

CareFirst.  
BlueCross BlueShield



BluePreferred

*Why don't **you** have it?*

Take control
of your health
care coverage.

*Health Care Coverage for Northern Virginia
residents who buy their own health insurance.*

BluePreferred

*A health insurance plan that leaves
the important choices up to you.*



Why Don't *You* Have Health Insurance?

Too busy to make the arrangements?

Think you can't afford it?

It's a fact. For the cost of many of the things you buy each day, you can have the security and peace of mind of health coverage.

BluePreferred, a health plan from CareFirst BlueCross BlueShield (CareFirst) combines the freedom to select any doctor or specialist, ***even without a referral***, with the flexibility to customize your plan based on the cost options that you select. And to help you control those out-of-pocket costs, we offer you significant savings when you visit a doctor within the CareFirst Preferred Provider Network.

BluePreferred offers you:

- ◆ **Maximum flexibility** – six benefit levels to choose from – so you can find a plan that's right for you!
- ◆ **Freedom to choose any doctor or hospital** – no referrals to delay your visit to a specialist – you just make the appointment.
- ◆ **A preventive care package** that saves you money with no charge for well child care up to age 18 and predictable \$25 copays for adult preventive services – both with no deductible to meet – when you visit Preferred Providers!
- ◆ **Major Medical coverage** with no policy maximum – to protect you against the high cost of a lengthy illness.
- ◆ **Easy access to your benefits** with Blue Cross Blue Shield *BlueCard*® Program – your direct link to healthcare services nationwide.
- ◆ **Security of knowing that you're protected** by one of the state's leading health care insurers protecting individuals who buy their own insurance.

CareFirst provides its members with protection against the high cost of health care. We offer health insurance options to meet the needs and budget of individuals who purchase their own insurance.

Lower Your Expenses

CareFirst provides you with access to more than 29,000 providers and 42 hospitals in the Washington, D.C. Metropolitan service area who participate in our *Preferred Provider Organization*. When you choose to seek your care from one of these providers, CareFirst is able to offer you lower deductibles and coinsurance. Ask your doctor if he or she is a member of our PPO plan or check our website at www.carefirst.com.

Of course, BluePreferred also offers you the flexibility to select any doctor – either in or out of the CareFirst network. If you decide to go out-of-network for any covered services, you will simply share more of the costs, in the form of higher coinsurance and deductibles.

What are the benefits of selecting an in-network doctor?

- ◆ **Lower Out-of-Pocket Costs** – When you receive services from our Preferred Providers, or in-network doctors, you will be responsible for a lower deductible and lower coinsurance amounts.
- ◆ **Preventive Care** – BluePreferred helps keep you and your family healthy with well-child care (up to age 18) and cancer screenings with no deductible or copays. Plus, adult preventive exams and routine GYN visits are available at one predictable copay with no deductible to meet.
- ◆ **No Balance Billing** – Your provider agrees to accept the Preferred Provider Allowed Benefit as payment in full for covered services after you pay any applicable copayment or coinsurance. The Preferred Provider Allowed Benefit is the pre-negotiated fee agreed to by both the doctor and CareFirst. This means no unexpected costs to you.

How is an out-of-network doctor different?

Freedom – One of the biggest benefits of BluePreferred is that you actually *can* select any doctor you choose. Unlike some managed care plans in which you select a single primary care physician to manage your care, BluePreferred gives you the option to seek care on your own from physicians and specialists *outside* of the network. Of course, this option will require you to share more of the costs, in the form of higher coinsurance and deductibles.

Can I go “out-of-network” and still save money?

Yes. Some out-of-network providers are CareFirst Participating Providers, which means that they have a special agreement with CareFirst regarding how much they charge. This agreement may limit the amount you owe, but you will still be responsible for your deductible and coinsurance amounts up to the out-of-network allowed benefit.

What if I choose to see an Out-of-Network Non-Participating Provider?

