CareFirst

Consumer Health Insurance Plans 2014

For People Who Buy Their Own Insurance

NORTHERN VIRGINIA

Welcome

In our 75 years of service to your family, friends and neighbors, this is the first time that all of the plans we're offering from CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) are brand-new. That's because all 15 of our plans were designed to meet—and have met—the new guidelines of the Affordable Care Act (ACA), or, health care reform.

Because the ACA is new, we know this is the first time anyone will be buying an ACA plan. Everyone will benefit from learning the ACA terms and ideas in the short overview section following this one.

That's why we recommend you read this brief, step-by-step guide from front to back. Written in an easy-to-understand style, it will:

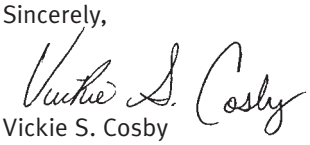
- Explain ACA and how it will affect you
- Define basic health insurance concepts and terms
- Explain new financial help that can lower your costs
- Give you info about ACA Metal Levels
- Provide rate tables so you can calculate your premium
- Give you 3 ways to enroll today

The new ACA health care landscape may not be familiar, but CareFirst is.

We've always been committed to making sure you have the best information, when you need it. If you need more than you find in this book and the accompanying charts, visit **www.CareFirst.com/individual** or call us at 800-544-8703, 7 days a week, 8:00 am – 8:00 pm. You can use the same number for our no-charge bi-lingual services, too.

As always, we're here for you.

Sincerely,



Vickie S. Cosby
Vice President, Consumer Direct Sales

Ready to go shopping?

You can also visit us online at **www.CareFirst.com/individual** to research and compare plans.

What's Inside…

Get to know the basics

Choosing your CareFirst health care plan

Enroll today

Additional information

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.

Get to know the basics

How health care reform will affect you

The Affordable Care Act (ACA), or health care reform, became law in 2010 and will affect the majority of people who buy their own insurance. In addition to requiring nearly everyone to buy health insurance starting in 2014, the ACA will have an impact on almost every other aspect of your health care. That's why you should understand the following basics about the law as you choose your new CareFirst health insurance plan.

- The ACA guarantees that no one can be denied coverage or be charged more because they're sick or because they have a pre-existing medical condition.
- The law also requires that each state's plans *all cover the same core benefits*. So all of the plans you're about to review will offer these **Essential Health Benefits**:
  - ☐ Ambulatory patient services
  - ☐ Emergency services
  - ☐ Maternity & newborn care
  - ☐ Hospitalization
  - ☐ Prescription drugs
  - ☐ Mental health/substance abuse services
  - ☐ Laboratory services
  - ☐ Rehabilitative/habilitative services & devices
  - ☐ Preventive/wellness care
  - ☐ Pediatric dental & vision services
- All plans (except Young Adult Catastrophic) must fit into one of 4 **Metal Levels**. Bronze, Silver, Gold & Platinum plans all cover the same benefits, but each level differs in how much of your care you'll pay. You'll find details about all plan types in the next section.
- To help make health insurance more affordable, the federal government offers **Financial Assistance, called Subsidies**. You may qualify if your projected 2014 household income is:
  - ☐ less than $45,960 for an Individual
  - ☐ less than $62,040 for a Family of 2
  - ☐ less than $78,120 for a Family of 3
  - ☐ less than $94,200 for a Family of 4
  - ☐ less than $110,280 for a Family of 5

  We used 2013 income levels above to give you an idea of the income levels that may qualify for Subsidies. These levels change slightly each year. You'll find detailed information on **www.CareFirst.com/healthreform.**

The next section outlines some other things you should understand, to make choosing your health insurance plan easier.

What you need to know before you shop

Now that you have a basic understanding of health care reform (ACA), you should also understand some of the ways it will affect the plans you're about to compare, and what you'll pay.

Before you actually start comparing, spend a few minutes now to make sure you're comfortable with the terms used to describe how plans provide coverage. We've broken it down into two sections: terms related to plans and providers, and financial-related terms.

Plans & providers

Provider Network—CareFirst has a large group or "network" of providers—doctors, hospitals and pharmacies—you receive benefits and services from.

Plan Types—**(HMO, PPO, POS)** refer to how your plan provides coverage and which network of providers you receive care from. The differences have to do with how much freedom you have when choosing providers, balanced with how much of that provider's costs you will have to pay.

- CareFirst's **HMO** plans use the BlueChoice network. When you see any of our more than 28,000 participating providers, you'll save the most money. Except for emergency services, if you go outside of the BlueChoice network, your medical services will not be covered.
- CareFirst's **PPO** plans offer the most choice. You can receive care from the PPO network of more than 34,000 providers locally and thousands nationally. In addition, you can pay slightly more to go out-of-network.
- With our more flexible **POS** plans, your cost depends on which network you get your services in. POS policyholders can see providers:
  - in the HMO network for the most savings
  - in the PPO network and pay slightly more
  - outside of CareFirst's networks, where you'll likely pay charges that exceed CareFirst's Allowed Amount.

What's in a name?

Our 4 plan names tell you what type of plan it is.

- **BlueChoice** plans are HMO plans
- **BluePreferred** plans are PPO plans
- **HealthyBlue** and **BlueChoice Plus** plans are POS plans

Paying for coverage & care

Premium—the money you pay each month for your plan, or policy, is your premium. Premiums are based on your age, where you live, the family members the plan will cover, and how much of your health care costs the plan pays.

Allowed Amount—is the fee that providers in CareFirst's network have agreed to accept for a particular medical service. CareFirst has negotiated very favorable discounts on medical services for the people we insure. If you see a doctor who is not on your plan's network who charges more, the difference is your responsibility.

Cost Sharing—the portion of your health care costs that your plan doesn't pay is your share. Generally, the more costs you're willing to pay, the lower your premiums. The less cost sharing you want to be responsible for, the higher your premiums will be.

Cost sharing is different from your premium. It's made up of three things:

- **Deductible**—is the amount of money you must pay each calendar year before a plan begins paying its portion of your costs. "Meeting your deductible" of $1,500, for example, means you'll pay the first $1,500 for health care services covered by your plan, and then CareFirst will start paying for part or all of the services after that. Only costs based on CareFirst's Allowed Amount will count toward your deductible.

  Look closely at the plan options you are considering. All of them offer no charge preventive care that is not subject to a deductible. Some even cover all primary care visits, urgent care and generic drugs without needing to meet a deductible first.

- **Copayment**—or "copay" is a fixed-dollar amount you pay when you visit a provider, like $25 when you visit a doctor, or $100 for a trip to the emergency room. Depending on the plan, you may pay copays before or after you meet your deductible.

- **Coinsurance**—is the percentage you pay of the Allowed Amount after you've met your deductible. So if your plan has "20% coinsurance," you would pay $20 for a $100 charge, and CareFirst would pay the remaining $80.

Out-of-Pocket Maximum—is the most you will have to pay in deductibles, copays, coinsurance and prescription drug costs in a calendar year. After that, CareFirst will pay 100% of the Allowed Amount for covered services—except for your premiums—for the rest of that year.

How much will I pay for medical services?

**Depending on the plan, you may have coverage for certain services even before you meet your deductible*

HSA-Compatible Plans—can help lower your health care costs. HSA stands for Health Savings Account, a tax-deductible account that works like an IRA for health expenses. CareFirst offers five HSA-compatible plans that can help lower health care costs for high-deductible, lower-premium plans. By contributing tax-deductible money (usually the money you save on lower premiums), you build up savings in your HSA that you use to cover you, your spouse and your dependents—even if they are not enrolled in your medical plan.

Opening an HSA provides you with a number of benefits, including:

- *Tax Savings*—Your deposits and the interest you earn are tax-free, as is the money you take out to pay for qualified medical expenses.
- *Freedom & Control*—Use the money in your HSA to pay for things like your copays, prescriptions and dental and vision care.
- *Portability*—Your HSA account balance is yours even if you change your health plan or move out of state.
- *Growth*—Balances can grow because they earn interest. You can also use other bank investment services to grow your savings even more.
- *Long-Term Access*—Unused funds roll over and accumulate year to year; there's no "use it or lose it" rule.
- *Retirement Savings*—When you turn 65, you can use money in your HSA Bank Account as retirement savings, or continue to use it for medical expenses.

