

# BlueChoice • Opt-Out *Plus* Open Access

## Summary of Benefits

Services	In-Network You Pay	Out-of-Network You Pay
<b>ANNUAL DEDUCTIBLE (BENEFIT PERIOD)<sup>1,2</sup></b>		
Individual	None	500
Individual & Child(ren) <sup>3</sup>	None	1,000
Individual & Adult	None	1,000
Family	None	1,000
<b>ANNUAL OUT-OF-POCKET LIMIT (BENEFIT PERIOD)<sup>4,5</sup></b>		
Individual	\$1,300	2,500
Individual & Child(ren) <sup>3</sup>	\$2,600	5,000
Individual & Adult	\$2,600	5,000
Family	\$2,600	5,000
<b>LIFETIME MAXIMUM BENEFIT</b>	None	None
<b>PREVENTIVE SERVICES</b>		
Well-Child Care		
0-24 months	No charge*	20% of Allowed Benefit
24 months-13 years (immunization visit)	No charge*	20% of Allowed Benefit
24 months-13 years (non-immunization visit)	No charge*	20% of Allowed Benefit
14-17 years	No charge*	20% of Allowed Benefit
Adult Physical Examination	No charge*	Not covered
Routine GYN Visits	No charge*	Deductible, then 20% of Allowed Benefit
Mammograms	No charge*	Deductible, then 20% of Allowed Benefit
Cancer Screening <sup>6</sup>		
Pap Test and Prostate	No charge*	Pap Test and Prostate: 20% of Allowed Benefit
Colorectal	No charge*	Colorectal: Deductible, then 20% of Allowed Benefit
<b>OFFICE VISITS, LABS AND TESTING</b>		
Office Visits for Illness	\$10 PCP/\$20 Specialist per visit	Deductible, then 20% of Allowed Benefit
Diagnostic Services <sup>6</sup>	\$10 PCP/\$20 Specialist per visit	Deductible, then 20% of Allowed Benefit
X-ray and Lab Tests	No charge*	Deductible, then 20% of Allowed Benefit
Allergy Testing <sup>6</sup>	\$10 PCP/\$20 Specialist per visit	Deductible, then 20% of Allowed Benefit
Allergy Shots <sup>6</sup>	\$10 PCP/\$20 Specialist per visit	Deductible, then 20% of Allowed Benefit
Outpatient Physical, Speech and Occupational Therapy	\$20 per visit (limited to 30 visits/condition/benefit period)	Deductible, then 20% of Allowed Benefit
Outpatient Spinal Manipulation	\$20 per visit (limited to 20 visits/benefit period)	Deductible, then 20% of Allowed Benefit
<b>EMERGENCY CARE AND URGENT CARE</b>		
Physician's Office	\$10 PCP/\$20 Specialist per visit	Deductible, then 20% of Allowed Benefit
Urgent Care Center	\$20 per visit	Paid as in-network
Hospital Emergency Room	\$50 per visit (waived if admitted)	Paid as in-network
Ambulance (if medically necessary)	No charge*	Deductible, then 20% of Allowed Benefit
<b>HOSPITALIZATION</b>		
Inpatient Facility Services	No charge*	Deductible, then 20% of Allowed Benefit
Outpatient Facility Services	No charge*	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	No charge*	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	\$10 PCP/\$20 Specialist per visit	Deductible, then 20% of Allowed Benefit

Services	In-Network You Pay	Out-of-Network You Pay
<b>HOSPITAL ALTERNATIVES</b>		
Home Health Care	No charge*	Deductible, then 20% of Allowed Benefit
Hospice	No charge*	Deductible, then 20% of Allowed Benefit
Skilled Nursing Facility	No charge*	Deductible, then 20% of Allowed Benefit
<b>MATERNITY</b>		
Prenatal and Postnatal Office Visits	\$10 PCP/\$20 Specialist per visit (up to 10 times the copay per pregnancy)	Deductible, then 20% of Allowed Benefit
Delivery and Facility Services	No charge*	Deductible, then 20% of Allowed Benefit
Nursery Care of Newborn	No charge*	Deductible, then 20% of Allowed Benefit
Initial Office Consultation(s) for Infertility Services/Procedures	\$20 Specialist per visit	Deductible, then 20% of Allowed Benefit
Artificial Insemination <sup>7</sup>	\$20 per visit	Not covered
In Vitro Fertilization Procedures <sup>7</sup>	Not covered	Not covered
<b>MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)</b>		
Inpatient Facility Services	No charge* (limited to 30 days/benefit period)	Deductible, then 20% of Allowed Benefit (limited to: 25 days per benefit period up to age 19; 20 days per benefit period ages 19 and older)
Inpatient Physician Services	No charge* (limited to 1 visit per day during a covered admission)	Deductible, then 20% of Allowed Benefit (limited to 1 visit/day during a covered admission)
Outpatient Services (MH and SA)	\$10 per visit (limited to 20 visits/benefit period)	Visits 1-5: Deductible, then 20% of Allowed Benefit Visits 6-20: Deductible, then 50% of Allowed Benefit (limited to 20 visits/benefit period)
Partial Hospitalization	No charge* (every two days counts as one day toward inpatient limit)	Deductible, then 20% of Allowed Benefit (limited to 15 days/benefit period)
Medication Management Visit	\$10 PCP/\$20 Specialist per visit	Deductible, then 20% of Allowed Benefit
<b>MISCELLANEOUS</b>		
Durable Medical Equipment	25% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Acupuncture	Not covered (except when approved or authorized by CareFirst when used for anesthesia)	Not covered (except when approved or authorized by CareFirst when used for anesthesia)
Transplants	Covered as stated in the Evidence of Coverage	Covered as stated in the Evidence of Coverage
Hearing Aids	Not covered	Not covered
<b>VISION</b>		
Routine Exam (limited to 1 visit/benefit period)	\$10 per visit	Not covered
Eyeglasses and Contact Lenses	Discounts from participating vision centers	Not covered