That’s what makes BluePreferred so desirable – It’s so flexible! If you choose to visit an out-of-network, Non-Participating Provider, you will be required to pay the out-of-network deductible and coinsurance amounts, and you will also be responsible for filing the necessary paperwork. In addition, you will be responsible for paying the price difference between CareFirst’s allowed benefit and what the provider actually charges, also called balance billing.

Questions?

Call us toll free at 1-800-544-8703 or call your insurance broker.

You Choose the Coverage Level Right for You

As a member of the BluePreferred plan, you can choose the personal health care program that's right for you – and your budget. The more you share in the cost of the coverage through higher deductibles and coinsurance payments, the lower your monthly premium.

This is how BluePreferred helps make health care coverage fit your budget – by letting you decide how much of the plan's cost you want to share through deductibles and coinsurance. Refer to the chart below and the rate charts included in this package to help you make your decision.

Deductibles, Coverage Levels and Out-of-Pocket Maximums Per Individual:

Your Deductible		Your Coverage Level		Your Out-of-Pocket Maximum	
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
\$100	\$300	90%	70%	\$2,500	\$5,000
\$300	\$600	90%	70%	\$2,500	\$5,000
\$300	\$600	80%	60%	\$2,500	\$5,000
\$500	\$1,000	80%	60%	\$2,500	\$5,000
\$750	\$1,500	80%	60%	\$3,500	\$7,000
\$2,500	\$5,000	80%	60%	\$5,000	\$7,500

It's very important to note that your out-of-pocket maximum includes your deductible and most coinsurance payments.

Questions?

Call us toll free at 1-800-544-8703 or call your insurance broker.

How the Plan Works

- ◆ You pay the deductible when applicable – **Remember, no deductible is required for preventive care provided by an in-network doctor.**
- ◆ Once the deductible has been met, BluePreferred pays a percentage (90%, 80%, 70% or 60%) of the allowed amount. This is the coverage percentage that you initially select.
 - When you visit any CareFirst Participating Provider, after you meet the deductible, you only pay the associated coinsurance.
 - If you visit an out-of-network, non-participating provider you will not only be responsible for the coinsurance, but also for paying the difference between CareFirst’s allowed benefit and what the provider actually charges.
 - Each member must meet his/her individual deductible, though families never pay more than two times the individual deductible.
- ◆ Unlike many other plans, your medical deductible is included as part of your out-of-pocket maximum, which is the maximum a person on your policy spends towards coinsurance and deductibles per year
- ◆ Members are responsible for their coinsurance until they reach the out-of-pocket calendar year maximum.
- ◆ Once your out-of-pocket maximum is reached, BluePreferred pays 100% of the allowed amount for most covered services.
- ◆ Prescription drug benefits are subject to separate deductibles, copayments, and maximums.
- ◆ A family never has to meet more than two individual out-of-pocket maximums per calendar year. An individual family member cannot contribute more than the individual out-of-pocket limit toward meeting the family out-of-pocket limit.

In-Network Benefits at a Glance

Benefit	Covered	You Pay
Well-Child Care	<input checked="" type="checkbox"/>	\$0
Mammograms, Pap Tests and PSAs (cancer screenings)	<input checked="" type="checkbox"/>	\$0
Adult Preventive Physical Exams	<input checked="" type="checkbox"/>	\$25 (no deductible)
Allergy Shots	<input checked="" type="checkbox"/>	\$5 (no deductible)
OB/GYN Preventive Care	<input checked="" type="checkbox"/>	\$25 (no deductible)
Physician Office Visits	<input checked="" type="checkbox"/>	\$25 (no deductible)
Emergency Care – Emergency Room	<input checked="" type="checkbox"/>	\$50 (subject to deductible and coinsurance)
365 days Hospitalization per year	<input checked="" type="checkbox"/>	Your selected coinsurance percentage (after deductible)
Inpatient Physician Services	<input checked="" type="checkbox"/>	Your selected coinsurance percentage (after deductible)
Inpatient/Outpatient Surgery	<input checked="" type="checkbox"/>	Your selected coinsurance percentage (after deductible)
Diagnostic Tests and X-rays	<input checked="" type="checkbox"/>	Your selected coinsurance percentage (after deductible)
Annual Routine Eye Exam	<input checked="" type="checkbox"/>	\$10 (no deductible)
Physical Therapy	<input checked="" type="checkbox"/>	Your selected coinsurance percentage (after deductible)
Prescription Drugs*	<input checked="" type="checkbox"/>	\$100 deductible \$10 Generic copay \$25 Preferred Brand copay \$45 Non-Preferred Brand copay \$1,500 annual benefit maximum

