What is HIPAA?
In 1996, the Health Insurance Portability and Accountability Act (HIPAA) was signed into law. This groundbreaking health insurance act allows you to maintain insurance coverage when you leave a group insurance plan.

All insurance policyholders are entitled to receive a “certificate of creditable coverage” when leaving one insurance plan for another. This certificate lists the amount of time a policyholder has accumulated in their health insurance plan, and can be used to reduce a pre-existing waiting period (which could be up to 12 months) when signing up for a new group insurance plan.

How Does HIPAA Affect Me?
HIPAA specifies that under certain situations, those applying for individual (non-group) health insurance coverage for themselves or their family may no longer be subject to waiting periods or be required to complete a medical underwriting questionnaire in order to obtain health insurance benefits.

Qualifying for HIPAA Coverage.
To enroll in HIPAA coverage you must submit a completed application and Certificate of Creditable Coverage. You and your covered dependents may enroll without a medical examination, waiting period or health evaluation questionnaire if all of the following criteria are met:

- Have 18 or more months of creditable coverage with the most recent coverage under individual health insurance coverage, a group employer-sponsored plan, governmental plan, church plan, State Children’s Health Insurance Plan (S-CHIP) or benefit plan offered in conjunction with any of these plans. Certificates of creditable coverage must indicate at least 18-months of aggregate health insurance coverage.
- Have elected and exhausted health insurance benefits through a COBRA or similar group, state or federal continuation plan, including the Federal Employee Health Benefits Program (FEHBP), FEHBP Temporary Continuation of Coverage (TCC) or state continuation coverage, if available.
- Have no more than a 63-day break in coverage.
- Not be eligible for Medicare A or B, Medicaid, or any other employer-sponsored plan.
- Not be covered by any other health insurance plan.
- Not have had prior insurance coverage terminated because of the applicant’s failure to pay the required premium or fraudulent/intentional misrepresentations made by the applicant.

Our Commitment to Preventive Care.
CareFirst BlueChoice aims to keep you healthy—emphasizing prevention, early detection and early treatment. That’s one of the main advantages of your coverage. We work with you to help prevent illness. We do this by offering you annual routine examinations and office visits. We encourage you to seek care when it is first needed, rather than waiting.

Well-Child Care
BlueChoice Group Conversion/HIPAA aims to start your children on the road to good health with coverage for childhood immunizations and check-ups. We believe in giving your baby a healthy start, and want to encourage parents to take advantage of this most important service.

Women’s Health / Men’s Health
In addition, BlueChoice Group Conversion/HIPAA provides women’s health coverage, such as routine mammograms and PAP tests and men’s health coverage, which includes routine prostate screenings. Colorectal cancer screenings are covered for both women and men.

Choose your own doctor.
You and your family members each choose a Primary Care Physician (PCP) from the CareFirst BlueChoice regional network to coordinate all your health care needs. Your PCP oversees your routine and preventive care, administers your prescriptions, becomes familiar with your medical history and works closely with you to help make your medical decisions. When specialized care is needed, your PCP will refer you to a specialist within the CareFirst BlueChoice network.
Your PCP is there to coordinate all of your health care needs. All CareFirst BlueChoice doctors offer 24-hour coverage, so you are never far away from proper medical advice. You and your PCP work as a team to help maintain your good health.

**Vision Care Services.**
Vision coverage can also be added to your medical plan. Vision services are offered through our network administrator, Davis Vision, Inc. When you use a provider in the Davis Vision network – which includes both independent and retail providers – you are guaranteed a routine annual eye exam, including dilation, for only $10. Additionally, through Davis Vision, Inc., you also receive discounts on frames and lenses or contact lenses.

Your vision benefits are not available until you are approved for medical coverage. Once you have been approved for coverage, you will be provided with more specific information about your vision program.

**Emergency Care—When you Need it Most.**
Each CareFirst BlueChoice physician has 24-hour coverage with doctors on call so that you are never out of reach of your PCP. Just call your doctor when assistance is needed. If the condition is serious, but not life threatening, your doctor will give you instructions on what to do next. You may be asked to visit the office immediately or to go to the nearest medical center for care.