\* No copayments or coinsurance.

<sup>1</sup> If you have Individual and Adult or Individual and Child(ren) coverage, each Member must satisfy his/her own deductible by meeting the individual deductible. If you have family coverage, all Members' individual deductibles will be combined to meet the family deductible; however, no individual Member may contribute more than the individual deductible amount.

<sup>2</sup> Copayment or portion of deductible may be required at the point of sale while in the deductible period. Member will never be required to pay more than CareFirst's Allowed Benefit for service rendered.

<sup>3</sup> Please refer to your Evidence of Coverage to determine your coverage level.

<sup>4</sup> If you have Individual and Adult or Individual and Child(ren) coverage, each Member must satisfy his/her own out-of-pocket maximum by meeting the individual out-of-pocket maximum. If you have family coverage, all Members' individual out-of-pocket maximums will be combined to meet the family out-of-pocket maximum; however, no individual Member may contribute more than the individual out-of-pocket amount.

<sup>5</sup> The actual out-of-pocket limit may vary based on the types of coverage selected by your employer.

<sup>6</sup> If office copayment has been paid, additional copayment not required for this service.

<sup>7</sup> Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility.

However, assisted reproduction (AI & IVF) services performed as treatment options for infertility are only available under the terms of the members contract. Preauthorization required.

Note: Upon enrollment in BlueChoice Opt-Out Plus Open Access, you must select a Primary Care Physician (PCP). To select a PCP, go to [www.carefirst.com](http://www.carefirst.com) for the most current listing of PCPs from our online provider directory. You may also call the Member Services toll free phone number on the front of your CareFirst BlueChoice ID card for assistance in selecting a PCP.

Out-of-Network coinsurances are based on a percentage of the out-of-network Allowed Benefit. If services are received from a non-participating provider, the member is responsible for 100% of charges above the Allowed Benefit. However, if services are received from a participating provider, the member is only responsible for amount up to the Allowed Benefit.

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

These benefits are issued under policy form numbers: VA/CFBC/GC (R. 1/09) • VA/CFBC/EOC (R. 1/09) • VA/CFBC/DOL APPEAL (R. 8/06) • VA/CFBC/DOCS (R. 1/09) • VA/BC-OOP/SOB (R. 1/09) • VA/CFBC/ATTC (R. 1/07) • VA/BC-OOP/VISION (R. 6/04) and any amendments or riders.



[www.carefirst.com](http://www.carefirst.com)

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## Exclusions and Limitations

