CareFirst BlueChoice

Essential and Standard HMO

Do you employ 20-50 workers in the State of Virginia?

*If so, CareFirst BlueChoice is pleased to offer you two health maintenance organization (HMO) options – our **Essential HMO** and our **Standard HMO** plans.*

CareFirst BlueChoice Offers Cost-Effective Coverage

Both the Essential HMO and the Standard HMO plans offer access to a range of medical services through a network of approximately 5,000 primary care physicians and 38 hospitals, with copayments and no claim filing.

We also understand the value you place on staying healthy. That's why both the Essential HMO and Standard HMO plans provide wellness and preventive benefits to minimize potential long-term care problems.

Both Plans Offer a Wide Variety of Benefits

Our **Essential HMO** plan provides you and your employees with basic health care benefits, including:

- Hospitalization
- Professional services, including office visits, inpatient visits and surgery plus limited outpatient visits for mental health care or alcohol and drug abuse treatment
- Maternity care
- Emergency care
- Labs and X-rays
- Adult physical exams
- Mammography screenings *(age limits apply)*
- Well child care
- Access to prescription drug benefits

Our **Standard HMO** plan provides coverage for all of the above, plus benefits for:

- Allergy treatment, including testing and injections
- Audiology services
- Home health care
- Hospice care
- Skilled Nursing Facility care
- Rehabilitative care

Coverage

Both our Essential HMO and Standard HMO plans have no maximum lifetime limitation. Both cap annual out-of-pocket expenses at $5,000 for individuals, $10,000 for two-party and $15,000 for family memberships.

So, allow yourself and your employees to benefit from:

- Direct access to approximately 5,000 Primary Care Physicians in the Washington metropolitan area
- Wellness programs

Whatever the size of your company or budget, we're the healthy choice.
For more information, please contact us at 202-479-8595.

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Comparison of the Virginia Essential and Standard HMO Plans

	Benefit/Cost to Member	
Covered Services	**VA Essential (Minimum)**	**VA Standard (Maximum)**
Maximums		
Maximum Annual Out-of-Pocket ■ Individual ■ Two-Party ■ Family	$5,000 $10,000 $15,000	$5,000 $10,000 $15,000
Medical Services		
Adult Physical Exam	$20 copay PCP $20 copay Specialist	$20 copay PCP $20 copay Specialist
Allergy Treatment	Not covered	$20 copay per visit
Ambulance Services limited to emergency services	No copay	No copay
Audiology Services	Not covered	$20 copay per visit
Durable Medical Equipment	No copay	No copay
Emergency Room *(Copay waived if admitted)*	$20 copay per visit	$20 copay per visit
Home Health Care	Not covered	No copay
Hospice	Not covered	No copay
Hospitalization	$400 per admission copay	$400 per admission copay
Inpatient Medical & Surgical Services	No copay	No copay
Labs & X-Rays	No copay	No copay
Mammography Age 35-39: One baseline mammogram of each breast. Age 40-49: One preventive mammogram of each breast every two years. Age 50 and above: One preventive mammogram of each breast per calendar year.	No copay	No copay
Maternity Care *(Benefits limited to subscriber and spouse only)*	$20 copay per visit	$20 copay per visit
Mental Health Care and Substance Abuse Treatment ■ **Inpatient Facility Charges** *(Limited to 21 days per calendar year)* ■ **Inpatient Professional Charges** *(Limited to 1 visit per covered admission)* ■ **Outpatient** *(Limited to 20 visits per calendar year)*	$400 per admission copay $20 copay per visit $20 copay per visit	$400 per admission copay $20 copay per visit $20 copay per visit
Office Visit *(Copayment includes related services)*	$20 copay PCP; $20 copay Specialist	$20 copay PCP; $20 copay Specialist
Skilled Nursing Facility	Not covered	No copay
Outpatient Hospital Services	$20 copay per visit	$20 copay per visit
Well Child Care *(Limited to children under age 18, copayment includes all related services)*	$20 copay per visit	$20 copay per visit
Prescription Drugs *(Limited to generics unless "not available." "Not available" means if physician checks "dispense as written" (DAW), or the generic drug cannot be reasonably obtained.)*	$10 per prescription; up to 90-day supply	$10 per prescription; up to 90-day supply
Vision	**Coverage for children under age 18 only**	**Coverage for children and adults**
Routine eye exam *(Limited to one/calendar year)*	$20 copay at Plan Physician office (referral required). $10 copay at Plan Designated Vision Center (no referral required)	$20 copay at Plan Physician office (referral required). $10 copay at Plan Designated Vision Center (no referral required)
Frames & lenses *(Limited to 1 pair of frames & lenses/calendar year)*	No copay	No copay
Contact lenses	Not covered	Not covered