Federal Financial Subsidies—as you saw in the ACA overview on page 3, there is financial help available for people with certain incomes to help make health care more affordable. There are two kinds of Subsidies available:

- **The Premium Subsidy**—helps reduce monthly premiums, so less of your income is spent on buying health insurance. If you qualify, the money can be sent directly to CareFirst, leaving a smaller premium (if any) for you to pay. You must apply for this Subsidy on Virginia's Health Insurance Marketplace (also known as Exchange) and it can only be used to help you pay for a plan purchased on the Marketplace. You can use this Subsidy on any ACA plan except the BlueChoice Young Adult (Catastrophic) plan, discussed in the next section.
- **The Cost-Share Subsidy**—lowers the maximum dollar amount you are required to pay for out-of-pocket expenses. Lowering your maximum means your plan begins paying 100% of your costs earlier than it would have without the help. The Cost-Share Subsidy is available only for Silver Plans bought on the Marketplace.

If you qualify for a Subsidy, you can still purchase a CareFirst plan; you will just have to buy it on the public Marketplace, which, again, is the only place you can apply for Subsidies. To get more detailed information, visit your Health Insurance Marketplace at **www.Healthcare.gov.**

Paying taxes vs. paying for health care

For example...	*$3,300 without an HSA*	*$3,300 in an HSA*
Federal tax (25%)	$825	$0
Virginia tax (4%)	$132	$0
Social Security & Employment Taxes (7.65%)	$252	$0
Total taxes paid	$1,209	$0
Portion left to pay for your medical expenses	$2,091	$3,300
Tax savings	**$0**	**$1,242**

For illustration purposes only. Your rates may differ.

Prescription coverage

All prescription drug charges count toward your out-of-pocket maximums. You'll pay your share in the form of coinsurance or a copay. You'll pay different amounts for different types of drugs (ranked into tiers/categories), with generics costing the least. For example, you can get a 3-month supply of a generic maintenance drug for just 2 copays at our participating retail stores. Learn more at **CareFirst.com/rx.**

Generic drugs work the same as brand-name drugs, but cost much less. So you'll pay less to use them. Some plans also divide generics into Preferred Generics and Non-preferred Generics based on cost.

Preferred Brand drugs are brand-name medications that are not yet available in generic form, but are chosen for their effectiveness and affordability compared to alternatives. They cost more than Generics, but less than Non-preferred Brand drugs.

- If a Generic drug becomes available, the Preferred Brand drug will be moved to the Non-preferred Brand category.

Non-preferred Brand drugs are often available in less-expensive forms, either as Generics or Preferred Brand drugs. You will pay more for this category of drugs.

- Mandatory Generic Substitution: If your provider prescribes a Non-preferred Brand drug and you get a Non-preferred Brand drug when a Generic is available, you will pay the Non-preferred Brand copay or coinsurance PLUS the difference between the Generic and Non-preferred Brand drug cost up to the cost of the prescription.

Specialty drugs (excluding insulin) often have the highest out-of-pocket cost. In most cases, these are high-cost prescription drugs that may require special handling, administration or monitoring and may be oral or injectable medications used to treat serious or chronic medical conditions.

You should ask your provider to prescribe a generic drug, or choose a generic version of the prescribed brand-name drug if one is available.

Again depending on the plan, you may have to meet your plan's deductible before prescription coverage begins (it is "integrated" with your other medical expenses). Other plans have a separate, lower deductible just for drugs, which gives you drug coverage much sooner. We've included an outline of prescription benefits in the fold-out chart that came with this book. Check out line 37 in that chart for details.

Choosing your CareFirst health care plan

Understanding your plans

What you get with *every* CareFirst plan

As you review the details of each plan in the following pages, and in the fold-out chart, keep in mind that **all** CareFirst plans feature the following benefits:

- **A vast network of at least 28,000 providers**
- **No charge, no deductible for in-network:**
  - adult physicals
  - well-child exams and immunizations
  - OB/GYN visits
  - cancer screenings including mammograms, pap tests, prostate and colorectal screenings
  - routine pre-natal maternity services
  - preventive maternity services
- **No referrals needed to see a specialist**
- **Over 60,000 pharmacies nationwide**
- **Vision and dental coverage for kids under age 19**
- **No charge, no deductible adult eye exam every 12 months**
- **24-hour advice by a registered nurse with NurseLine—FirstHelp™**
- **Discounts on contact lenses, laser vision correction surgery and glasses**
- **Exclusive discounts on health and wellness services such as:**
  - weight loss programs
  - discounted gym memberships
  - personal trainers & spa services
  - massage therapy
  - and more (see pages 27–28)
- **Away From Home Care**
  - Some Blues plans offer policyholders living temporarily in other states the same coverage they have at home. See participating states on page 28.

Understanding metal levels

CareFirst's plans within each Metal Level give you choices of networks, different cost-sharing arrangements and, of course premiums. Here's a summary of what you can expect to find in each Metal Level.

Highest annual deductibles
Lowest monthly premiums
Three tax-saving HSA options

- **Bronze Level Plans** feature our lowest premiums for people willing to pay a larger share of their health care costs. Offering a full range of provider networks, our four Bronze plans feature three with a money-saving HSA option. *Premium subsidy option available.*

Higher annual deductibles
Lower monthly premiums
Two tax-saving HSA options

- **Silver Level Plans** combine slightly higher premiums with modest deductibles. Two plans have an HSA option and two cover additional medical services before you meet the plan's deductible. *Premium and cost-share subsidies available.*

Lower annual deductibles
Higher monthly premiums
Additional no-cost services

- **Gold Level Plans** appeal to people who want to pay a higher premium in exchange for a plan with lower deductibles. Three of the four plans feature additional services you can use before having to meet a deductible. *Premium subsidy option available.*

No annual deductibles
Highest monthly premiums
Additional no-cost services

- **Platinum Level Plans** have no deductible, so they begin paying their share of health care costs immediately. Their higher premiums also shrink out-of-pocket maximums to the lowest of any of our plans. *Premium subsidy option available.*

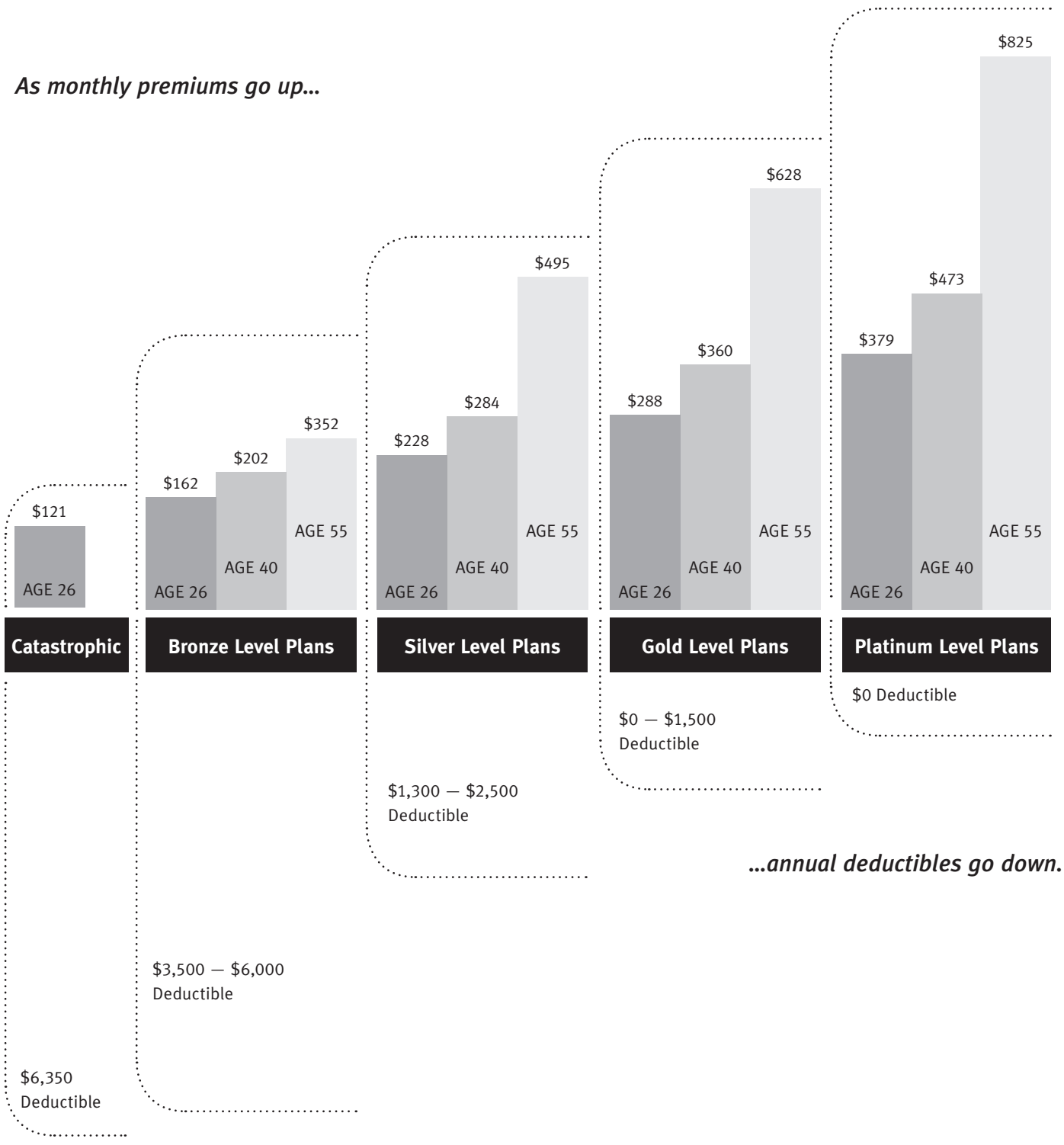
High annual deductible
Lower monthly premium
"Safety net" for serious incident

