflected on our website.

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, 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. (See pages 49 and 101). We encourage you to contact the plan to discuss specific services if you if you participate in a clinical trial.
- Research costs-costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials.
- This plan does not cover these costs.

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 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) for more information.

- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. 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 1-800-772-1213 (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

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

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

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

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

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

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

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

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

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

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

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 copays and deductibles pertaining to medical services and supplies provided by physicians and other Healthcare professionals.

You can find more information about how one plan coordinates benefits with Medicare in CareFirst BlueChoice at www.carefirst.com/hmo/hmo

- **Tell us about your Medicare coverage**

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

- **Medicare Advantage (Part C)**

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

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

This Plan and our Medicare Advantage plan:

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.

When you have the original Medicare Plan (Part A, Part B, or both)

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays.

Note: We pay our regular benefits for emergency services to a facility provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the MRA statement is submitted to determine our payment for covered services provided to you if Medicare is primary, when Medicare does not pay the VA facility.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

- If your physician accepts Medicare assignment, then you pay nothing for covered charges (see note below for Basic Option).
- If your physician does not accept Medicare assignment, then you pay the difference between the "limiting charge" or the physician's charge (whichever is less) and our payment combined with Medicare's payment (see note below for Basic Option).

Note: Under Basic Option, you must see Preferred providers in order to receive benefits. See page 21 for the exceptions to this requirement.

It is important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the "limiting charge." The Medicare Summary Notice (MSN) form that you receive from Medicare will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

If you are Medicare-eligible and elect to take Medicare Part A, and also enroll in Medicare Part B, you will not be subject to any in-network medical copays and deductibles under your CareFirst BlueChoice plan option. This will apply to all Medicare eligible members on your policy who elect Medicare Part A and Medicare Part B.

- For example, the policy may include a spouse or a disabled dependent. If you a family policy, the discount will not apply to any other non-Medicare eligible members on your policy.
- In the instance where you, the subscriber, elect Medicare Part A and B, the non-Medicare eligible dependent would still be subject to all copays and the individual deductible on your policy.
- In the instance of multiple non-Medicare eligible dependents on your policy the customary copay and family deductible would still apply. Each dependent's deductible cost share accumulates toward meeting the family deductible.

Section 10. Definitions of terms we use in this brochure

Allowed benefit

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

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

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

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

Note that, under the Hearing aid benefit, the provider may have the member sign a document requiring them to pay an amount which exceeds our allowed benefit for certain services. See pages 39 and 94.

Calendar year

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

Care Plan

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

Clinical Trials Cost Categories

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.

- 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

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 23.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 23.

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 23.

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

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

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

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

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

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's illness, injury or disease;
3. not primarily for the convenience of a patient or health care provider; 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.

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

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

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

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

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

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

Us/We

Us and We refer to CareFirst BlueChoice, Inc.

You

You refers to the enrollee and each covered family member.

Urgent care claims

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

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

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

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

Section 11. 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 three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program,** also known as **FSAFEDS** lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. 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.

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 spending account (LEX HCFSA) is $2,500 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).

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.

- **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.
- 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.

"FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan."

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 Monday through Friday, 9 a.m. until 9 p.m. Eastern Time. TTY: (800) 952-0450.

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-condition limitations for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retires, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

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

- Class A (Basic) service, which include oral examinations, prophylaxis, diagnostic evaluations, sealants, and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges, and prosthodontics services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia. 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 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. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more Information, call (800) LTC-FEDS (800) 582-3337), TTY: (800)-843-3557 or visit www.ltcfeds.com.

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Summary of Benefits -High Open Access for 2015

Do not rely on this chart alone.

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

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

High Open Access Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	In network: No copay for preventive care; $25 Primary Care Physician and $35 Specialist Out of network: You pay all charges	28
Services provided by a hospital:		
• **Inpatient**	In network: $200 per admission copay Out of network: You pay all charges	57
• **Outpatient**	In network: $50 copay for medical $50 for Ambulatory Surgical Center for surgical services $100 for Hospital outpatient care associated with surgical services Out of network: You pay all charges	58
Emergency benefits:		
• **In-area**	$100 per emergency room visit	62
• **Out-of-area**	$100 per emergency room visit	62
Mental health and substance abuse treatment:	Regular cost-sharing	64
Prescription drugs:	*If a drug is available in generic, and your doctor specifies that you are not to take the generic, you pay only the copay. If your doctor does not specify, and you get the brand name drug, you will pay the cost difference between the brand and the generic as well as the copay.*	67
• Retail	For up to a 34-day supply: • 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 - $150 for specialty drugs	67

	For 35-day through 90-day supply, two copays apply for all tiers.	
• Mail order	**Maintenance drugs: for up to a 34-day supply:** • 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 - $150 for specialty drugs For 35-day through 90-day supply, two copays apply for all tiers.	68
Dental care:	No benefit except for services related to an accidental injury	71
Vision care:	In network: Davis network providers: $10 per visit copay for routine eye exams All other providers: You pay all charges	40
Special features: 24 hr. nurse line; Care team program; Guest membership program	No additional cost	72
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $1,900/Self Only or $5,500 Family enrollment per year Some costs do not count toward this protection	24

Summary of Benefits -Standard HealthyBlue for 2015

Do not rely on this chart alone.