Dental Services are limited to the following:

Service	Member Coinsurance
Prophylaxis (cleaning, limited to 2 treatments per member per calendar year)	30% of Plan Allowance
Topical fluoride (limited to 1 administration per member per calendar year)	30% of Plan Allowance
Space maintainers for early lost teeth	30% of Plan Allowance
Sealants for permanent molars (limited to children ages 6-17 only)	30% of Plan Allowance
Oral examinations (limited to 2 per calendar year)	30% of Plan Allowance
X-rays	30% of Plan Allowance
Diagnostic radiographs (not available under Essential plan, limited to adults age 18 and over)	30% of Plan Allowance
Oral surgery	30% of Plan Allowance
Pulpotomy	30% of Plan Allowance
Root canal treatment	30% of Plan Allowance
Temporary crowns (limited to stainless steel and polycarbonate)	30% of Plan Allowance
Emergency care (palliative care, trauma care, repair of space maintainers, replacement crowns, repair of dentures)	30% of Plan Allowance
Deductible – N/A	
Annual out-of-pocket maximum ■ $3,000 for individual coverage ■ $6,000 for two-party or family coverage	
Lifetime maximum – $1,000,000 per member	
Note: The Essential benefit covers children <18 only. The Standard benefit covers children and adults. Dental benefits are optional, however, if a group declines dental coverage, the Group Administrator must sign a waiver of dental coverage.	

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.

The benefits described are issued under policy numbers:
BlueChoice HMO Essential Plan - CC/VASG GEA 9/95; CC VASG EOC; VA ESS/CC/ATTA 01-01;
VA ESS/CC/ATTB 01-01; CC VASG ATTC and any amendments.

BlueChoice HMO Standard Plan - CC/VASG GEA 9/95; CC VASG EOC; VA CC/STD/ATTA 01-01;
VA CC/STD/ATTB 01-01; CC VASG ATTC and any amendments.

Dental Plan policy form numbers: VASE SADENT/GC 3-01; VASE SADENT/GPS 3-01; VASE SADENT/COC 3-01;
VASE SADENT/DOC 3-01; VASE SADENT/ATTB 3-01; VASE SADENT/ATTC 3-01 and any amendments.

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Dental Exclusions

Limitations:

a. In the event you transfer from the care of one Dentist to that of another Dentist during the course of treatment of any covered Dental Service, or if more than one Dentist renders services for one dental procedure, we will pay not more than the amount we would have paid had only one Dentist provided the treatment or rendered the service.

b. When more than one covered Dental Service could provide suitable treatment (good dental practice as determined by the American Dental Association), we have the right to determine the covered Dental Service on which payment will be based and the expenses that will be included as covered Dental Services.

Exclusions:

Benefits will not be provided for:

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

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

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

b. Except as provided for in Section 3.5 of the Certificate of Coverage, Dental Services rendered prior to the effective date of your coverage under this Contract, or Dental Services rendered after the effective date if such services were begun prior to such effective date.

c. Prescription drugs, other than injectable drugs administered by a Dentist for therapeutic purposes.

d. Orthognathic surgery.

e Charges exceeding the Plan Allowance for any given service.

f. Benefits will not be provided for any treatment, procedure, facility, equipment, drug, drug usage, device or supply which, in our judgement, is experimental, investigational or not in accordance with accepted medical or dental practices and standards in effect at the time of treatment.

g. Services which are provided for or received at no charge to the Member in any federal hospital or facility, or through any federal, state or local governmental agency or department, not including Medicaid. This exclusion does not apply to care received in a Veteran's hospital or facility unless the care is rendered for a condition that is a result of the Member's military service.

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

i. Services or supplies for conditions that State or local laws, regulation, ordinances or similar provisions require to be provided in a public institution.

j. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar persons or groups.

k. Services solely on court order or as a condition of parole or probation unless approved by the Plan.

l. Any illness or injury caused by War, declared or undeclared, including armed aggression.

m. Any service, supply or procedure which is not specifically listed in your Contract as a covered benefit including services not specifically listed as Covered Dental Service under Section 3.

Exclusions and Limitations

10.1 Coverage Is Not Provided For:

A. Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by the Plan.

B. Services that are Experimental or Investigational as determined by the Plan.

C. The cost of services that:

1. Are furnished without charge; or
2. Are normally furnished without charge to persons without health insurance coverage;
3. Would have been furnished without charge if you were not covered under this Certificate or under any health insurance.

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

E. Routine foot care including any service related to hygiene including the trimming of corns or calluses, flat fee, fallen arches, chronic foot strain, or partial removal of a nail without the removal of the matrix except when we determine that Medically Necessary treatment was required because of an underlying health condition such as diabetes, and that all other conditions for coverage have been met.