- While not technically a Metal Level, **BlueChoice Young Adult (Catastrophic Coverage)** is the affordable alternative to living without any health insurance, with premiums of about $121 a month. Instead of having to pay tens or even hundreds of thousands of dollars that a serious injury or illness could cost, people under age 30* with this "safety net" plan would have those expenses capped at $6,350 for the calendar year they occurred in.

*Also available to people who have received certification from an Exchange that they are exempt from the individual mandate because they do not have an affordable coverage option or because they qualify for a hardship exemption. Visit your public Exchange for more details.

Snapshot comparison of plans

Here you can see how each type of plan relates to annual premiums* and individual annual deductible.



* Rates are based on the average for each plan per metal level for the age indicated.

Narrowing down your selection

This chart shows the features people use most often to compare plans. Use it to find your top 3 or 4 choices—based on plan type or deductible, or specific features like the option to add an HSA account, or out-of-network coverage, coinsurance level...whatever's most important to you. Check the plans you want to find your rates for, which is what awaits in the next section.

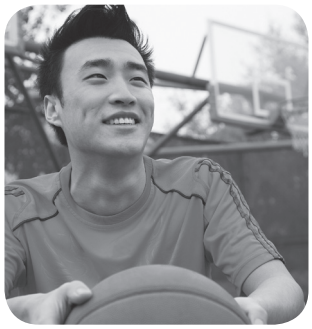
	Catastrophic	Bronze Level Plans				Silver Level Plans	
Plan Name	**BlueChoice Young Adult * $6,350**	**BlueChoice HSA Bronze $6,000**	**BlueChoice Plus Bronze $5,500**	**BlueChoice HSA Bronze $4,000**	**BluePreferred HSA Bronze $3,500**	**BlueChoice Plus Silver $2,500**	**BlueChoice Silver $2,000**
Check to compare plans	☐	☐	☐	☐	☐	☐	☐
Plan Type (page 5)	HMO	HMO	POS	HMO	PPO	POS	HMO
You Pay (page 6)							
Individual Deductible	$6,350	$6,000	$5,500	$4,000	$3,500	$2,500	$2,000
Individual Out-of-Pocket Max	$6,350	$6,000	$6,350	$6,350	$6,350	$6,350	$6,350
Coinsurance	0%	0%	20%	30%	20%	20%	20%
Copays (PCP/ Specialist)	$0	$0	$35 / $45	$30 / $40	$30 / $40	$20 / $40	$30 / $40
Plan Features							
Lower Deductible							
Out-of-Network Coverage			✓		✓	✓	
Pay no deductible for PCP, urgent care and preferred generics			✓			✓	✓
No-charge and no-deductible for PCP, labs, x-rays and generic drugs							
HSA-Compatible (page 7)		✓		✓	✓		
HealthyRewards Program (page 25)							
Non-emergency coverage in the U.S. (page 28)			✓		✓	✓	
Pediatric Dental	✓	✓	✓	✓	✓	✓	✓

* Available to individuals under the age of 30. Also available to people who have received certification from an Exchange that they are exempt from the individual mandate because they do not have an affordable coverage option or because they qualify for a hardship exemption. Visit your public Exchange for more details.

Silver Level Plans		Gold Level Plans				Platinum Level Plans	
BluePreferred HSA Silver $1,500	**BlueChoice HSA Silver $1,300**	**HealthyBlue Gold $1,500**	**BlueChoice Gold $1,000**	**BluePreferred Gold $500**	**BlueChoice Gold $0**	**BluePreferred Platinum $0**	**HealthyBlue Platinum $0**
☐	☐	☐	☐	☐	☐	☐	☐
PPO	HMO	POS	HMO	PPO	HMO	PPO	POS
$1,500	$1,300	$1,500	$1,000	$500	$0	$0	$0
$5,500	$6,350	$3,450	$3,750	$3,750	$6,350	$1,800	$2,000
30%	20%	0%	10%	20%	30%	10%	0%
$30 / $40	$30 / $40	$0 / $40	$20 / $30	$30 / $40	$20 / $30	$20 / $30	$0 / $30
			✓	✓	✓	✓	✓
✓		✓		✓		✓	✓
		✓	✓		✓	✓	✓
		✓					✓
✓	✓						
		✓					✓
✓		✓		✓		✓	✓
✓	✓	✓	✓	✓	✓	✓	✓

A variety of plans for a variety of needs

Everyone's health insurance needs are different. We know cost is a concern when selecting the best plan for you and your family. But we also know you have specific things you want your plan to cover. As you'll see from these examples, and from our plans, our plans offer the value you've come to expect with the choices you deserve.



Like most young people, 27-year-old Kyle didn't think about health insurance much. When he found out the law was going to require him to get it, he learned about affordable plans that limit the medical expenses of a serious injury or illness that could cost him tens or hundreds of thousands of dollars. Kyle trusts CareFirst and wants to buy the BlueChoice Young Adult Plan or a Bronze plan if he qualifies for a substantial premium subsidy.

Although Amanda is excited to finally be running her own business at age 39, she doesn't get employer-sponsored health insurance like she used to. Amanda decided she is okay paying a little more each month for a low to moderate deductible similar to her old plan. She is going to look at Silver and Gold plans.

Cheryl loves her job at the small event-planning company where she's worked for two years. She trusts the owners when they say they'll offer health insurance one day. For now, because she qualifies for both Subsidies, Cheryl is going to get a Silver plan so she can save the most money.

Justin and Rose just welcomed twins into the world, so quality health insurance is even more important than it was before. Earning a decent dual income, Justin and Rose like the lower out-of-pocket and deductibles in the Gold plans, but are leaning toward Platinum plans to make sure they get the best coverage for their new family.

Dental and vision

Vision (included)

Every CareFirst health plan includes basic eye-care benefits for everyone covered by your plan. These important benefits are offered to you through our network administrator, Davis Vision. An independent company, Davis Vision does not provide CareFirst products or services, but is the administrator for the products, services and discounts described below.

Included in your CareFirst qualified health plan (age 19 and over):

- One no-charge in-network routine exam per calendar year, or
  - out-of-network exams are reimbursed up to $40 per calendar year
- If needed, get discounts of approximately 30% on:
  - eyeglass lenses, frames and contacts
  - laser vision correction
  - scratch resistant lens coating & progressive lenses
- No claims to file when you see a Davis Vision provider

For family members up to age 19, our Pediatric vision benefits include:

- One no-charge in-network eye exam per calendar year, or
  - Up to $40 reimbursement for out-of-network exam per calendar year
- No copay in Davis Vision collection (in network) for:
  - frames and basic spectacle lenses or contact lenses
- Reimbursement for single vision lenses, up to $40, and frames up to $70, from an out-of-network provider

For a routine eye exam, just call and make an appointment with one of our many providers. Remember, both the pediatric and adult vision benefits listed above are available to you for no additional charge to your monthly premium.
To locate a vision care provider, contact Davis Vision at (800) 783-5602 or visit **www.carefirst.com/doctor.**

A family approach to dental care

When you buy a CareFirst health plan, you have options to take care of your whole body, including your teeth. We have dental coverage for everyone in your family…starting with the kids, whose dental benefits are a no-charge part of all our plans.