### 10.1 Coverage Is Not Provided For:

- A. Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by the Plan.
- B. Services that are Experimental or Investigational as determined by the Plan.
- C. The cost of services that:
  - 1. Are furnished without charge • or
  - 2. Are normally furnished without charge to persons without health insurance coverage;
  - 3. Would have been furnished without charge if you were not covered under this Certificate or under any health insurance.
- D. Services that are not described as covered in this Certificate or that do not meet all other conditions and criteria for coverage, as determined by the Plan. Referral by a Primary Care Physician and/ or the provision of services by a Plan Provider does not, by itself, entitle a Member to benefits if the services are non-covered or do not otherwise meet the conditions and criteria for coverage.
- E. Routine foot care including any service related to hygiene including the trimming of corns or calluses, flat feet, fallen arches, chronic foot strain, or partial removal of a nail without the removal of the matrix except when we determine that Medically Necessary treatment was required because of an underlying health condition such as diabetes, and that all other conditions for coverage have been met.
- F. Dental care including extractions • treatment of cavities • care of the gums or bones supporting the teeth • treatment of periodontal abscess • removal of impacted teeth • orthodontia • false teeth • or any other dental services or supplies. These services may be covered under a separate rider or endorsement purchased by your Group and attached to this Certificate.
- G. Cosmetic surgery (except benefits for Breast Reconstructive Surgery) or other services primarily intended to correct, change or improve appearances. Cosmetic means a service or supply which is provided with the primary intent of improving appearances and not for the purpose of restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention as determined by the Plan.
- H. Treatment rendered by a health care provider who is a member of the Member's family (parents, spouse, brothers, sisters, children).
- I. Any prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Certificate or a rider or endorsement purchased by your Group and attached to this Certificate.
- J. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
- K. Services to reverse voluntary surgically induced infertility such as a reversal of sterilization.
- L. All assisted reproductive technologies (except artificial insemination) including in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same unless covered under a rider or endorsement purchased by your Group and attached to this Certificate.
- M. Fees or charges relating to fitness programs, weight loss or weight control programs • physical conditioning • pulmonary rehabilitation programs • exercise programs • physical conditioning • use of passive or patient-activated exercise equipment.
- N. Treatment for obesity except for the surgical treatment of Morbid Obesity.
- O. Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications.
- P. Services furnished as a result of a referral prohibited by law.
- Q. Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by the Plan.
- R. Health education classes and self-help programs, other than birthing classes or for the treatment of diabetes.
- S. Acupuncture services except when approved or authorized by the Plan when used for anesthesia.
- T. Any service related to recreational activities. This includes, but is not limited to: sports • games • equestrian • and athletic training. These services are not covered unless authorized or approved by the Plan even though they may have therapeutic value or be provided by a health care provider.
- U. Cardiac rehabilitation programs.
- V. Any service received at no charge to the Member in any federal hospital or facility, or through any federal, state, or local governmental agency or department, not including Medicaid. This exclusion does not apply to care received in a Veteran's Hospital or facility unless that care is rendered for a condition that is a result of the Member's military service.
- W. Benefits will not be provided for Habilitative Services. Benefits for physical therapy, occupational therapy and speech therapy do not include benefits for Habilitative Services.

### 10.2 Organ and Tissue Transplants. Benefits will not be provided for the following:

- A. Non-human organs and their implantation.
- B. Any hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.
- C. Any charges related to transportation, lodging, and meals unless authorized or approved by the Plan.
- D. Services for a Member who is an organ donor when the recipient is not a Member.
- E. Any service, supply or device related to a transplant that is not listed as a benefit in this Certificate.

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

- A. Private room, unless Medically Necessary and authorized or approved by the Plan. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.
- B. Non-medical items and convenience items, such as television and phone rentals.
- C. A Hospital admission or any portion of a Hospital admission that had not been authorized or approved by the Plan, whether or not services are Medically Necessary and/or meet all other conditions for coverage.
- D. Private duty nursing unless authorized or approved by the Plan.

**10.4 Hospice Benefits.** The following are not covered:

- A. Services, visits, medical equipment or supplies that are not included in the Plan-approved plan of treatment.
- B. Services in the Member's home if it is outside the Service Area.
- C. Financial and legal counseling.
- D. Any service for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.
- E. Chemotherapy or radiation therapy, unless used for symptom control.
- F. Reimbursement for volunteer services.
- G. Domestic or housekeeping services.
- H. Meal on Wheels or similar food service arrangements.
- I. Rental or purchase of renal dialysis equipment and supplies.

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

- A. Psychological testing, unless Medically Necessary, as determined by the Plan, and appropriate within the scope of covered services.
- B. Services solely on court order or as a condition of parole or probation unless approved or authorized by the Plan's Medical Director.
- C. Mental retardation, after diagnosis.
- D. Psychoanalysis.

**10.6 Inpatient Mental Health and Substance.** The following services are excluded:

- A. Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the Plan's Medical Director.
- B. Custodial Care.
- C. Observation or isolation.

**10.7 Emergency Services and Urgent Care.** Benefits will not be provided for:

- A. Emergency care if the Member could have foreseen the need for the care before it became urgent (for example, periodic chemotherapy or dialysis treatment).
- B. Medical services rendered outside of the Service Area which could have been foreseen by the Member prior to departing the Service Area.
- C. Charges for Emergency and Urgent Care services received from a non-Plan Provider after the Member could reasonably be expected to travel to the nearest Plan Provider.
- D. Charges for services when the claim filing and notice procedures stated in Section 7 of this Certificate have not been followed by the Member.
- E. Charges for follow-up care received in the Emergency or Urgent Care facility outside of the Service Area unless the Plan determines that the member could not reasonably be expected to return to the Service Area for such care.
- F. Except for covered ambulance services, travel, whether or not recommended by a Plan Provider.