* Generic drugs must be chosen when available or an additional expense will be incurred. Self-injectable drugs are covered at a 50% coinsurance up to a maximum member copayment of \$75 per covered injectable medication and are subject to the annual benefit maximum.

Note: If you use a provider who does not participate with any Blue Cross and Blue Shield plan, you will be responsible for any applicable deductible, copayment and coinsurance plus charges over the allowed benefit.

Out-of-network service(s) will require the completion of a claim form to obtain reimbursement for the covered benefit(s).

Prescription Drug Card Program

Your BluePreferred coverage includes a 4-Tier Prescription Drug Card Program, designed to combat rising drug costs that drive up your premiums and overall healthcare costs. The Prescription Drug Program covers both non-maintenance and maintenance prescription drugs dispensed by a retail pharmacy or the Walgreens mail service pharmacy. You can use

your card at more than 59,000 participating pharmacies – including chains and independent pharmacies – nationwide. And, by visiting a participating pharmacist there are no claims to file.

What's more, if you take maintenance medications over an extended period of time, your Prescription Drug Program offers you a way to save time and money. While maintenance drugs can be obtained either through retail pharmacies or through our mail-order program, the mail order program provides additional savings and convenience. When you use the mail order program, you pay only two copays for a 90-day supply of maintenance drugs, not three copays as you would through the retail program. Plus, you don't have to make a special trip to the pharmacy. Visit www.carefirst.com/rx to learn more about your prescription drug coverage.

Vision Care Services

BluePreferred offers you eye care benefits as part of your medical plan, through our network administrator, Davis Vision, Inc. For annual routine eye examinations, just call and make an appointment with one of the participating providers and pay the \$10 copay at the time of service. Additionally, through Davis Vision, you receive discounts of approximately 30% on eyeglass lenses and frames or contact lenses. *For medical eye care, please follow your normal medical procedures.*

Optional Maternity and Prenatal Coverage

You may also choose to add maternity and prenatal care coverage to your policy (for yourself or your covered spouse). For an additional \$126 a month, you will receive benefits for covered pre-and post-natal care as well as covered services associated with the delivery. If you add maternity coverage at any time following your initial enrollment in BluePreferred, there will be a 10-month waiting period for maternity benefits.

BlueCard® Program Features

Taking your benefits with you when you travel.

With BluePreferred, getting access to care while out of town is as easy as presenting your CareFirst BlueCross BlueShield identification card. Providers, hospitals and urgent-care facilities who participate with the local Blue Cross Blue Shield PPO plan – wherever you are in the U.S. – will recognize and honor your card. Need help finding a provider? Just call the BlueCard® phone number listed on your CareFirst ID card for personal assistance.

When You Need Care



UTILIZATION MANAGEMENT

When you need to be hospitalized or need therapy, your doctor will work with the Utilization Management team to ensure you receive the right care in the right place at the right time.

Hospital Precertification and Review

Any time you face non-emergency surgery or hospitalization, the Hospitalization Precertification and Review program works with your provider to determine if the hospital is the most appropriate place for your procedure and recovery. If you are hospitalized, a Utilization Management nurse will review your information and assist with discharge planning or approve additional inpatient hospital days if necessary.