CareFirst offers the four Dental Plans highlighted to the right for family members 19 and older. With affordable premiums, a large network and a range of deductibles and cost-sharing, CareFirst has a dental plan that's right for your family.

Want more information?

If you want more information on any one of our four optional Dental plans, including an application, just mail in the postage-paid card on the next page.

If you'd rather talk to a Product Consultant, please call (800) 544-8703.

Pediatric dental (included)

	In-Network	Out-of-Network
	Member Pays	
Individual Cost Per Day	Included in your medical plan premium-no additional monthly charge	
Deductible	$25 Individual per calendar year (Applies to Classes II, III & IV)	$50 Individual per calendar year (Applies to Classes II, III & IV)
Network	Over 3,600 providers in MD, DC, and Northern VA. 63,000 dentists nationally.	
Preventive & Diagnostic Services (Class I)	No charge	20% of Allowed Amount* (no deductible)
Basic Services (Class II) *Fillings, simple extractions, non-surgical periodontics*	20% of Allowed Amount* after deductible	40% of Allowed Amount* after deductible
Major Services – Surgical (Class III) *Surgical periodontics, endodontics, oral surgery*		
Major Services – Restorative (Class IV) *Inlays, onlays, dentures, crowns*	50% of Allowed Amount* after deductible	65% of Allowed Amount* after deductible
Orthodontic Services (Class V) when medically necessary	50% of Allowed Amount* no deductible	65% of Allowed Amount* no deductible

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.

*CareFirst payments are based upon the CareFirst Allowed Amount. Participating dentists accept 100% of the CareFirst Allowed Amounts as payment in full for covered services. Non-participating dentists may bill the member for any amount over the Allowed Amount. Providers are not required to accept CareFirst's Allowed Amounts on non-covered services. This means you may have to pay your dentist's entire billed amount for these non-covered services. At your dentist's discretion, they may choose to accept the CareFirst Allowed Amount, but are not required to do so. Please talk with your dentist about your cost for any dental services.

Optional dental plans

All CareFirst medical plans provide you with Pediatric Dental benefits. To get dental coverage for adult members aged 19 and older on your policy, you can choose from four dental plans: Dental HMO, Preferred Dental, BlueDental Preferred and Preferred Dental Plus.

	Dental HMO	Preferred Dental	BlueDental Preferred	Preferred Dental Plus
	In-Network Only	In-Network	In-Network	In-Network
		Out-of-Network Coverage available		
	Member Pays			
Individual Cost Per Day	Less than $.35	Less than $.50	Less than $1.00	Less than $1.30
Deductible	None	None	$25 Individual/$75 Family (Applies to Classes II, III & IV) per calendar year	$25 Individual/$75 Family (Applies to Classes II, III & IV) per contract year
Network	Over 580 providers in MD, DC, and Northern VA	Over 3,600 providers in MD, DC, and Northern VA	Over 3,600 providers in MD, DC, and Northern VA 63,000 dentists nationally	
Preventive & Diagnostic Services (Class I)	$20 copay per office visit	No charge	No charge	No charge
Basic Services (Class II) *Fillings, simple extractions, non-surgical periodontics*	$20-$70 copay per office visit	Not covered	20% of Allowed Amount* after deductible	20% of Allowed Amount* after deductible
Major Services – Surgical (Class III) *Surgical periodontics, endodontics, oral surgery*	Copays per service			20% of Allowed Amount* after deductible & 12 month Benefit Waiting Period
Major Services – Restorative (Class IV) *Inlays, onlays, dentures, crowns*			50% of Allowed Amount* after deductible	50% of Allowed Amount* after deductible & 12 month Benefit Waiting Period
Orthodontic Services (Class V)	Child: $2,500 per member / Adult: $2,700 per member		50% of Allowed Amount* (no deductible) when medically necessary	50% of Allowed Amount* after 12 month Benefit Waiting Period

Please note: Annual benefit maximums apply to some plans. The benefit summary above is incomplete and does not provide full benefit details.

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.

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For BlueDental Preferred and Preferred Dental Plus, you can apply online! Go to:
www.CareFirst.com/individual

The rewards of enrolling in HealthyBlue plans

We're proud our health insurance plans are there when our policyholders need them. But we're just as proud to create exclusive programs like HealthyBlue that promote, inform, encourage and actually reward you for taking an active role in living a healthy lifestyle.

More and more people are choosing our HealthyBlue plans because they actually get a financial reward for committing to living a healthier lifestyle. If you choose our HealthyBlue Gold $1,500 or our HealthyBlue Platinum $0 plan, you can earn a gift card that you can use to pay your premium, deductible, gym memberships, athletic equipment and other fitness-related items.

Each year with a HealthyBlue plan, you can earn a Healthy Reward gift card worth $200 per adult, or up to $500* per family. To qualify, HealthyBlue plan members:

- Choose a CareFirst BlueChoice PCP
- Take an online Health Assessment
- Complete a Health and Wellness Evaluation with their PCP

As you can see, Healthy Rewards is a simple process. But the benefits are far greater than a gift card. Because the gift of better health can last a lifetime.

Learn more about Healthy Rewards at **www.CareFirst.com/healthyblue** for a full list of eligible items.

?

HealthyBlue plan holders can use the Healthy Reward they earn on everything from:

Hearing aids	to	hunting gear
Blood tests	to	boys' or girls' camps
Eldercare	to	exercise equipment
Dental xrays	to	diet workshops
BP monitors	to	bicycle parts

See the full list at **www.CareFirst.com/healthyblue**

HealthyBlue
Focused on you.

*Children age 2–17 can receive $25 by completing Steps 1–3. Children under age 2 are not eligible for a Healthy Reward.

Taking your health to the next level

CareFirst believes everyone has a vibrant, healthy person inside them. And whether you've been healthy all your life, or simply aspire to be, our renowned Health & Wellness program offers the information, inspiration and communication you need to look great, feel great and to be great! CareFirst offers a community like no other for you to reach your health and wellness goals. Here are some of the ways we do it.

Healthy deals

Blue365 is an exciting program that offers exclusive health and wellness deals to keep you healthy and happy, every day of the year. Blue365 delivers great discounts from top national and local retailers on fitness gear, gym memberships, family activities, healthy eating and more.

Visit **www.CareFirst.com/wellnessdiscounts** for the latest deals.

24/7 access to a registered nurse

You can't always plan when you'll need a trusted answer to a health care questions. With Nurse Line—First Help™, you can plan on having a nurse answer your call to help guide you to the best care for the situation. You deserve to have a reliable answer to your questions. When you call 800-535-9700, that's exactly what you'll get.

The info you need, at your fingertips

CareFirst gives you a world of valuable information online at **www.CareFirst.com/mycarefirst**. More than 300 interactive health tools are waiting for you, as well as 400+ podcasts, searchable recipes, video, tutorials and an encyclopedia with info on more than 3,000 conditions.

Keep track of your health with our Pedometer App

If you've got an iPhone, iPod Touch or Droid, you've got a powerful way to control your weight, reduce stress, strengthen your heart and lungs and improve bone density. The free *Ready, Step, Go!* App counts your steps, distance traveled and calories burned. Search for it on your favorite app store.

Stay in the know

Vitality Magazine has tools to help you achieve a healthier lifestyle. Three times a year you'll get info on health and wellness topics, updates to your health plan, articles about nutrition, preventive health, physical fitness and more…all free of charge! **www.CareFirst.com/vitality.**

Wellness in your Inbox

Want even more frequent news you can use to be the healthiest you ever? Every month, we'll send you more articles and recipes, personalized to the areas of interest you choose when you sign up online at **www.CareFirst.com/healthnews.**

Health Coaching by phone

Some of us achieve our goals faster with the help and encouragement of another person. Our Telephone Health Coaching program will give you confidence as you learn new and positive lifestyle behaviors. You can get your coaching through a secure, private Web-based message board and by phone to develop a personalized plan with milestones along the way to achieving your goals. Everyone needs a coach now and then. Yours is waiting for you.