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

- A. Convenience item. Any item that increases physical comfort or convenience without serving a Medically Necessary purpose (e.g., elevators, hoist/stair lifts, shower/bath bench).
- B. Furniture items. Movable articles or accessories which serve as a place upon which to rest (people or things) or in which things are placed or stored (e.g., chair or dresser).
- C. Exercise Equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body (e.g., exercycle or other physical fitness equipment).
- D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home (e.g., parallel bars).
- E. Environmental control equipment. Any device such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.
- F. Eyeglasses, contact lenses, hearing aids, dental prostheses or appliances.
- G. Corrective shoes, unless they are an integral part of the lower body brace, shoe lifts or special shoe accessories.

# Prescription Drug Program

\$0 Deductible ■ \$15/35/60 Retail Copays  
50% Injectables Coinsurance\*

## The Four Tier Prescription Drug Program

This program is based on the CareFirst BlueCross BlueShield (CareFirst) or CareFirst BlueChoice, Inc. (CareFirst BlueChoice) preferred drug list, which is made up of all generic prescription drugs (Tier 1) and preferred brand name prescription drugs (Tier 2). Your participating physician has a complete copy of the CareFirst or CareFirst BlueChoice preferred drug list. The preferred drug list changes frequently in response to Food and Drug Administration (FDA) requirements. The list is also adjusted when a generic drug is introduced for a brand name drug. When that happens, the generic drug will be added to the Tier 1 list and the brand name drug will move from Tier 2 to Tier 3.

## How Do I Use My Benefit?

Talk to your doctor when you are prescribed medications to see if you are using drugs that are on the preferred drug list – these are also known as Tier 1 or Tier 2 drugs. You will save the most money if you can take those medications. You can get your prescription filled by using the retail or mail order programs. If you have questions about your coverage, call Argus Health Systems at (800) 241-3371.

### Retail Program

The retail program provides up to a 34-day supply of medication. Simply present your prescription drug identification card at a participating pharmacy nationwide and pay the appropriate copayment for your medication.

### Mail Order Program

The mail service program is a convenient way for you to order medications. Your prescription is reviewed and dispensed by registered pharmacists and mailed directly to your home. Call Walgreens Mail Service at (800) 745-6285 for more information.

### Maintenance Drugs

Up to a 90-day supply of maintenance drugs are available through mail order or retail pharmacy at twice the appropriate copayment for your medications. Maintenance medication is a prescription drug anticipated to be required for 6 months or more to treat a chronic condition.

\* *Injectables = Self-Administered Injectables.*



Access [www.carefirst.com/rx](http://www.carefirst.com/rx) for more information and for the most up-to-date preferred drug list.

# Prescription Drug Program

## Summary of Benefits

Plan Feature	Amount	Description
<b>Deductible</b>	None	Your benefit does not have a deductible.
<b>Out-of-Pocket Maximum</b>	None	Your benefit does not have a family deductible maximum.
<b>Generic Drugs (Tier 1)</b> (up to a 34-day supply)	\$15	All generic drugs are covered at this copay level.
<b>Preferred Brand Name Drugs (Tier 2)</b> (up to a 34-day supply)	\$35	All preferred brand name drugs are covered at this copay level.
<b>Non-Preferred Brand Name Drugs (Tier 3)</b> (up to a 34-day supply)	\$60	All non-preferred brand name drugs are covered at this copay level. These drugs are not on the preferred drug list. Check the online preferred drug list to see if there is an alternative drug available. Discuss using alternatives with your physician or pharmacist.
<b>Self-Administered Injectables</b> (excluding insulin) <b>(Tier 4)</b> (up to a 34-day supply)	50% coinsurance up to a maximum payment of \$100	All Self-Administered Injectable drugs (excluding insulin) are covered at this payment level. Insulin is covered at appropriate copay level.
<b>Annual Maximum</b>	N/A	Your benefit does not have an annual benefit maximum.
<b>Maintenance Copays</b> (up to a 90-day supply)	generic: \$30 preferred: \$70 non-preferred: \$120 Self-Administered Injectables: 50% coinsurance, up to a maximum payment of \$200	Maintenance drugs of up to a 90-day supply are available for twice the copay through the mail service or retail pharmacy. Injectables (excluding insulin) are covered at 50% coinsurance up to a maximum payment of \$200.
<b>Generic Substitution</b>	Yes	If you choose a non-preferred brand name drug (Tier 3) over its generic equivalent (Tier 1) you will pay the highest copay PLUS the difference in cost between the non-preferred brand name drug and the generic drug up to the cost of the prescription.
<b>Prior Authorization</b>	Yes	Some prescription drugs require Prior Authorization. Prior Authorization is a tool used to ensure that you will achieve the maximum clinical benefit from the use of specific targeted drugs. Your physician or pharmacist must call (800) 294-5979 to begin the prior authorization process. For the most up-to-date prior authorization list, visit the prescription drug web site at <a href="http://www.carefirst.com/rx">www.carefirst.com/rx</a> .