**Discount Drug Program.**
As a CareFirst BlueChoice member, you will receive valuable discounts on prescription drugs at over 59,000 pharmacies nationwide – for free! With this program, members are guaranteed the lowest price available in that pharmacy at the time of purchase. There is no additional cost to you to take advantage of this program.

**No Hassle Billing.**
Simply present your identification card at each office visit, pay your copayment, and you’re all set. You don’t have to fill out any claim forms. And you won’t receive any “balance due” bills.

**Health Information on the Internet.**
Visit [www.carefirst.com](http://www.carefirst.com) for your own on-line interactive guide to health topics. Called “My Care First,” this site offers information on nutrition, fitness, chronic illnesses, stress, mental health, and much more. You’ll also find support if you’re trying to lose weight or quit smoking. *My Care First* covers the latest developments in medicine and health. Learn how you can maintain a healthier lifestyle.
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.

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

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 Management

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
**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 BlueChoice 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](http://www.carefirst.com).

**BlueCard® Program**

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

In addition, “Away From Home Care” membership is available in an affiliated Blue Cross and Blue Shield HMO for members and dependents away from home for at least 90 days. This special plan provides coverage for non-emergency services and is perfect for extended out-of-town business or travel, semesters at school or families living apart.

**FirstHelp® Nurse Line**

Members of CareFirst BlueChoice who are sick, injured, or have medical questions can get quick help with just a toll-free phone call. The FirstHelp® Nurse Line is staffed by registered nurses and is available 24-hours a day, 7 days a week. FirstHelp® nurses will discuss your symptoms and concerns, then help you to decide whether to contact your doctor, seek urgent care, or go to the emergency room.
## General Information

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<th>Member Deductible</th>
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### Out-of-Pocket Maximum

| Individual | $3,600 |
| Individual & Child(ren)*/Individual & Adult** | $7,200 |
| Family*** | $11,000 |

### Lifetime Maximum

| No lifetime maximum |

## Preventive Services and Office Visits

| Well-Child - Exams & Immunizations | $20 PCP/$30 Specialist |
| Adult Routine Preventive Health | $20 PCP/$30 Specialist |
| Routine Gynecological Visits (No charge for Pap Smears) | $20 PCP/$30 Specialist |
| Prostate Screening Visits (No charge for PSA test) | $20 PCP/$30 Specialist |
| Colorectal Cancer Screening Test | $20 PCP/$30 Specialist |
| Mammography Screenings | No charge |
| Allergy Testing and Treatment | $20 PCP/$30 Specialist |
| Annual Routine Eye Exam | $10 at a plan designated vision care center |
| at participating Davis Vision provider (optometrists and ophthalmologist) | $30 in a plan providers office |
| Hearing Screening | $20 PCP/$30 Specialist |

## Outpatient Medical and Surgical Services

| Physician Office Visit for Illness | $20 PCP/$30 Specialist |
| Rehabilitative Services (Physical, Occupational and Speech Therapy; each limited to 30 visits per illness or injury per calendar year) | $20 PCP/$30 Specialist |
| Surgical Services - Professional | $20 PCP/$30 Specialist |
| Surgical Services - Hospital or Other Facility | $50 facility copayment plus $20 PCP/$30 Specialist copayment |
| Diagnostic Procedures | $20 PCP/$30 Specialist |
| X-Rays and Lab Tests at Plan Facilities | No charge |

## Inpatient Hospital Services

| 365 Days Room and Board (Semi-Private Room) | $700 facility copay per admission |
| Medical and Surgical Services | No charge |

## Prescription Drugs (Inpatient)

| No charge |

### Maternity Services

| Prenatal and Postnatal Care | $20 per visit (up to $200 per pregnancy) |
| Medical Services | $30 per visit (up to $300 per pregnancy) |
| Hospital Facility | $700 facility copay per admission |
| Delivery | No charge |
| Birthing Center | $30 per visit |
| Nursery Care (for newborns) | No charge |

## Emergency or Urgent Care

| Ambulance (When medically necessary) | No charge |
| Plan-Affiliated Urgent Care Facility | $30 |
| Hospital Emergency Room or Non-Plan Urgent Care Facility (Waived if Admitted) | $50 |
| Ambulance (When medically necessary) | No charge |

