

SERVICES	Preferred Providers In-Network You Pay <sup>2</sup>	Non-Preferred Providers Out-Of-Network You Pay <sup>3</sup>
<b>ANNUAL DEDUCTIBLE (Benefit period)<sup>4, 8</sup></b>		
Individual	None	\$500
Individual & Child(ren) <sup>7</sup>	None	\$1,000
Individual & Adult	None	\$1,000
Family	None	\$1,000
<b>ANNUAL OUT-OF-POCKET LIMIT (Benefit period)<sup>5</sup></b>		
Individual	\$1,000	\$2,000
Individual & Child(ren) <sup>7</sup>	\$2,000	\$4,000
Individual & Adult	\$2,000	\$4,000
Family	\$2,000	\$4,000
<b>LIFETIME MAXIMUM</b>	None	
<b>PREVENTIVE SERVICES</b>		
Well-Child Care		
0-24 months	No charge <sup>6</sup>	Plan pays 100% of Allowed Benefit
24 months-13 years (immunization visit)	No charge <sup>6</sup>	Plan pays 100% of Allowed Benefit
24 months-13 years (non-immunization visit)	No charge <sup>6</sup>	Plan pays 100% of Allowed Benefit
14-17 years	No charge <sup>6</sup>	Plan pays 100% of Allowed Benefit
Adult Physical Examination	\$15 per visit	Deductible, then 20% of Allowed Benefit
Routine GYN Visits	\$15 per visit	Deductible, then 20% of Allowed Benefit
Mammograms	No charge <sup>6</sup>	Plan pays 100% of Allowed Benefit
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge <sup>6</sup>	Plan pays 100% of Allowed Benefit
<b>OFFICE VISITS, LABS &amp; TESTING</b>		
Office Visits for Illness	\$15 per visit	Deductible, then 20% of Allowed Benefit
Diagnostic Services	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit
X-ray and Lab Tests	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit
Allergy Testing	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit
Allergy Shots	\$5 per visit	Deductible, then 20% of Allowed Benefit
Outpatient Physical, Speech and Occupational Therapy	\$15 per visit	Deductible, then 20% of Allowed Benefit
Outpatient Spinal Manipulation	\$15 per visit	Deductible, then 20% of Allowed Benefit
<b>EMERGENCY CARE AND URGENT CARE</b>		
Physician's Office	\$15 per visit	Paid as in-network
Urgent Care Center	\$15 per visit	Paid as in-network
Hospital Emergency Room (limited to emergency services)	\$50 per visit (waived if admitted)	Paid as in-network
Ambulance (if medically necessary)	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit
<b>HOSPITALIZATION</b>		
Inpatient Facility Services	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit
Outpatient Facility Services	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit

SERVICES	Preferred Providers In-Network You Pay <sup>2</sup>	Non-Preferred Providers Out-Of-Network You Pay <sup>3</sup>
<b>HOSPITAL ALTERNATIVES</b>		
Home Health Care (limited to 90 visits per episode of care)	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit
Hospice (limited to a maximum 180 day Hospice eligibility period)	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit
Skilled Nursing Facility (limited to 60 days per benefit period)	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit
<b>MATERNITY<sup>7</sup></b>		
Prenatal and Postnatal Office Visits	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit
Delivery and Facility Services	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit
Nursery Care of Newborn	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit
Artificial Insemination <sup>1</sup>	Not covered	Not covered
Initial Office Consultation(s) for Infertility Services/Procedures	\$15 per visit	Deductible, then 20% of Allowed Benefit
In Vitro Fertilization Procedures <sup>1</sup>	Not covered	Not covered
<b>MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)</b>		
Inpatient Facility Services (limited to 25 days benefit period)	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services (limited to 25 days per benefit period)	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit
Outpatient Services (MH) (limited to 20 visits per benefit period)		
Visits 1 – 5	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit
Visits 6 – 20	50% of Preferred Provider Allowance	Deductible, then 50% of Allowed Benefit
Outpatient Services (SA) (limited to 20 visits per benefit period)		
Visits 1 – 5	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit
Visits 6 – 20	50% of Preferred Provider Allowance	Deductible, then 50% of Allowed Benefit
Partial Hospitalization (limited to 15 days per benefit period)	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit
Medication Management Visit	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit
<b>MISCELLANEOUS</b>		
Durable Medical Equipment	No charge <sup>6</sup>	Deductible, then 20% of Allowed Benefit
Acupuncture	Not covered, only when plan approved for anesthesia	Not covered, only when plan approved for anesthesia
Transplants	Covered as stated in the Evidence of Coverage	Covered as stated in the Evidence of Coverage
Hearing Aids for ages 0-18	Not covered	Not covered
<b>VISION</b>		
Routine Exam (limited to 1 visit/benefit period)	\$10 per visit at participating vision providers	Total charge minus \$33
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers	Not covered

<sup>1</sup> Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment option for infertility. However, assisted reproduction (AI & IVF) services performed as treatment option for infertility are only available under the terms of the members contract. Preauthorization required.

<sup>2</sup> In-network: When you have care rendered by a provider in the Preferred Provider network. In-network coinsurances are based on a percentage of the Preferred Provider Allowance. The Preferred Provider Allowance is generally the contracted rates or fee schedules that Preferred Providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueCross BlueShield (CareFirst), however, in certain circumstances, an allowance may be established by law.

<sup>3</sup> Out-of-network: When you have care rendered by a provider not in the Preferred Provider network, care is reimbursed as out-of-network. Out-of-network coinsurances are based on a percentage of the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that Participating Providers have agreed to accept as payment of covered services. These payments are established by CareFirst, however, in certain circumstances, an allowance may be established by law. When services are rendered by Non-Participating Providers, charges in excess of the Allowed Benefit are the member's responsibility.