This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

**Policy Form Numbers:** VA/CFBC/RX3 (R. 1/04) • VA/CF/RX3 (R. 1/04) • VA/CC/DOC 5/01 • PPP-A-1/95 and any amendments.

## Did You Know?

- If the cost of your medication is less than your copayment, you pay the cost of the medication.
- A generic drug is a prescription drug that by law must have the equivalent chemical composition as a specific brand name prescription drug.
- You can use your prescription drug card at more than 59,000 participating pharmacies nationwide.
- Frequently asked questions about your prescription benefits are available at [www.carefirst.com/rx](http://www.carefirst.com/rx).



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# Prescription Drug Program

**Below are the limitations and exclusions contained in your CareFirst or CareFirst BlueChoice medical policy to which the prescription rider is attached.**

## **Medical Limitations and Exclusions – CareFirst BlueChoice**

### **10.1 Coverage Is Not Provided For:**

- A. Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by the Plan.
- B. Services that are Experimental or Investigational as determined by the Plan.
- C. The cost of services that:
  - 1. Are furnished without charge; or
  - 2. Are normally furnished without charge to persons without health insurance coverage;
  - 3. Would have been furnished without charge if you were not covered under this Certificate or under any health insurance.
- D. Services that are not described as covered in this Certificate or that do not meet all other conditions and criteria for coverage, as determined by the Plan. Referral by a Primary Care Physician and/or the provision of services by a Plan Provider does not, by itself, entitle a Member to benefits if the services are non-covered or do not otherwise meet the conditions and criteria for coverage.
- E. Routine foot care including any service related to hygiene including the trimming of corns or calluses, flat feet, fallen arches, chronic foot strain, or partial removal of a nail without the removal of the matrix except when we determine that Medically Necessary treatment was required because of an underlying health condition such as diabetes, and that all other conditions for coverage have been met.
- F. Dental care including extractions; treatment of cavities; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia; false teeth; or any other dental services or supplies. These services may be covered under a separate rider or endorsement purchased by your Group and attached to this Certificate.
- G. Cosmetic surgery (except benefits for Breast Reconstructive Surgery) or other services primarily intended to correct, change or improve appearances. Cosmetic means a service or supply which is provided with the primary intent of improving appearances and not for the purpose of restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention as determined by the Plan.
- H. Treatment rendered by a health care provider who is a member of the Member's family (parents, spouse, brothers, sisters, children).
- I. Any prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Certificate or a rider or endorsement purchased by your Group and attached to this Certificate.
- J. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
- K. Services to reverse voluntary surgically induced infertility such as a reversal of sterilization.
- L. All assisted reproductive technologies (except artificial insemination) including in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same unless covered under a rider or endorsement purchased by your Group and attached to this Certificate.
- M. Fees or charges relating to fitness programs, weight loss or weight control programs; physical conditioning; pulmonary rehabilitation programs; exercise programs; physical conditioning; use of passive or patient-activated exercise equipment.

- N. Treatment for obesity except for the surgical treatment of Morbid Obesity.
- O. Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications.
- P. Services furnished as a result of a referral prohibited by law.
- Q. Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by the Plan.
- R. Health education classes and self-help programs, other than birthing classes or for the treatment of diabetes.
- S. Acupuncture services except when approved or authorized by the Plan when used for anesthesia.
- T. Any service related to recreational activities. This includes, but is not limited to: sports; games; equestrian; and athletic training. These services are not covered unless authorized or approved by the Plan even though they may have therapeutic value or be provided by a health care provider.
- U. Cardiac rehabilitation programs.
- V. Any service received at no charge to the Member in any federal hospital or facility, or through any federal, state, or local governmental agency or department, not including Medicaid. This exclusion does not apply to care received in a Veteran's Hospital or facility unless that care is rendered for a condition that is a result of the Member's military service.
- W. Except as otherwise provided in the evidence of coverage, benefits will not be provided for Habilitative Services. Benefits for physical therapy, occupational therapy and speech therapy do not include benefits for Habilitative Services.

### **10.2 Organ and Tissue Transplants.**

Benefits will not be provided for the following:

- A. Non-human organs and their implantation.
- B. Any hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.
- C. Any charges related to transportation, lodging, and meals unless authorized or approved by the Plan.
- D. Services for a Member who is an organ donor when the recipient is not a Member.
- E. Any service, supply or device related to a transplant that is not listed as a benefit in this Certificate.