Away from home care

You and your family have access to routine and urgent care when you're away from home for more than 90 consecutive days in these participating states: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Texas, Virginia, and Wisconsin.

Account info to go!

The free *My Account* mobile app puts the account information you need just a tap or swipe away. It lets you take a more active role in managing your care, accessing your claims info and having an easy backup view of your ID card. It's also a quick way to find a doctor or urgent care provider when you need one fast. Optimized for smartphones and tablets, you'll find the *My Account* app in your favorite app store: just do a search for "CareFirst" and you'll be set!

Staying connected

We've been committed to being an active part of your community for more than 75 years, and that includes the online communities you spend time in. Join our 10,000+ Facebook followers and contribute to our vibrant Twitter community to get the latest information on health care reform, healthy recipes, wellness tips, fitness challenges and great prizes—directly to your news feed. Or check us out on YouTube to learn about the basics of health care reform and how it will impact you.

Enroll today

Three ways to enroll in your new CareFirst plan

At this point, you should have decided on the CareFirst plan that's best for your needs. You're almost done!

There are three ways you can enroll for your new plan, if you live in the cities of Alexandria and Fairfax, the town of Vienna, Arlington County and the areas of Fairfax and Prince William Counties in Virginia lying east of Route 123.

- Enroll online at:
  - **www.CareFirst.com/individual**

  It's fast and you'll get an instant confirmation.
- Use this paper application and mail it to us in the pre-paid envelope. We'll mail you a confirmation.
- Enroll through your broker.

When you're ready to review a listing of providers, visit **www.CareFirst.com/findadoc.** If you'd prefer a printed directory, give us a call and we'll send you one.

If you're still undecided about which CareFirst plan is best for you, give one of our Product Consultants a call at (410) 356-8000 or toll free at (800) 544-8703, 7 days a week, 8:00 am – 8:00 pm.

Need language assistance?

You can use the same number for our no-charge bi-lingual services.

Ready to buy your CareFirst plan with financial assistance?

To apply for a plan with Subsidies you must contact Virginia's Health Insurance Marketplace.

When your coverage will start

The effective date is the date your coverage begins.

Enroll:	*For effective date of:*
Oct. 1 – Dec. 20	Jan. 1, 2014
Dec. 21 – Jan. 20	Feb. 1, 2014
Jan. 21 – Feb. 20	Mar. 1, 2014
Feb. 21 – Mar. 20	Apr. 1, 2014
Mar. 21 – Mar. 31	May 1, 2014

Note: If you are enrolling through Virginia's Health Insurance Marketplace, please be sure to check your effective date directly with the Marketplace. The dates listed above apply to enrollments through CareFirst.com only.

Paying for your plan

Payment is due before your effective date in order for your coverage to begin.

If you enroll through:	*Send your first premium:*
The CareFirst site	before your effective date
This paper form	within 30 days (we'll mail you a bill)
Virginia's Health Insurance Marketplace	within 30 days of enrollment

Convenient e-Billing

When you set up automated recurring monthly premium payments, your first payment will be sent to CareFirst automatically. You can also set it up in Section 7 of this application or online at **www.CareFirst.com/myaccount** where you'll be able to view and pay bills and monitor payments 24/7.

Additional information

Our commitment to you

CareFirst's privacy practices

The following statement applies to CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield, and their affiliates (collectively, CareFirst).

When you apply for any type of insurance, you disclose information about yourself and/or members of your family. The collection, use and disclosure of this information are regulated by law. Safeguarding your personal information is something that we take very seriously at CareFirst. CareFirst is providing this notice to inform you of what we do with the information you provide to us.

Categories of Personal Information We May Collect

We may collect personal, financial and medical information about you from various sources, including:

- Information you provide on applications or other forms, such as your name, address, social security number, salary, age and gender.
- Information pertaining to your relationship with CareFirst, its affiliates or others, such as your policy coverage, premiums and claims payment history.
- Information (as described in preceding paragraphs) that we obtain from any of our affiliates.
- Information we receive about you from other sources, such as your employer, your provider and other third parties.

How Your Information Is Used

We use the information we collect about you in connection with underwriting or administration of an insurance policy or claim or for other purposes allowed by law. At no time do we disclose your personal, financial and medical information to anyone outside of CareFirst unless we have proper authorization from you or we are permitted or required to do so by law. We maintain physical, electronic and procedural safeguards in accordance with federal and state standards that protect your information.

In addition, we limit access to your personal, financial and medical information to those CareFirst employees, brokers, benefit plan administrators, consultants, business partners, providers and agents who need to know this information to conduct CareFirst business or to provide products or services to you.

Disclosure of Your Information

In order to protect your privacy, affiliated and nonaffiliated third parties of CareFirst are subject to strict confidentiality laws. Affiliated entities are companies that are a part of the CareFirst corporate family and include health maintenance organizations, third party administrators, health insurers, long-term care insurers and insurance agencies. In certain situations related to our insurance transactions involving you, we disclose your personal, financial and medical information to a nonaffiliated third party that assists us in providing services to you. When we disclose information to these critical business partners, we require these business partners to agree to safeguard your personal, financial and medical information and to use the information only for the intended purpose, and to abide by the applicable law. The information CareFirst provides to these business partners can only be used to provide services we have asked them to perform for us or for you and/or your benefit plan.

Changes in Our Privacy Policy

CareFirst periodically reviews its policies and reserves the right to change them. If we change the substance of our privacy policy, we will continue our commitment to keep your personal, financial and medical information secure – it is our highest priority. Even if you are no longer a CareFirst customer, our privacy policy will continue to apply to your records. You can always review our current privacy policy online at **www.CareFirst.com.**

Rights and responsibilities

Notice of Privacy Practices

CareFirst BlueCross BlueShield (CareFirst) is committed to keeping the confidential information of members private. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to send our Notice of Privacy Practices to members. This notice outlines the uses and disclosures of protected health information, the individual's rights and CareFirst's responsibility for protecting the member's health information.

To obtain an additional copy of our Notice of Privacy Practices, go to **www.CareFirst.com** and click on *"Legal Mandates"* at the bottom of the page, click on *"Patient Rights & Responsibilities"* then click on *"Members Privacy Policy."*

Member Satisfaction

CareFirst wants to hear your concerns and/or complaints so that they may be resolved. We have procedures that address medical and non-medical issues. If a situation should occur for which there is any question or difficulty, here's what you can do:

- If your comment or concern is regarding the quality of service received from a CareFirst representative or related to administrative problems (e.g., enrollment, claims, bills, etc.) you should contact Member Services. If you send your comments to us in writing, please include your member ID number and provide us with as much detail as possible regarding any events. Please include your daytime telephone number so that we may contact you directly if we need additional information.
- If your concern or complaint is about the quality of care or quality of service received from a specific provider, contact Member Services. A representative will record your concerns and may request a written summary of the issues. To write to us directly with a quality of care or service concern, you can:
  - ☐ Send an email to: **quality.care.complaints@carefirst.com**
  - ☐ Fax a written complaint to: (301) 470-5866
  - ☐ Write to: **CareFirst BlueCross BlueShield Quality of Care Department, P.O. Box 17636, Baltimore, MD 21297**

If you send your comments to us in writing, please include your identification number and provide us with as much detail as possible regarding the event or incident. Please include your daytime telephone number so that we may contact you directly if we need additional information. Our Quality of Care Department will investigate your concerns, share those issues with the provider involved and request a response. We will then provide you with a summary of our findings. CareFirst member complaints are retained in our provider files and are reviewed when providers are considered for continuing participation with CareFirst.

If you wish, you may also contact the appropriate jurisdiction's regulatory department regarding your concern:

Virginia Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Toll-free within Virginia: 1-800-552-7945
804-371-9691

Complaint Intake
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, VA 23233-1463
Toll free: 1-800-955-1819
Richmond metropolitan area: 804-367-2106
Fax: 804-527-4503
E-mail: mchip@vdh.virginia.gov

For assistance in resolving a billing or payment dispute with the health plan or a health care provider, contact the Health Education and Advocacy Unit of the Consumer Protection Division of the Office of the Attorney General at:

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Toll-free: 1-877-310-6560
804-371-9032
Email: Ombudsman@scc.virginia.gov

Hearing Impaired

To contact a Member Services representative, please choose the appropriate hearing impaired assistance

number below, based on the region in which your coverage originates.