F. Dental care including extractions; treatment of cavities; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia; false teeth; or any other dental services or supplies. These services may be covered under a separate rider or endorsement purchased by your Group and attached to this Certificate.

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

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

I. Any prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Certificate or a rider or endorsement purchased by your Group and attached to this Certificate.

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

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

L. All assisted reproductive technologies (except artificial insemination) including in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same unless covered under a rider or endorsement purchased by your Group and attached to this Certificate.

M. Fees or charges relating to fitness programs, weight loss or weight control programs; physical conditioning; pulmonary rehabilitation programs; exercise programs; physical conditioning; use of passive or patient-activated exercise equipment.

N. Treatment for obesity except for the surgical treatment of Morbid Obesity.

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

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

Q. Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by the Plan.

R. Health education classes and self-help programs, other than birthing classes or for the treatment of diabetes.

S. Acupuncture services except when approved or authorized by the Plan when used for anesthesia.

T. Any service related to recreational activities. This includes, but is not limited to: sports; games; equestrian; and athletic training. These services are not covered unless authorized or approved by the Plan even though they may have therapeutic value or be provided by a health care provider.

U. Cardiac rehabilitation programs.

V. Any service received at no charge to the Member in any federal hospital or facility, or through any federal, state, or local governmental agency or department, not including Medicaid. This exclusion does not apply to care received in a Veteran's Hospital or facility unless that care is rendered for a condition that is a result of the Member's military service.

W. Benefits will not be provided for Habilitative Services. Benefits for physical therapy, occupational therapy and speech therapy do not include benefits for Habilitative Services.

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

A. Non-human organs and their implantation.

B. Any hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.

C. Any charges related to transportation, lodging, and meals unless authorized or approved by the Plan.

D. Services for a Member who is an organ donor when the recipient is not a Member.

E. Any service, supply or device related to a transplant that is not listed as a benefit in this Certificate.

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

A. Private room, unless Medically Necessary and authorized or approved by the Plan. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.

B. Non-medical items and convenience items, such as television and phone rentals.

C. A Hospital admission or any portion of a Hospital admission that had not been authorized or approved by the Plan, whether or not services are Medically Necessary and/or meet all other conditions for coverage.

D. Private duty nursing unless authorized or approved by the Plan.

10.4 Hospice Benefits. The following are not covered:

A. Services, visits, medical equipment or supplies that are not included in the Plan-approved plan of treatment.

B. Services in the Member's home if it is outside the Service Area.

C. Financial and legal counseling.

D. Any service for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.

E. Chemotherapy or radiation therapy, unless used for symptom control.

F. Reimbursement for volunteer services.

G. Domestic or housekeeping services.

H. Meal on Wheels or similar food service arrangements.

I. Rental or purchase of renal dialysis equipment and supplies.

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

A. Psychological testing, unless Medically Necessary, as determined by the Plan, and appropriate within the scope of covered services.

B. Services solely on court order or as a condition of parole or probation unless approved or authorized by the Plan's Medical Director.

C. Mental retardation, after diagnosis.

D. Psychoanalysis.

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

A. Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the Plan's Medical Director.

B. Custodial Care.

C. Observation or isolation.

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

A. Emergency care if the Member could have foreseen the need for the care before it became urgent (for example, periodic chemotherapy or dialysis treatment).

B. Medical services rendered outside of the Service Area which could have been foreseen by the Member prior to departing the Service Area.

C. Charges for Emergency and Urgent Care services received from a non-Plan Provider after the Member could reasonably be expected to travel to the nearest Plan Provider.

D. Charges for services when the claim filing and notice procedures stated in Section 7 of this Certificate have not been followed by the Member.

E. Charges for follow-up care received in the Emergency or Urgent Care facility outside of the Service Area unless the Plan determine that the member could not reasonably be expected to return to the Service Area for such care.

F. Except for covered ambulance services, travel, whether or not recommended by a Plan Provider.

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

A. Convenience item. Any item that increases physical comfort or convenience without serving a Medically Necessary purpose e.g. elevators, hoyer/stair lifts, shower/bath bench.

B. Furniture items. Movable articles or accessories which serve as a place upon which to rest (people or things) or in which things are placed or stored e.g. chair or dresser.

C. Exercise Equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body e.g. exercycle or other physical fitness equipment.

D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home e.g. parallel bars.

E. Environmental control equipment. Any device such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.

F. Eyeglasses, contact lenses, hearing aids, dental prostheses or appliances.

G. Corrective shoes, unless they are an integral part of the lower body brace, shoe lifts or special shoe accessories.