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

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

•HealthyBlue has a calendar year in-network deductible of $500 per Self-Only contract and $1,000 per Self and Family contract, and an out-of-network deductible of $1,000 for Self-Only contract and $2,000 for Self and Family coverage. The in-network deductible is included in the out-of-network total.

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

Standard HealthyBlue	You pay	Page
Medical services provided by a physician		
Diagnostic and treatment services provided in the office	In Network: No deductible or copay for primary care provider and $35 for a specialist Out of Network: After calendar year deductible, $70 copay	28
Services provided in a hospital:		
• **Inpatient**	In Network: After calendar year deductible, $200 per admission copay Out of Network: After calendar year deductible, $500 per admission copay	57
• **Outpatient**	In Network: After deductible: • $35 copay for medical care • Ambulatory Surgical Center copay is $35 for surgical care • Outpatient Hospital copay is $100 for surgical care Out of Network: After calendar year deductible: • $70 copay for medical care • Ambulatory Surgical Center copay is $70 for surgical care • Outpatient Hospital copay is $140 for surgical care	58
Emergency Benefits:		
• **In-area**	$100 per emergency room visit	62
• **Out-of-area**	$100 per emergency room visit	62
Mental health and substance abuse treatment:	Regular cost sharing	64

Standard HealthyBlue	You pay	Page
Prescription drugs:	*If a drug is available in generic, and the brand name drug is dispensed, you are responsible for the difference between price of the brand and the generic in addition to the appropriate copay.*	67
• Retail	**For up to a 34-day supply:** • **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 - $150 for specialty drugs** **For 35-day through 90-day supply, two copays apply for all tiers.**	67
• Mail order	Maintenance Drugs: for up to a 34-day supply: • 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 - $150 for specialty drugs For 35-day through 90-day supply, two copays apply for all tiers.	67
Dental care:	No benefit except for services related to an accidental injury	71
Vision care:	Davis network providers: $10 per visit copay for routine eye exams.	40
Special features: 24-hour nurse line; Care team program; Guest membership. Care plans, Healthy Reward.	No additional cost	72
Protection against catastrophic costs (out-of-pocket maximum)	In network: Nothing after $1,900 Self only or $5,500 family per year based on contract, not members Out-of-network: After $3,600 Self only or $7,200 family per year based on contract, the member is liable for charges in excess of our allowed benefit. Some costs do not count toward this protection	24

Summary of Benefits -HealthyBlue Advantage HDHP for 2015

Do not rely on this chart alone.

All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside. If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

In 2015 for each month you are eligible for the Health Savings Account (HSA [Plan] will deposit $37.50 per month for Self-Only enrollment or $75 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 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 $37.50 per month for Self-Only enrollment and $75 for 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-enrollment or $2,800 per family enrollment for in-network services and $3,000 per self-enrollment and $6,000 per family enrollment for out-of-network care each calendar year. The 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 $250 per Self-Only enrollment and up to $500 per Self and Family enrollment. See page 119 for a description of how this credit works.

HealthyBlue Advantage HDHP	You pay	Page
Medical services provider by a physician		
Diagnostic and treatment services provided in the office	In network: Preventive Care and Women's Health: No copay for primary care provider and $35 for a specialist All other office care: After deductible, No copay for primary care provider and $35 for a specialist Out-of-network: After deductible, $70 copay	89
Services provided in a hospital:		
• **Inpatient**	In network: After deductible, $300 per admission Out of network: After deductible, $500 per admission	107
• **Outpatient**	In Network: • Medical care: After deductible, $35 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. Out-of-network:	108

	• Medical care: After deductible, $70 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.	
Emergency Benefits:		
• **In area**	After the deductible: • $50 copay for Urgent care center • $50 ambulance services • $200 for Emergency Room services	62
• **Out-of-area**	After the deductible: • $50 copay for Urgent care center • $50 ambulance services • $200 for Emergency Room services	111
Mental health and substance abuse treatment:	Regular cost sharing	113
Prescription drugs:	*If a drug is available in generic, and your doctor specifies that you are not to take the generic, you pay only the copay. If your doctor does not specify, and you get the brand name drug, you will pay the cost difference between the brand and the generic as well as the copay.*	115
• Retail	No Deductible for selected generic drugs for the treatment of asthma, blood pressure, cholesterol, depression and diabetes After deductible: • 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 - Specialty Drugs- $150 copay for up to 34-day-supply; $300 copay for 35-day to 90-day supply	115
• Mail order	Benefit is designed for maintenance drugs only. No Deductible for selected generic drugs for the treatment of asthma, blood pressure, cholesterol, depression and diabetes After deductible: • Tier 1 - Generic drugs - $0 copay	115

	• 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 - Specialty Drugs - $150 copay for up to 34-day-supply; $300 copay for 35-day to 90-day supply	
Dental care:	No benefit except for services related to an accidental injury	118
Vision	In Network: $10 for routine eye exams Out-of-Network: You pay all charges Discount program is available for lenses, frames and contacts	95
Special features: 24 nurse line; Care team program; Guest membership; Care plans; Healthy Reward	No additional costs	119
Protection against catastrophic costs (out-of-pocket maximum):	In-network: Nothing after $,4000 under a Self-Only enrollment and $8,000 on a Self and Family enrollment per year. Out-of-network: After $6,000 on a Self-Only enrollment and $12,000 on a Self and Family enrollment. The member remains liable for charges in excess of our allowed benefit. Some costs do not count toward this protection.	24

2015 Rate Information

For 2015 health premium information, please see:
http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.