Maryland Relay Program: (800) 735-2258
National Capital Area TTY: (202) 479-3546.
Please have your Member Services number ready.

Language Assistance

Interpreter services are available through Member Services. When calling Member Services, inform the representative that you need language assistance.

Note: CareFirst appreciates the opportunity to improve the level of quality of care and services available for you. As a member, you will not be subject to disenrollment or otherwise penalized as a result of filing a complaint or appeal.

Confidentiality of Subscriber/ Member Information

All health plans and providers must provide information to members and patients regarding how their information is protected. You will receive a Notice of Privacy Practices from CareFirst or your health plan, and from your providers as well, when you visit their office.

CareFirst has policies and procedures in place to protect the confidentiality of member information. Your confidential information includes Protected Health Information (PHI), whether oral, written or electronic, and other nonpublic financial information. Because we are responsible for your insurance coverage, making sure your claims are paid, and that you can obtain any important services related to your health care, we are permitted to use and disclose (give out) your information for these purposes. Sometimes we are even required by law to disclose your information in certain situations. You also have certain rights to your own protected health information on your behalf.

Our Responsibilities

We are required by law to maintain the privacy of your PHI, and to have appropriate procedures in place to do so. In accordance with the federal and state Privacy laws, we have the right to use and disclose your PHI for treatment, payment activities and health care operations as explained in the Notice of Privacy Practices. We may disclose your protected health information to the plan sponsor/employer to perform plan administration function. The Notice is sent to all policy holders upon enrollment.

Your Rights

You have the following rights regarding your own Protected Health Information. You have the right to:

- Request that we restrict the PHI we use or disclose about you for payment or health care operations.
- Request that we communicate with you regarding your information in an alternative manner or at an alternative location if you believe that a disclosure of all or part of your PHI may endanger you.
- Inspect and copy your PHI that is contained in a designated record set including your medical record.
- Request that we amend your information if you believe that your PHI is incorrect or incomplete.
- An accounting of certain disclosures of your PHI that are for some reasons other than treatment, payment, or health care operations.
- Give us written authorization to use your protected health information or to disclose it to anyone for any purpose not listed in this notice.

Inquiries and Complaints

If you have a privacy-related inquiry, please contact the CareFirst Privacy Office at (800) 853-9236 or send an email to: **privacy.office@carefirst.com**.

Members' Rights and Responsibilities Statement

Members have the right to:

- Be treated with respect and recognition of their dignity and right to privacy.
- Receive information about the health plan, its services, its practitioners and providers, and members' rights and responsibilities.
- Participate with practitioners in decision-making regarding their health care.
- Participate in a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities.

- Voice complaints or appeals about the health plan or the care provided.

Members have a responsibility to:

- Provide, to the extent possible, information that the health plan and its practitioners and providers need in order to care for them.
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Follow the plans and instructions for care that they have agreed on with their practitioners.
- Pay copayments or coinsurance at the time of service.
- Be on time for appointments and to notify practitioners/providers when an appointment must be canceled.

Eligible Individuals' Rights Statement Wellness and Health Promotion Services

Eligible individuals have a right to:

- Receive information about the organization, including wellness and health promotion services provided on behalf of the employer or plan sponsors; organization staff and staff qualifications; and any contractual relationships.
- Decline participation or disenroll from wellness and health promotion services offered by the organization.
- Be treated courteously and respectfully by the organization's staff.
- Communicate complaints to the organization and receive instructions on how to use the complaint process that includes the organization's standards of timeliness for responding to and resolving complaints and quality issues.

Compensation and premium disclosure statement

Our compensation to providers who offer health care services and behavioral health care services to our insured members or enrollees may be based on a variety of payment mechanisms such as fee-for-service payments, salary, or capitation. Bonuses may be used with these various types of payment methods.

If you desire additional information about our methods of paying providers, or if you want to know which method(s) apply to your physician, please call our Member Services Department at the number listed on your identification card, or write to:

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
Attention: Member Services

A. Methods of Paying Physicians

The following definitions explain how insurance carriers may pay physicians (or other providers) for your health care services.

The examples show how Dr. Jones, an obstetrician/gynecologist, would be compensated under each method of payment.

Salary: A physician (or other provider) is an employee of the HMO and is paid compensation (monetary wages) for providing specific health care services.

Since Dr. Jones is an employee of an HMO, she receives her usual bi-weekly salary regardless of how many patients she sees or the number of services she provides. During the months of providing pre-natal care to Mrs. Smith, who is a member of the HMO, Dr. Jones' salary is unchanged. Although Mrs. Smith's baby is delivered by Cesarean section, a more complicated procedure than a vaginal delivery, the method of delivery will not have an effect upon Dr. Jones' salary.

Capitation: A physician (or group of physicians) is paid a fixed amount of money per month by an HMO for each patient who chooses the physician(s) to be his or her doctor. Payment is fixed without regard to the volume of services that an individual patient requires.

Under this type of contractual arrangement, Dr. Jones participates in an HMO network. She is not employed by the HMO. Her contract with the HMO stipulates that she is

paid a certain amount each month for patients who select her as their doctor. Since Mrs. Smith is a member of the HMO, Dr. Jones monthly payment does not change as a result of her providing ongoing care to Mrs. Smith. The capitation amount paid to Dr. Jones is the same whether or not Mrs. Smith requires obstetric services.

Fee-for-Service: A physician (or other provider) charges a fee for each patient visit, medical procedure, or medical service provided. An HMO pays the entire fee for physicians it has under contract and an insurer pays all or part of that fee, depending on the type of coverage. The patient is expected to pay the remainder.

Dr. Jones' contract with the insurer or HMO states that Dr. Jones will be paid a fee for each patient visit and each service she provides. The amount of payment Dr. Jones receives will depend upon the number, types, and complexity of services, and the time she spends providing services to Mrs. Smith. Because Cesarean deliveries are more complicated than vaginal deliveries, Dr. Jones is paid more to deliver Mrs. Smith's baby than she would be paid for a vaginal delivery. Mrs. Smith may be responsible for paying some portion of Dr. Jones' bill.

Discounted Fee-for-Service: Payment is less than the rate usually received by the physician (or other provider) for each patient visit, medical procedure, or service. This arrangement is the result of an agreement between the payer, who gets lower costs and the physician (or other provider), who usually gets an increased volume of patients.

Like fee-for-service, this type of contractual arrangement involves the insurer or HMO paying Dr. Jones for each patient visit and each delivery; but under this arrangement, the rate, agreed upon in advance, is less than Dr. Jones' usual fee. Dr. Jones expects that in exchange for agreeing to accept a reduced rate, she will serve a certain number of patients. For each procedure that she performs, Dr. Jones will be paid a discounted rate by the insurer or HMO.

Bonus: A physician (or other provider) is paid an additional amount over what he or she is paid under salary, capitation, fee-for-service, or other type of payment arrangement. Bonuses may be based on many factors, including member satisfaction, quality of care, control of costs and use of services.

An HMO rewards its physician staff or contracted physicians who have demonstrated higher than average quality and productivity. Because Dr. Jones has delivered so many babies and she has been rated highly by her patients and fellow physicians, Dr. Jones will receive a monetary award in addition to her usual payment.

Case Rate: The HMO or insurer and the physician (or other provider) agree in advance that payment will cover a combination of services provided by both the physician (or other provider) and the hospital for an episode of care.

This type of arrangement stipulates how much an insurer or HMO will pay for a patient's obstetric services. All office visits for prenatal and postnatal care, as well as the delivery, and hospital-related charges are covered by one fee. Dr. Jones, the hospital, and other providers (such as an anesthesiologist) will divide payment from the insurer or HMO for the care provided to Mrs. Smith.