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

- A. Private room, unless Medically Necessary and authorized or approved by the Plan. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.
- B. Non-medical items and convenience items, such as television and phone rentals.
- C. A Hospital admission or any portion of a Hospital admission that had not been authorized or approved by the Plan, whether or not services are Medically Necessary and/or meet all other conditions for coverage.
- D. Private duty nursing unless authorized or approved by the Plan.

### **10.4 Hospice Benefits.** The following are not covered:

- A. Services, visits, medical equipment or supplies that are not included in the Plan-approved plan of treatment.
- B. Services in the Member's home if it is outside the Service Area.
- C. Financial and legal counseling.
- D. Any service for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.
- E. Chemotherapy or radiation therapy, unless used for symptom control.
- F. Reimbursement for volunteer services.
- G. Domestic or housekeeping services.

# Prescription Drug Program

- H. Meal on Wheels or similar food service arrangements.
- I. Rental or purchase of renal dialysis equipment and supplies.

## 10.5 Outpatient Mental Health and Substance Abuse.

Benefits will not be provided for:

- A. Psychological testing, unless Medically Necessary, as determined by the Plan, and appropriate within the scope of covered services.
- B. Services solely on court order or as a condition of parole or probation unless approved or authorized by the Plan's Medical Director.
- C. Mental retardation, after diagnosis.
- D. Psychoanalysis.

## 10.6 Inpatient Mental Health and Substance.

The following services are excluded:

- A. Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the Plan's Medical Director.
- B. Custodial Care.
- C. Observation or isolation.

## 10.7 Emergency Services and Urgent Care. Benefit will not be provided for:

- A. Emergency care if the Member could have foreseen the need for the care before it became urgent (for example, periodic chemotherapy or dialysis treatment).
- B. Medical services rendered outside of the Service Area which could have been foreseen by the Member prior to departing the Service Area.
- C. Charges for Emergency and Urgent Care services received from a non-Plan Provider after the Member could reasonably be expected to travel to the nearest Plan Provider.
- D. Charges for services when the claim filing and notice procedures stated in this Evidence of Coverage have not been followed by the Member.
- E. Charges for follow-up care received in the Emergency or Urgent Care facility outside of the Service Area unless the Plan determine that the member could not reasonably be expected to return to the Service Area for such care.
- F. Except for covered ambulance services, travel, whether or not recommended by a Plan Provider.

## Limitations and Exclusions for Medical Devices

Benefits will not be provided for the purchase, rental or repair of the following:

- A. Convenience item. Any item that increases physical comfort or convenience without serving a Medically Necessary purpose e.g. elevators, hoyer/stair lifts, shower/bath bench.
- B. Furniture items. Movable articles or accessories which serve as a place upon which to rest (people or things) or in which things are placed or stored e.g. chair or dresser.
- C. Exercise Equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body e.g. exercycle or other physical fitness equipment.
- D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home e.g. parallel bars.
- E. Environmental control equipment. Any device such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.
- F. Eyeglasses, contact lenses, hearing aids, dental prostheses or appliances.
- G. Corrective shoes, unless they are an integral part of the lower body brace, shoe lifts or special shoe accessories.

## Prescription Drug Exclusions

Benefits will not be provided under this Rider for:

1. Any devices, appliances, supplies, and equipment other than those specified in Section B, of this Rider.
2. Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities.
3. Prescription Drugs intended for cosmetic use.
4. Prescription Drugs administered by a physician or dispensed in a physician's office.
5. Drugs, drug therapies or devices that are considered experimental or investigational by CareFirst BlueChoice.
6. Drugs or medications lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a prescription ("Over-the-Counter" medications).
7. Vitamins, except CareFirst BlueChoice will provide a benefit for Prescription Drug:
  - a. prenatal vitamins.
  - b. fluoride and fluoride containing vitamins.
  - c. single entity vitamins, such as Rocaltrol and DHT.
8. Infertility drugs or agents for use in connection with infertility services or treatments that are excluded from coverage under the evidence of coverage to which this rider is attached.
9. Any portion of a Prescription Drug that exceeds:
  - a. a thirty-four (34) day supply for Prescription Drugs; or
  - b. a ninety (90) day supply for Maintenance Drugs.
10. Prescription Drugs that are administered or dispensed by a health care facility for a Member who is a patient in the health care facility. This exclusion does not apply to Prescription Drugs that are dispensed by a Pharmacy on the health care facility's premises for a Member who is not a patient in the health care facility.
11. Prescription Drugs for weight loss.
12. Biologicals and allergy extracts.
13. Blood and blood products. (May be covered under the medical benefits in the evidence of coverage to which this rider is attached.)