Maximizing Your Drug Benefit

To help you and your family face the challenge of the rising cost of prescription drugs, CareFirst develops drug utilization programs to encourage drugs that are effective and cost-efficient in order to maximize the value of your prescription drug benefit. In addition, we frequently update the preferred drug list (Formulary) which can be found at www.carefirst.com/rx. Here you can also find tools to help you get the most from your prescription dollar such as learning how to save money with generic alternatives, finding participating pharmacies and much more.



CASE MANAGEMENT

When faced with a serious diagnosis or condition, you and your family have many tough choices and decisions to make. The Case Management program can help you navigate the complex health care system and provide support during your time of need. Some of the conditions most frequently case managed include:

- ◆ serious trauma
- ◆ rehabilitation
- ◆ cancer
- ◆ special needs

Questions?

Call us toll free at 1-800-544-8703 or call your insurance broker.

Our case managers will:

- ◆ Work closely with you and your doctors to identify a treatment plan
- ◆ Coordinate necessary services
- ◆ Contact you regularly to see how you are doing
- ◆ Answer any of your questions
- ◆ Suggest community resources that may be available

DISEASE MANAGEMENT¹



Our disease management programs can help you avoid or delay the complications related to chronic conditions.

We have programs for:

- ◆ Diabetes
- ◆ Asthma
- ◆ Chronic obstructive pulmonary disease (COPD)
- ◆ Congestive heart failure
- ◆ Coronary heart disease

When you enroll, you will:

- ◆ Receive information on how to manage your condition
- ◆ Be able to call a toll-free number 24 hours a day, seven days a week, to speak with a registered nurse
- ◆ Have access to a Web site that has information about your condition
- ◆ Be able to email questions to a registered nurse

¹ *Disease management programs may not be available for some accounts. Please call Member Services at (866) 520-6099.*



Options Discount Program

Options discount program provides you with discounts on laser vision correction, hearing care services, fitness club memberships and mail order contact lenses, as well as alternative therapies such as acupuncture, massage therapy and chiropractic care. CareFirst BluePreferred members can also receive discounts on tai chi, qi gong, pilates, yoga, nutrition counseling, guided imagery, meditation instruction, mind-body instruction and personal training.

Options is not a covered benefit under your health plan, but rather a way for you to access health and wellness practitioners at discounted rates. To find out more, visit www.carefirst.com.

Frequently Asked Questions

Q: *Can I choose my own physician?*

A: Yes. You have the freedom to select any doctor or hospital. And you can still save on out-of-pocket expenses by using either our Preferred or Participating Provider Networks. To view a listing of BluePreferred or CareFirst Participating Providers who automatically file claims for you and will not balance bill you, please visit us on the web at www.carefirst.com. (For more information on balance billing, please read the FAQ on this page titled “What is balance billing and how does it affect my out-of-pocket costs?”)

Q: *What types of health costs should I expect?*

A: BluePreferred requires you to first pay your pre-chosen deductible before the insurance will pay. This deductible will vary depending on whether you visit an in-network or out-of-network doctor. Once the deductible is met you pay a coinsurance for most visits and procedures, which is a percentage of the total cost of the visit – this also varies depending on whether you visit an in-network or out-of-network doctor. (**Please note:** *Many BluePreferred preventive care benefits are covered even before you meet your deductible when you visit an in-network doctor.*)

Q: *What is balance billing and how does it affect my out-of-pocket costs?*

A: As a member of BluePreferred you have the option to visit doctors who do not participate with CareFirst. In addition to your coinsurance, you are also responsible for whatever amount the doctor charges over and above CareFirst’s negotiated amount (also called the Allowed Benefit) for the procedure.

For example, if the cost of a procedure is \$100, CareFirst’s negotiated amount for that procedure, when provided by a Participating Provider, may only be \$60. Should you choose to use a Non-Participating Provider, you would be responsible for the \$40 difference between the doctor’s actual charge and CareFirst’s Allowed Benefit.