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* A Child is your unmarried, dependent child under the age of 26.
** "Adult" means the spouse of the Subscriber who satisfies the eligibility requirements defined in the CareFirst BlueChoice Conversion Evidence of Coverage.
*** Family Membership provides coverage for two adults and children or grandchildren (defined as court-ordered custodians of the subscriber or the dependent spouse), or a single parent with more than one child or grandchild. Each additional child can be added to the Family membership at no extra cost.
It’s easy to enroll in BlueChoice

1) Choose your coverage
- Individual
- Individual and Child(ren)*
- Individual and Adult**
- Family [Two adults and eligible dependent(s)]

2) Determine your premium
Refer to the enclosed rate charts to determine your monthly premium.

3) Select a PCP
Select a Primary Care Physician (PCP) for each applicant and write the doctor’s name and ID number on your application.

4) Sign the application
Complete and sign the enclosed CareFirst BlueChoice Group Conversion/HIPAA application.

5) Send your payment
Return the completed and signed application, along with a payment for the initial monthly premium.*

6) Check your status
Once you have submitted your application, you can call the Application Status hotline toll-free at 1-877-746-7515 for a status report on your application. Information about your application status should be available 10 days from the day you mailed it in.

* “Child” means your unmarried, eligible child up to age 26. Eligibility requirements are defined in the CareFirst BlueChoice Group Conversion/HIPAA Evidence of Coverage.
** An “Adult” means the spouse of the subscriber who resides with the subscriber and satisfies the eligibility requirements as defined in the CareFirst BlueChoice Group Conversion/HIPAA Evidence of Coverage.

If you have any questions about eligibility, please call our Product Specialists at 1-866-520-6099.

† Please check with your former employer to determine the actual effective date of your disenrollment under the group policy. If your application is not postmarked within 31 days of your disenrollment, you will not be eligible for conversion coverage and your application and premium will be returned to you.

Plans to Meet Your Needs
- Medically underwritten traditional plans with a range of deductibles
- Medically underwritten HMO, PPO and Health Savings Account plans
- Catastrophic coverage
- Plans to supplement Medicare coverage
- Portability coverage, which is offered by the Maryland Health Insurance Plan (MHIP) at 1-866-780-7105, for those who meet the strict eligibility requirements defined under the Health Insurance Portability and Accountability Act (HIPAA).

If you would like more information on any of the above plans for you, your family or a friend, please contact our Product Specialists at 410-356-8000 or 1-800-544-8703. They’ll be happy to help.

Member Service
Dedicated customer service representatives are always just a phone call away for help with any questions you may have.

You can reach them
Monday through Friday .......... 7:00 a.m. to 7:00 p.m.
and Saturday .......................... 8:00 a.m. to 1:00 p.m.
by calling
410-356-4602 or
toll free 1-866-520-6099.
Exclusions

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.

Exclusions:

8.1 Services, tests or procedures that are not Medically Necessary. Although a service is listed as covered, benefits will be provided only if the service is Medically Necessary.

8.2 Experimental or Investigative: treatment; procedure; facility; equipment; drug; drug usage; device or supply.

8.3 The cost of services that:
   a. are furnished without charge; or,
   b. is normally furnished without charge to persons without coverage for health expenses.

   This exclusion does not apply to services that are covered under a State Assistance Program.

8.4 Services that are not described as covered in the Evidence of Coverage or that do not meet all other conditions and criteria for coverage, as determined by the Plan. Referral by a Primary Care Physician and/or the provision of services by a Plan Provider does not, by itself, entitle a Member to benefits if the services are non-covered services or do not otherwise meet the conditions and criteria for coverage.

8.5 Any routine foot care related to hygiene or preventive foot care 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.

8.6 Routine dental care such as extractions; treatment of cavities; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia; false teeth; or, any other dental services or supplies. These services may be covered under a Dental Endorsement purchased by the Subscriber and attached to the Evidence Of Coverage. The exclusion will not be used to deny covered services as described in Evidence of Coverage.