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

## Medical Limitations and Exclusions – CareFirst BlueCross BlueShield

### 10.1 Medical Necessity and Appropriateness.

Benefits will not be provided for services, tests, procedures or supplies which we determine are not necessary for the prevention, diagnosis or treatment of the Member's illness, injury or condition. Although a service or supply is listed as covered, benefits will be provided only if it is medically necessary and appropriate in the Member's particular case. A service or supply is medically necessary and appropriate only if, in our judgment it is:

- a. Necessary and appropriate for the symptom, diagnosis, prevention or treatment of the Member's illness, injury or condition;
- b. Consistent with the symptom, diagnosis, prevention or treatment of the Member's illness, injury or condition;
- c. The most appropriate supply, treatment or level of service that can be provided safely to the Member and, if the Member is an inpatient, cannot be provided safely on an outpatient basis; and
- d. Not primarily for the convenience of the Member or provider.

Services, supplies, and accommodations will not automatically be considered Medically Necessary because they were prescribed by an Eligible Provider. We may consult with professional medical consultants, peer review committees, or other appropriate sources for recommendations on whether the services, supplies, or accommodations a Member receives are Medically Necessary.

# Prescription Drug Program

**10.2 Accepted Medical Practice.** Benefits will not be provided for any treatment, procedure, facility, equipment, drug, drug usage, device or supply which, in our judgment, is experimental, investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment. A service or supply is deemed to be experimental or investigational if:

- a. A preponderance of scientific data, such as controlled studies in peer-reviewed journals or literature has not demonstrated that its use results in an improved net health outcome for a specific diagnosis;
- b. It is not in accordance with generally accepted standards of medical practice; or
- c. It does not have federal or other required governmental agency approval at the time it is received.
- d. This exclusion will not be used, however, to deny Patient Cost when the services for Clinical Trials meet all the requirements under the section entitled "Clinical Trial".

**10.3 Free Care.** Payment will not be made for services which, if the Member were not covered under the Group Contract, would have been provided without charge, including any charge or any portion of a charge which, by law, the provider is not permitted to bill or collect from the patient directly.

**10.4 Routine Care of Feet.** Benefits will not be provided for any services related to hygiene and preventative maintenance such as trimming of corns, calluses, flat feet, fallen arches, chronic foot strain or partial removal of a nail without the removal of its matrix, in the absence of an underlying health condition.

**10.5 Dental Care.** Except as provided in the evidence of coverage, benefits will not be provided for any other type of dental care including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess, removal of impacted teeth, orthodontia, false teeth or any other dental services or supplies, unless provided in a separate Rider or Endorsement to this Agreement.

**10.6 Oral Surgery.** Except as otherwise provided in the evidence of coverage, benefits will not be provided for procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae for cosmetic purposes or for correction of malocclusion are excluded.

**10.7 Cosmetic Services.** Benefits will not be provided for cosmetic surgery (except benefits for Reconstructive Breast Surgery and the treatment of morbid obesity) or other services primarily intended to correct, change or improve appearances. Cosmetic means a service or supply which is provided with the primary intent of improving appearances and not for the purpose of restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention as determined by the Plan.

**10.8 Prescription Drugs.** Except as provided in a separate rider or endorsement to this Agreement, benefits will not be provided for prescription drugs, unless administered to the Member in the course of covered outpatient or inpatient treatment. Take-home prescriptions or medications, including self-administered injections which can be administered by the patient or by an average individual who does not have medical training, or medications which do not medically require administration by or under the direction of a physician are not covered, except as may be provided in a separate rider or endorsement to this Agreement, even though they may be dispensed or administered in a physician or provider office or facility.

**10.9 Organ Transplants.** Organ transplant procedures, including complications resulting from any such procedure, services or supplies related to any such procedure such as, but not limited to, high dose chemotherapy, radiation therapy or any other form of therapy, or immunosuppressive drugs are not covered, except as provided in your Agreement.