Q: *Is preventive care covered?*

A: Yes. BluePreferred coverage includes a special package of preventive care benefits for only \$25 per doctor visit – and you don't have to meet your deductible first – when you see an in-network doctor. Plus, well child visits up to age 18 and cancer screenings are covered at 100% when you seek care from an in-network doctor.

Q: *When does coverage begin?*

A: Coverage begins the first day of the month following the date you're approved and is contingent upon receipt of payment.

Q: *What about waiting periods?*

A: There is a 10-month waiting period for pre-existing conditions.

Q: *What is medical underwriting and how long does it take?*

A: Medical underwriting is a systematic process that insurers use to evaluate information about a health insurance applicant. An underwriter at CareFirst carefully reviews the answers you provide to the health questions in your application. In addition, we may review past claims history on file, if applicable, and any medical reports completed by physicians. Based on this information we may approve the application at the requested rate or a higher rate, deny the request for coverage or deny coverage for a particular applicant. The review process typically takes 4-6 weeks.

* Products are available without medical underwriting or pre-existing condition waiting periods for those who meet the criteria specified by the Health Insurance Portability and Accountability Act (HIPAA). If you are HIPAA eligible, you have the option to be medically underwritten and qualify for a lower rate. (See insert.)

It's Easy to Apply

Follow these easy steps to apply for BluePreferred.

To be eligible for BluePreferred coverage, each family member applying for coverage must be a resident of Northern Virginia and complete a medical questionnaire.

We begin processing your application as soon as it is received. The review process typically takes 4-6 weeks. Once you have submitted your application, you can call the BluePreferred Application Status Hotline toll free at **1-877-746-7515** for a status report on your application.

1. Choose what type of coverage you need.

Individual

Individual and Child(ren)*

Individual and Adult**

Family - Two eligible adults and eligible dependent(s)

* “Child” means your unmarried, *eligible* child up to age 23. Eligibility requirements are defined in the BluePreferred contract.

** “Adult” means the spouse of the subscriber or the domestic partner of the subscriber who resides with the subscriber and satisfies the eligibility requirements defined in the BluePreferred contract. The subscriber and domestic partner may not share a blood or familial relationship, and must have shared a common legal residence continuously for at least six (6) months prior to applying for coverage.

If you have questions about eligibility, please call our Product Specialists at **1-800-544-8703**.

2. Choose the plan that fits your needs using the BluePreferred Deductibles, Coverage Levels and Out-of-Pocket Maximums chart on page 5.
3. Locate your monthly premium using the rate charts enclosed.
4. Complete the enclosed application. Please make sure that all information is complete and accurate. This will help speed up the application process.
 - ◆ Make sure you check “Yes” in the Maternity benefit selection area if you wish to include benefits for maternity services.
 - ◆ Also, you must sign and date the application.
5. Send no money now. You’ll receive an invoice when your coverage is approved.

Additional Coverage Options

Coverage Available from CareFirst BlueCross BlueShield

- **BluePreferred-Saver*** and **BluePreferred HSA*** – A Preferred Provider Organization (PPO) that reduces your out-of-pocket costs with a variety of deductible options including health savings account-compatible plans.
- **Supplement-65** – Traditional coverage to supplement your Medicare policy. For more information about this plan, please call our Product Specialist toll free at **1-800-275-3802**.

Other Coverage Available

- **BlueChoice HSA*** – A health savings account-compatible plan offered by CareFirst BlueChoice, Inc.

* *Medical questionnaire must be completed.*

Exclusions

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.

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 dental care.