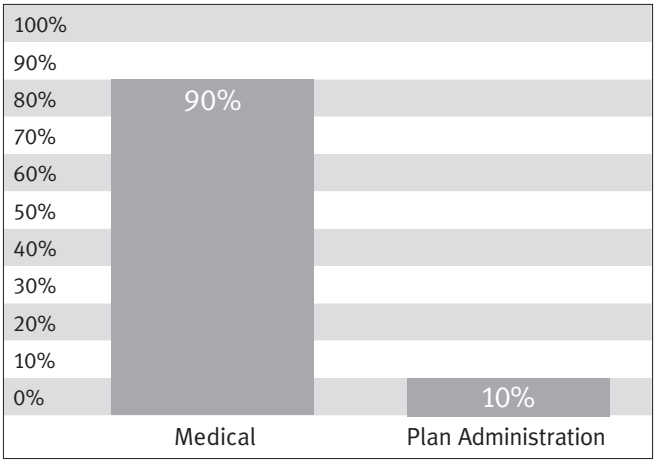
B. Percentage of Provider Payment Methods

CareFirst BlueChoice, Inc. is a network model HMO and contracts directly with the primary care and specialty care providers. According to this type of arrangement, CareFirst BlueChoice, Inc. reimburses providers primarily on a discounted fee-for-service payment method. The provider payment method percentages for CareFirst BlueChoice, Inc. are approximately 99% discounted fee-for-service with less than 1% capitated.

C. Distribution of Premium Dollars

The bar graph below illustrates the proportion of every $100 in premium used by CareFirst BlueChoice, Inc. to pay physicians (or other providers) for medical care expenses, and the proportion used to pay for plan administration.

These numbers represent an average for all HMO accounts based on our annual statement. The ratio of direct medical care expenses to plan administration will vary by account.



Exclusions and limitations

References to specific Sections are to pages in the member contract and not to pages in this brochure.

16.1 General Exclusions

Coverage is not provided for:

A. Any services, tests, procedures, or supplies which CareFirst determines are not necessary for the prevention, diagnosis, or treatment of the Member's illness, injury, or condition. Although a service or supply may be listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in the Member's particular case.

B. Any treatment, procedure, facility, equipment, drug, drug usage, device, or supply which, in CareFirst's judgment, is Experimental/Investigational, or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment, except for covered benefits for clinical trials.

C. The cost of services that:
   1. Are furnished without charge; or
   2. Are normally furnished without charge to persons without health insurance coverage; or
   3. Would have been furnished without charge if a Member were not covered under the Agreement or under any health insurance.

      This exclusion does not apply to:
      a) Medicaid;
      b) Care received in a Veteran's hospital unless the care is rendered for a condition that is a result of a Member's military service.

D. Any service, supply, drug or procedure that is not specifically listed in the Member's Agreement as a covered benefit or that do not meet all other conditions and criteria for coverage as determined by CareFirst, except as required to be covered under state or federal laws and regulations. Provision of services by a health care provider does not, by itself, entitle a Member to benefits if the services are not covered or do not otherwise meet the conditions and criteria for coverage.

E. Routine, palliative, or Cosmetic foot care (except for conditions determined by CareFirst to be Medically Necessary such as care rendered for diabetes or vascular disease), including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.

F. Any type of dental care (except treatment of accidental bodily injuries, oral surgery, cleft lip or cleft palate or both, or ectodermal dysplasia and pediatric dental services listed in the sections noted below), including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess and periodontal disease, removal of teeth, orthodontics, replacement of teeth, or any other dental services or supplies. Benefits for accidental bodily injury are described in Section 1.22.A. Benefits for oral surgery are described in Section 1.23. Benefits for treatment of cleft lip, cleft palate or both or ectodermal dysplasia are described in Section 1.5.E and Section 1.24. Benefits for pediatric dental services are described in Section 2. All other procedures involving the teeth or areas and structures surrounding and/or supporting the teeth, including surgically altering the mandible or maxillae (orthognathic surgery) for Cosmetic purposes or for correction of malocclusion unrelated to a documented functional impairment are excluded.

G. Cosmetic surgery (except benefits for reconstructive breast surgery or 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 CareFirst. This exclusion includes treatment of varicose veins or telangiectatic dermal veins (spider veins) for cosmetic purposes.

H. Treatment rendered by a health care provider who is the Member's Spouse, parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew, or resides in the Member's home.

I. All non-Prescription Drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained without a prescription and self-administered by the Member, except as listed as a Covered Service above, including but not limited to: cosmetics or health and beauty aids, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions, except for Over-the-Counter medication or supplies dispensed under a written prescription by a health care provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B".

J. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.

K. All assisted reproductive technologies including artificial insemination and intrauterine insemination, 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.

L. Services to reverse voluntary, surgically induced infertility, such as a reversal of a sterilization.

M. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.

N. Expenses related to a surrogate pregnancy when the surrogate is not a Member.

O. Paternity testing.

P. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.

Q. Fees and charges relating to fitness programs, weight loss, or weight control programs, physical 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, except for self-management training and educational services received as outpatient diabetes care or as part of a covered preventive services visit. This exclusion includes charges for health club memberships, health spa services, exercise classes, and personal trainer services. Cardiac rehabilitation programs are covered as described in Section 1.

R. Medical or surgical treatment for obesity, weight reduction, dietary control, commercial weight loss programs, or medical nutritional therapy for treatment of obesity. This exclusion does not apply to:

1. Surgical procedures for the treatment of Morbid Obesity;
2. Well child care visits for obesity evaluation and management;
3. Evidence-based items or services for preventive care and screening for obesity that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);
4. For infants, children, and adolescents, evidence-informed preventive care and screening for obesity provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
5. Office visits for the treatment of childhood obesity.

S. Nutritional counseling and related services, except when provided as part of diabetes education, hospice care, or when received as part of a preventive services screening.

T. Nutritional and/or dietary supplements, except as provided in Section 10 or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased Over the Counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

U. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof.

V. Services that are beyond the scope of the license of the provider performing the service.

W. Services that are solely based on court order or as a condition of parole or probation, unless approved by CareFirst.

X. Health education classes and self-help programs, other than programs for the treatment of diabetes or provided as part of a covered preventive services visit.

Y. Acupuncture services.

Z. 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 CareFirst even though they may have therapeutic value or be provided by a health care provider.

AA. 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.

BB. Non-medical services. including, but is not limited to:

1. Telephone consultations, failure to keep a scheduled visit, completion of forms (except for forms that may be required by CareFirst), copying charges or other administrative services provided by the health care provider or the health care provider's staff. This exclusion does not apply to telemedicine as described in Section 1.30.
2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under the Agreement are available for Covered Services rendered to the Member by a health care provider.

CC. Group Speech Therapy.

DD. Non-medical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.

EE. Services, drugs, or supplies the Member receives without charge while in active military service.

FF. Custodial Care.

GG. Services or supplies received before the Effective Date of the Member's coverage under the Agreement.

HH. Durable Medical Equipment or Medical Supplies associated or used in conjunction with non-covered items or services.

II. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

JJ. Work Hardening Programs. Work Hardening Program means a highly specialized rehabilitation program designed to simulate workplace activities and

surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

KK. Chiropractic services or spinal manipulation treatment other than spinal manipulation treatment for musculoskeletal conditions of the spine.

LL. Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.

MM. Biofeedback therapy, neurofeedback, and related testing.

NN. Applied behavioral analysis.

OO. Birthing centers.

16.2 Pediatric Dental Services

A. Limitations

1. Covered Dental Services must be performed by or under the supervision of a Dentist with an active and unrestricted license, within the scope of practice for which licensure or certification has been obtained.
2. Benefits will be limited to standard procedures and will not be provided for personalized restorations or specialized techniques in the construction of dentures including precision attachments, custom denture teeth and implant supported fixed or removable prostheses.
3. If a Member switches from one Dentist to another during a course of treatment, or if more than one Dentist renders services for one dental procedure, CareFirst shall pay as if only one Dentist rendered the service.
4. CareFirst will reimburse only after all dental procedures for the condition being treated have been completed (this provision does not apply to orthodontic services).
5. In the event there are alternative dental procedures that meet generally accepted standards of professional dental care for a Member's condition, benefits will be based upon the lowest cost alternative procedure.