8.7 Plastic surgery, cosmetic surgery or other services primarily intended to correct, change or improve appearance. Such services are excluded, regardless of the underlying cause of the condition or any expectation that an alteration of appearance may be psychologically or developmentally beneficial. This exclusion will not be used to deny covered services as described in covered services.

8.8 Treatment rendered by a health care provider who is a member of the Member’s family (parents, spouse, brothers, sisters, children).

8.9 Prescription and non-prescription drugs routinely obtained and self-administered by the Member for outpatient use; unless the prescription drug is specifically covered under the Evidence Of Coverage or a Prescription Drug Rider when such Endorsement is attached to the Evidence Of Coverage.

8.10 Artificial aids and corrective appliances, such as: braces; external prosthetic devices; orthopedic devices; hearing aids; corrective lenses; or, eyeglasses.

8.11 Any procedure or treatment related to changing a Member’s sex.

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

8.13 Infertility treatment including but not limited to: assisted reproductive technologies such as: in vitro fertilization; GIFT; ZIFT; related evaluative procedures; artificial insemination; and, any drugs, diagnostic services or medical preparation related to the same.

8.14 Fees or charges relating to: fitness programs; weight loss or weight control programs; physical, pulmonary or cardiac conditioning programs; exercise programs; physical conditioning; use of passive or patient-activated exercise equipment; or, self-care or self-help training or education, except covered under Part 7.12.

8.15 Treatment for obesity except in the instance of morbid obesity.

8.16 Wigs, except for hair prosthesis as described in the Evidence Of Coverage.

8.17 Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for keratotomy and other forms of refractive keratoplasty, or any complications thereof.

8.18 Services furnished as a result of a referral prohibited by law.

8.19 Services solely required or sought on the basis of a court order or as a condition of parole or probation unless approved by the Medical Director.

8.20 Chiropractic services.

8.21 Health education classes and self-help programs, except as approved by the Plan.

8.22 Acupuncture services, except for anesthesia.
8.23 Any service related to recreational activities. This includes, but is not limited to: sports; games; equestrian activities; and, athletic training. These services are not covered even though: they may have therapeutic value; or, be provided by a health care provider.

7.13 Durable Medical Equipment.
   b. Benefits are not provided for:
      1. A convenience item. Any item that increases physical comfort without serving a Medically Necessary purpose, such as a bedside table.
      2. Environmental control equipment. Any device or appliance that alters or maintains the conditions in the existing surroundings, such as an air conditioning unit.
      3. Furniture items. Movable articles or accessories which serve as a place upon which to rest (people or things) or in which things are placed or stored, such as a chair or a dresser.
      4. Exercise equipment. Any device or object that serves as a means to allow for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body.
      5. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home, such as parallel bars.

7.14 Organ/Tissue Transplants.
   b. Limitations and Exclusions.
      1. All services and charges related to transplanting non-human organs are excluded. This exclusion will not be used to deny Medically Necessary non-Experimental grafts that are covered under the Evidence Of Coverage.
      2. Donor benefits are not provided when the transplant recipient is not a Member.
      3. A transplant not listed above is not covered. This excludes coverage for:
         a. complications resulting from any procedure not listed in Part 7.14.a; and,
         b. services or supplies related to any procedure not listed in Part 7.14.a., such as: high dose chemotherapy; radiation therapy; and, any other form of therapy.
Privacy Practices:
Our Commitment to Our Members

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 BlueChoice. CareFirst BlueChoice 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 BlueChoice, 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 BlueChoice 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 BlueChoice employees, brokers, benefit plan administrators, consultants, business partners, providers and agents who need to know this information to conduct CareFirst BlueChoice 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 BlueChoice are subject to strict confidentiality laws. Affiliated entities are companies that are a part of the CareFirst BlueChoice 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 BlueChoice 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 BlueChoice customer, our privacy policy will continue to apply to your records. You can always review our current privacy policy online at www.carefirst.com.

For questions, please contact us by calling the Member Services telephone number listed on your membership card.
Form Numbers:
VA/CC/GC EOC (8/01); VA/CC/GC Schedule (8/01) and any amendments.