10.6 Oral Surgery. Benefits are limited to non-dental diagnostic procedures for congenital defects, such as hare lip, cleft palate, or ectodermal dysplasia and for medically necessary medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to procedures to correct accidental injuries of the jaw, cheeks, lips, tongue, roof and floor of the mouth; the reduction of, dislocation of, or excision of temporomandibular joints; procedures involving accessory sinuses, salivary glands or ducts; excision of tumors and cysts of the jaw, cheeks, roof and floor of the mouth when pathological examination is required; excision of exostosis of the jaw and hard palate when not related to the fitting of dentures; extraoral incision and drainage of abscesses with cellulitis. All other procedures involving the teeth or areas surrounding the teeth will not be covered, except for diagnostic and surgical treatment involving a bone or joint of the head, neck, face or jaw, if the treatment is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed medically necessary to attain functional capacity of the affected part.

10.7 Cosmetic Services. Benefits will not be provided for plastic surgery, cosmetic surgery or other services primarily intended to correct, change or improve the Member's appearance. Except as provided in paragraph (b) below, such services are excluded, regardless of the underlying cause of the condition or any expectation that an alteration of the patient's appearance may be psychologically or developmentally beneficial to the patient. Benefits for reconstructive surgery are limited to surgical procedures that, in our judgment, are:

- a. Medically necessary to correct conditions which have resulted in a functional physiological defect; or
- b. required to correct a congenital anomaly (must be a physical defect that was apparent at birth) that has produced a major physical effect on the Member's condition and provided the surgery or procedure can be reasonably expected to correct the condition; or
- c. required to correct conditions which have resulted from accidental injury or non-cosmetic surgery if:
The accident or surgery has produced a major physical effect on the Member's appearance; and In our judgment, the surgery can be reasonably expected to correct the condition.
- d. Required for Reconstructive Breast Surgery which is performed as a result

of a Mastectomy to re-establish symmetry between two breasts. Reconstructive Breast Surgery includes the augmentation, mammoplasty, reduction, manoplasty, and mastopexy. The coverage shall include all stages of Reconstructive Breast Surgery performed on a non-diseased breast to establish symmetry with the diseased breast when Reconstructive Breast Surgery on the diseased breast is performed.

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 that is maintenance therapy for a chronic disease or condition or 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 which are provided for or 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 the care is rendered for a condition that is a result of the Member's military service.)
- 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, including artificial insemination, invitro fertilization, embryo or ovum transplants and gamete intra fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.
- o. Partial removal of a nail without the removal of the matrix.
- p. Services solely on court order or as a condition of parole or probation unless approved by the Plan.
- q. Any illness or injury caused by war, declared or undeclared, including armed aggression.
- r. Any service, supply or procedure which is not specifically listed in your Agreement as a covered benefit.
- s. 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 EXCLUSIONS

Benefits will not be provided for:

- 1. Any devices, appliances, supplies, and equipment other than those specified in Section B, of the Prescription Drug Rider;
- 2. routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities;
- 3. prescription Drugs intended solely 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 Investigative by CareFirst or the FDA;
- 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. therapeutic classes where there is a therapeutic equivalent Over-the-Counter product available.
- 8. Vitamins, except CareFirst will provide a benefit for Prescription Drug:
 - a. prenatal vitamins;
 - b. fluoride and fluoride containing vitamins; and,
 - c. single entity vitamins, such as Rocaltrol and DHT.
- 9. All infertility drugs or agents;
- 10. any portion of a Prescription Drug that exceeds:
 - a. a thirty (30) day supply for non-Maintenance Drugs; or,
 - b. a ninety (90) day supply for Maintenance Drugs;
- 11. prescription Drugs that are dispensed by a nursing home, extended care facility or other such facility for use during a skilled nursing facility inpatient stay.
- 12. Appetite suppressants;
- 13. biologicals and allergy extracts; and,
- 14. blood and blood products. Refer to the medical benefits under the Certificate.

Take control of your
health care coverage.
Call 1-800-544-8703 today!
Or, apply online using
Individual Express at
www.carefirst.com/eSales.

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.

Policy Form Numbers: V/DP/IEA-5/96, PPP-A-BPDB-4/96,
CMM/ATTB BPDB-4/96, ELIG-C BPDB-4/96,
VA/CF/IND RX3 (1/03) and any amendments.



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