<sup>4</sup> If you have two-party coverage, each Member must satisfy his/her own deductible by meeting the individual deductible. If you have family coverage, all Members' individual deductibles will be combined to meet the family deductible; however, no individual Member may contribute more than the individual deductible amount.

<sup>5</sup> If you have two-party coverage, each Member must satisfy his/her own out-of-pocket limit by meeting the individual out-of-pocket Limit. If you have family coverage, all Members' individual out-of-pocket limits will be combined to meet the family out-of-pocket limit; however, no individual Member may contribute more than the individual out-of-pocket amount.

<sup>6</sup> No copayments or coinsurance.

<sup>7</sup> Please refer to your Evidence of Coverage and Schedule of Benefits to determine your coverage level.

<sup>8</sup> Copayment or portion of deductible may be required at the point of sale while in the deductible period. Member will never be required to pay more than CareFirst's Allowed Benefit for service rendered.

The benefits described are issued under form numbers: GC-A-4/95; GPS-F1-4/95; VA/CERT-5/96; PPP-A-5/95; V/CMM/MM ATTB 1/00; VA/NCA/ELIG-C 5/97; VA/CF/VISION (R. 1/06) and any amendments.

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## EXCLUSIONS

**10.1 Medical Necessity and Appropriateness.** Benefits will not be provided for services, tests, procedures or supplies which we determine are not medically necessary for the prevention, diagnosis or treatment of your 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 your particular case. A service or supply is medically necessary and appropriate only if, in our judgment, it is:

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

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

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

- a. A preponderance of scientific data, such as controlled studies in peer-reviewed journals or literature, has not demonstrated that its use results in an improved net health outcome for a specific diagnosis;
- b. It is not in accordance with generally accepted standards of medical practice; or
- c. It does not have federal or other required governmental agency approval at the time it is received.

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

**10.4 Routine Care of Feet.** Benefits will not be provided for any services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet or partial removal of a nail without the removal of its matrix. However, benefits will be provided for these services if we determine that medical attention was medically necessary because of a medical condition affecting the feet, such as severe diabetes and, that all other conditions for coverage have been met.

**10.5 Dental Care.** Except as provided in section 3.9, benefits will not be provided for any other type of dental care including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess, removal of impacted teeth, orthodontia, false teeth or any other dental services or supplies, unless provided in a separate Rider or Endorsement to this Agreement.

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

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

- a. Medically necessary to correct conditions which have resulted in a functional physiological defect; or
- b. Required to correct a congenital anomaly (must be a physical defect that was apparent at birth) that has produced a major physical effect on the Member's condition and provided the surgery or procedure can be reasonably expected to correct the condition; or
- c. Required to correct conditions which have resulted from accidental injury or non-cosmetic surgery if:
  - The accident or surgery has produced a major physical effect on the Member's appearance; and
  - At the time of the accident or surgery, the Member was covered under the Group Contract or another Plan-issued contract; and
  - In our judgment, the surgery can be reasonably expected to correct the condition.

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

**10.9 Organ Transplants.** Organ transplant procedures, including complications resulting from any such procedure, and services or supplies related to any organ transplant procedure such as, but not limited to, high dose chemotherapy, radiation therapy or any other form of therapy, or immunosuppressive drugs are not covered, except as provided in sections 3.10 and 3.11.

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

- a. Services or supplies received before the effective date of your coverage under this Certificate.
- b. Treatment of sexual dysfunctions or inadequacies except for surgical implants for impotence (medical therapy and psychiatric treatment are not covered).
- c. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
- d. Weight reduction or obesity treatment.
- e. Speech therapy, occupational therapy or physical therapy that is maintenance therapy for a chronic disease or condition or nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.
- f. Fees and charges relating to fitness programs, weight loss or weight control programs, physical, pulmonary conditioning programs or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education. Cardiac rehabilitation programs are covered as described in section 4.3.f.
- g. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof.
- h. Services to the extent they are covered by any governmental unit, except in Veteran's Administration or armed forces facilities for services received, such as for non-service connected disabilities, for which the recipient is liable. Services or supplies for injuries or diseases related to a covered person's job to the extent the covered person is required to be covered by a workers' compensation law. Services or supplies resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
- i. Services that are beyond the scope of the license of the provider performing the service.
- j. Except for covered ambulance services, travel, whether or not recommended by an Eligible Provider.
- k. Services or supplies for conditions that State or local laws, regulation, ordinances, or similar provisions require to be provided in a public institution.

- l. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.
- m. Contraceptive devices.
- n. Assistive reproductive procedures, including artificial insemination, in vitro fertilization, embryo or ovum transplants and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.
- o. Partial removal of a nail without the removal of the matrix.
- p. Services solely on court order or as a condition of parole or probation unless approved by the Plan.
- q. Any illness or injury caused by war, declared or undeclared, including armed aggression.
- r. Any service, supply or procedure which is not specifically listed in your Certificate as a covered benefit.

#### **EXCLUSIONS TO VISION CARE RIDER:**

##### **The following services are excluded from coverage under the Vision Care Rider:**

1. Diagnostic services, except as listed in Vision Care Rider.
2. Medical care or surgery. Covered services related to medical conditions of the eye may be covered under the evidence of coverage to which the Vision Care Rider is attached.
- 3 Prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the evidence of coverage or a rider or endorsement purchased by your Group and attached to the evidence of coverage to which the Vision Care Rider is attached.
4. Services or supplies not specifically approved by the Vision Care Designee where required in Vision Care Rider.
5. Orthoptics, vision training and low vision aids.
6. Glasses, sunglasses or contact lenses.
7. Vision Care services for cosmetic use.