**10.10 Other Exclusions.** Benefits will not be provided for the following:

- a. Services or supplies received before the effective date of your coverage under this Agreement.
- b. Treatment of sexual dysfunctions or inadequacies except surgical implants for impotence (medical therapy and psychiatric treatment are not covered).
- c. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
- d. Weight reduction or obesity treatment, except the surgical treatment of Morbid Obesity.
- e. Speech therapy, occupational therapy or physical therapy, unless we determine that your condition is subject to improvement. Coverage does not include nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.
- f. Fees and charges relating to fitness programs, weight loss or weight control programs, physical, pulmonary conditioning programs or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education. Cardiac rehabilitation programs are covered as described in your Agreement.
- g. Services or supplies for the medical or surgical treatment of errors of refraction, such as myopia or hyperopia, including but not limited to radial keratotomy or any like or similar procedures or any complications arising therefrom.
- h. Services to the extent they are covered by any governmental unit, except in Veteran's Administration or armed forces facilities for services received, such as for non-service connected disabilities, for which the recipient is liable. Services or supplies for injuries or diseases related to a covered person's job to the extent the covered person is required to be covered by a workers' compensation law. Services or supplies resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy, excluding no fault insurance.
- i. Services that are beyond the scope of the license of the provider performing the service.
- j. Except for covered ambulance services, travel, whether or not recommended by an Eligible Provider.
- k. Services or supplies for conditions that State or local laws, regulation, ordinances, or similar provisions require to be provided in a public institution.
- l. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar persons or groups.
- m. Contraceptive devices.
- n. Assistive reproductive procedures, except when provided in a separate rider or endorsement to your Agreement.
- o. Services solely on court order or as a condition of parole or probation unless approved by the Plan.
- p. Any illness or injury caused by war, declared or undeclared, including armed aggression.
- q. Any service, supply or procedure which is not specifically listed in your Agreement as a covered benefit.
- r. Except as otherwise provided in the evidence of coverage, benefits will not be provided for Habilitative Services. Benefits for physical therapy, occupational therapy and speech therapy do not include benefits for Habilitative Services.

# Prescription Drug Program

## Limitations and Exclusions for Medical Devices

- a. Benefits will not be provided for purchase, rental or repair of:
  - Medical equipment/supplies of an expendable nature, except as specifically listed as a Covered Medical Supply in paragraph b., above. Non-covered supplies include incontinence pads and ace bandages.
  - Equipment that can be used for non-medical purposes, such as air conditioners, humidifiers, electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.
  - Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for a Member, i.e., exercycle or other physical fitness equipment, elevators, hoier lifts, shower/bath bench.
  - Eyeglasses or contact lenses (except as stated above), hearing aids or dental prostheses or appliances.
  - Corrective shoes (unless required to be attached to a leg brace), shoe lifts or special shoe accessories.
- b. Benefits will be limited to the lower of purchase or rental, taking into account the length of time you required or are reasonably expected to require the equipment, the durability of the equipment, etc.
- c. The purchase price or rental cost must be the least expensive of its type adequate to meet the medical needs of the Member. If the Member selects a deluxe version of the appliance, device or equipment not determined by us to be medically necessary, we will pay an amount which does not exceed our payment for the basic device (minus the Member copayment) and the Member will be fully responsible for paying the remaining balance.
- d. Benefits for the repair, maintenance or replacement of Covered Durable Medical Equipment are limited as follows:
  - Coverage of maintenance costs is limited to routine servicing such as testing, cleaning, regulating and checking of equipment.
  - Coverage of repairs costs is limited to adjustment required by normal wear or by a change in the Member's condition and repairs necessary to make the equipment/appliance serviceable. Repair will not be authorized if the repair costs exceed the market value of the appliance, prosthetic or equipment.
  - Replacement coverage is limited to once every two years due to irreparable damage and/or normal wear or a significant change in medical condition. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the Member or of a family Member are NOT covered.

## Prescription Drug Exclusions

Benefits will not be provided under this rider for:

1. Any devices, appliances, supplies, and equipment except as otherwise provided in Section B, above.
2. Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities.
3. Prescription Drugs for cosmetic use.
4. Prescription Drugs administered by a physician or dispensed in a physician's office.
5. Drugs, drug therapies or devices that are considered experimental or investigational by CareFirst.
6. Drugs or medications lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a prescription ("Over-the-Counter" medications).
7. Vitamins, except CareFirst will provide a benefit for Prescription Drug:
  - a. prenatal vitamins.
  - b. fluoride and fluoride containing vitamins.
  - c. single entity vitamins, such as Rocaltrol and DHT.
8. Infertility drugs and agents for use in connection with infertility services or treatments that are excluded from coverage under the evidence of coverage to which this rider is attached.
9. Any portion of a Prescription Drug that exceeds
  - a. a thirty-four (34)-day supply for Prescription Drugs; or,
  - b. a ninety (90)-day supply for Maintenance Drugs.
10. Prescription Drugs that are administered or dispensed by a health care facility for a Member who is a patient in the health care facility. This exclusion does not apply to Prescription Drugs that are dispensed by a Pharmacy on the health care facility's premises for a Member who is not a patient in the health care facility.
11. Prescription Drugs for weight loss.
12. Biologicals and allergy extracts.
13. Blood and blood products. (May be covered under the medical benefits in the evidence of coverage to which this rider is attached.)

Not all services and procedures are covered by your benefits contract. This list is a summary and is not intended to itemize every procedure not covered by CareFirst BlueCross BlueShield. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.