B. Exclusions

Benefits will not be provided for:

1. Replacement of a denture or crown as a result of loss or theft.
2. Replacement of an existing denture or crown that is determined by CareFirst to be satisfactory or repairable.
3. Replacement of dentures, metal and/or porcelain crowns, inlays, onlays and crown build-ups within 60 months from the date of placement or replacement for which benefits were paid in whole or in part under the terms of the Agreement and are judged by CareFirst to be adequate and functional.
4. Gold foil fillings.
5. Periodontal appliances.
6. Bacteriologic studies, histopathologic exams, accession of tissue, caries susceptibility tests, diagnostic radiographs, and other pathology procedures, unless specifically listed as a Covered Dental Service.
7. Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service.
8. Additional fees charged for visits by a Dentist to the Member's home, to a hospital, to a nursing home, or for office visits after the Dentist's standard office hours. CareFirst shall provide the benefits for the dental service as if the visit was rendered in the Dentist's office during normal office hours.
9. Transseptal fiberotomy.
10. Orthognathic Surgery.
11. The repair or replacement of any orthodontic appliance, unless specifically listed as a Covered Dental Service.
12. Any orthodontic services after the last day of the month in which Covered Dental Services ended except as specifically described in Section 2.
13. Separate billings for dental care services or supplies furnished by an employee of a Dentist which are normally included in the Dentist's charges and billed for by them.
14. Transitional orthodontic appliance, including a lower lingual holding arch placed where there is not premature loss of the primary molar.
15. Limited or complete occlusal adjustments in connection with periodontal surgical treatment when received in conjunction with restorative service on the same date of service.
16. Orthodontic or any other services for Cosmetic purposes.
17. Oral orthotic appliances, unless specifically listed as a Covered Dental Service.
18. Bridges and recementation of bridges.

16.3 Pediatric Vision Services

Benefits will not be provided for the following:

A. Any pediatric vision service stated in Section 3 for Members over age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive covered pediatric vision services through the rest of that Calendar Year.

B. Diagnostic services, except as listed in Section 3.

C. Services or supplies not specifically approved by the Vision Care Designee where required in this Description of Covered Services.

D. Orthoptics, vision training, and low vision aids.

E. Non-prescription (Plano) lenses and/or glasses, sunglasses or contact lenses.

F. Except as otherwise provided, Vision Care services that are strictly Cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;

G. Services and materials not meeting accepted standards of optometric practice.

H. Services and materials resulting from the Member's failure to comply with professionally prescribed treatment.

I. Office infection control charges.
J. State or territorial taxes on vision services performed.
K. Special lens designs or coatings other than those described herein.
L. Replacement of lost and/or stolen eyewear.
M. Two pairs of eyeglasses in lieu of bifocals.
N. Insurance of contact lenses.

16.4 Organ and Tissue Transplants

Benefits will not be provided for the following:

A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary non-Experimental/Investigational skin grafts that are covered.
B. Any hospital or professional charges related to any accidental injury or medical condition of the donor of the transplant material.
C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst.
D. Services for a Member who is an organ donor when the recipient is not a Member.
E. Donor search services, including compatibility testing of potential donors who are not immediate, blood related family members.
F. Any service, supply, or device related to a transplant that is not listed as a benefit.

16.5 Inpatient Hospital Services

Coverage is not provided (or benefits are reduced, if applicable) for the following:

A. Private room, unless Medically Necessary and/or authorized or approved by CareFirst. 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, guest trays, and laundry charges.
C. Except for covered Emergency Services and maternity care, a health care facility admission or any portion of a health care facility admission (other than Medically Necessary Ancillary Services) that had not been approved by CareFirst, whether or not services are Medically Necessary and/or meet all other conditions for coverage.
D. Private duty nursing.
E. Care provided by interns, residents, or other hospital employees that are billed separately from the hospital.

16.6 Home Health Care Services

Coverage is not provided for:

A. Custodial Care, domestic, or housekeeping services.
B. Meals on Wheels or other similar food service arrangements.

16.7 Hospice Care Services

Benefits will not be provided for the following:

A. Services, visits, medical equipment, or supplies not authorized by CareFirst.
B. Financial and legal counseling.
C. Any services for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.
D. Reimbursement for volunteer services.
E. Chemotherapy or radiation therapy, unless used for symptom control.
F. Meals on Wheels or other similar food service arrangements.
G. Rental or purchase of renal dialysis equipment and supplies. Benefits for dialysis equipment and supplies are available in Section 10, Medical Devices and Supplies.

16.8 Mental Health and Substance Use Disorder Services

Coverage is not provided for:

A. Services solely on court order or as a condition of parole or probation unless approved or authorized by the CareFirst Medical Director.
B. Cognitive rehabilitation therapy or coma stimulation therapy.
C. Treatment of social maladjustment without symptoms of a psychiatric disorder.
D. Custodial Care.
E. Remedial or special education services.
F. Inpatient admissions for environmental changes.

16.9 Medical Devices and Supplies

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

A. Convenience Items: Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for a Member (e.g., an exercycle or other physical fitness equipment, elevators, hoyer lifts, and shower/bath bench).
B. Furniture items, movable objects or accessories that 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 not appropriate for use in the home (e.g., parallel bars).

E. Environmental control equipment: Equipment that can be

used for non-medical purposes, 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 or contact lenses, dental prostheses, appliances, or hearing aids (including the examinations to prescribe or fit hearing aids), except as otherwise provided herein for cleft lip or cleft palate or both, or ectodermal dysplasia or as stated in Section 1.21, Section 1.22.A.1, Section 2, and Section 3.

G. Corrective shoes (unless required to be attached to a leg brace), shoe lifts, or special shoe accessories or inserts.

H. Tinnitus maskers.

Experimental/ investigational services

The definition of Experimental Medical Care also referenced as Experimental and Investigational Services is as follows:

The term "experimental/ investigational" describes services or supplies that are in the developmental stage and are in the process of human or animal testing. Services or supplies that do not meet all (5) of the criteria listed below are deemed to be experimental and investigational:

1. The technology* must have final approval from the appropriate government regulatory bodies; and
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes; and
3. The technology must improve the net health outcome; and
4. The technology must be as beneficial as any established alternatives; and
5. The improvement must be attainable outside the investigational setting.

**Technology includes drugs, devices, processes, systems or techniques.*

POLICY NUMBERS:

CAT: VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO/CAT SOB (1/14)

BluePreferred HSA Bronze $3,500: VA/CF/DB/BP (1/14); VA/CF/EXC/BP/BRZ SOB (1/14)

BlueChoice HSA Bronze $4,000: VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO HSA/4000 BRZ SOB (1/14)

BlueChoice Plus Bronze $5,500: **In-Network:** VA/CFBC/DB/BCOO/INN (1/14); VA/CFBC/EXC/BC+ IN/BRZ SOB (1/14). **Out-of-Network**: VA/CF/DB/BCOO/OON (1/14); VA/CF/EXC/BC+ OON/BRZ SOB (1/14)

BlueChoice HSA Bronze $6,000: VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO HSA/6000 BRZ SOB (1/14)

BlueChoice HSA Silver $1,300: VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO HSA/SIL SOB (1/14)

BluePreferred HSA Silver $1,500: VA/CF/DB/BP/MSP (1/14); VA/CF/EXC/BP/SIL SOB (1/14)

BlueChoice Silver $2,000: VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO/SIL SOB (1/14)

BlueChoice Plus Silver $2,000: **In-Network**: VA/CFBC/DB/BCOO/INN (1/14); VA/CFBC/EXC/BC+ IN/SIL SOB (1/14). **Out-of-Network**: VA/CF/DB/BCOO/OON (1/14); VA/CF/EXC/BC+ OON/SIL SOB (1/14)

BlueChoice Gold $0: VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO/GOLD 0 SOB (1/14)

BluePreferred Gold $500: VA/CF/DB/BP MSP (1/14; VA/CF/EXC/BP/GOLD SOB (1/14)

BlueChoice Gold $1,000: VA/CFBC/DB/HMO (1/14); VA/CFBC/EXC/HMO/GOLD 1000 SOB (1/14)

HealthyBlue Gold $1,500: **In-Network**: VA/CFBC/DB/HB/INN (1/14); VA/CFBC/EXC/HB IN/GOLD SOB (1/14). **Out-of-Network**: VA/CF/DB/HB/OON (1/14); VA/CF/EXC/HB OON/GOLD SOB (1/14)

HealthyBlue Platinum $0: **In-Network**: VA/CFBC/DB/HB/INN (1/14); VA/CFBC/EXC/HB IN/PLAT SOB (1/14). **Out-of-Network**: VA/CF/DB/HB/OON (1/14); VA/CF/EXC/HB OON/PLAT SOB (1/14)

BluePreferred Platinum $0: VA/CF/DB/BP (1/14); VA/CF/EXC/BP/PLAT SOB (1/14)

AND ANY AMENDMENTS.

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CDS1103-1P (9/13)