BlueChoice Advantage Medical Plan

Eligible Employees and Non-Medicare Retirees
Effective January 1, 2022

FAIRFAX COUNTY PUBLIC SCHOOLS

Your Rights and Protections Against Surprise Medical Bills

As of 1/1/2022 when you get emergency care or are treated by an out-of-network provider at an in-network facility, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other healthcare provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—for example when you have an emergency or schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Insurers are required to tell you which providers and facilities are in their networks. Providers and facilities must tell you with which provider networks they participate. This information is available on the insurer's, provider's or facility's website or on request.

You are protected from balance billing for:

- Emergency services—If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as deductibles, copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.
- Certain services at an in-network facility—When you get services from an in-network facility, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, laboratory, surgeon and assistant surgeon services, and professional ancillary services such as anesthesia, pathology, radiology, neonatology, hospitalist or intensivist services. These providers **can't** balance bill you and **can't** ask you to give up your protections not to be balance billed.

If you receive other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

When balance billing is not allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the copayments, coinsurance and deductibles that you would pay if the provider or facility was in network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you have been wrongly billed, contact the No Surprises Help Desk at 1-800-985-3059 from 8 am to 8 pm EST, 7 days a week, to submit your question or a complaint.

You're **never required** to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

Contents

A Guide to Your Benefits

This book is your guide to the CareFirst benefits provided through the Fairfax County Public Schools (FCPS) plan. Please read it carefully and familiarize yourself with the provisions of the plan. Be sure to review the benefits, the limitations, and the exclusions of the plan. You may also want to share this material with your spouse and/or any other family members covered by this plan.

Right to change, modify or terminate the plan

FCPS reserves the right to change, modify, or terminate the plan in part or whole at any time. Any changes in the benefit structure will occur on January 1, 2022 unless otherwise communicated. Official notification of plan changes and modifications will appear in editions of the FCPS News You Choose—Employee News and/or other media FCPS deems appropriate.

The FCPS benefits plan

Benefits created for you

Welcome to the CareFirst BlueChoice Advantage plan. FCPS developed the plan to help meet your health care needs. CareFirst BlueCross BlueShield (CareFirst) administers the plan in partnership with CareFirst BlueChoice, Inc. and the Blue Cross and Blue Shield Association (an association of independent Blue Cross and Blue Shield plans) to offer access to the CareFirst BlueChoice Advantage network (for services received in the CareFirst service area) and the Preferred Provider Organization (PPO) network (for services received both inside and outside the CareFirst service area). You are not required to select a primary care provider with this plan. The plan offers network physicians where FCPS participants live and work.

If you have a question about the network, your plan benefits, or a claim, please call Member Services at 800-296-0724. The Member Services telephone number is also listed on the back of your member ID card. When calling Member Services, please have your member identification number available.

You may also write the Member Services department. Written correspondence is preferable so that a record of your inquiry is maintained. When writing, please include your member identification number. The address is:

Mail Administrator
P.O. Box 14114
Lexington, KY 40512-4114

Your prescription drug coverage is provided by CVS Caremark. You can contact their Customer Care Center at 888-217-4161.

Comprehensive vision coverage is provided by Davis Vision through CareFirst for those participating in the BlueChoice Advantage Plan. You can contact their Customer Service Unit at 888-343-3462.

See page 29 for more information about your vision benefits.

Keep this book handy

This book is designed as a guide to using your plan benefits. It contains information regarding benefit provisions, exclusions, and limitations.

If you have questions about enrollment, contact the Fairfax County Public Schools Human Resources Client Services at 571-423-3000.

Eligibility and Enrollment Provisions

If you have questions about enrollment under the BlueChoice Advantage plan, types of coverage available, changing your coverage or coverage options when you move, please contact Fairfax County Public Schools (FCPS) Human Resources Client Services at 571-423-3000.

Employee coverage

You are eligible for employee coverage while you are an eligible employee or non-Medicare retiree as defined by School Board regulations.

Effective date of coverage

For new employees, coverage is effective the first of the month after your hire date provided you request coverage during your first 30 calendar days of employment. If it is the first day of the month, coverage is effective that date. For employees enrolling during open enrollment, your coverage is effective on January 1.

Qualified dependent

These are the persons for whom you may obtain dependent coverage:

- Your spouse, as defined in the FCPS Employee Benefits Handbook and/or the FCPS Retiree Benefits Handbook
- Children under age 26 who are
  - Your biological child(ren) or stepchild(ren)
  - Your adopted child(ren) or child(ren) placed for adoption
  - Child(ren) for whom you have been appointed legal guardian or for whom you have legal custody
  - Certain eligible foster children
- Children age 26 or older who depend on you for support and maintenance due to a handicap or disability which occurred prior to age 26 and who have been certified as disabled by the plan

You have 30 calendar days from your hire/re-hire date (or date of status change or qualifying event) as defined by the FCPS Employee Benefits Handbook and/or the FCPS Retiree Benefits Handbook, to submit applicable documentation demonstrating dependents meet the eligibility criteria.

Important:

- Your spouse is no longer your qualified dependent when you are divorced.
- Generally, your dependent children are eligible for coverage from birth until the last day of the month in which the dependent turns 26.
- An FCPS eligible employee who also is a qualified dependent may not have dual enrollment and be covered under multiple coverages (i.e., cannot be covered as both an employee and a dependent under the FCPS plan).

The rules for obtaining dependent coverage are detailed in the following section titled *When coverage takes effect.*

The rules for obtaining Continued Health Care Expense Coverage are detailed in the following section titled *Continuing your group health coverage under COBRA.*

When coverage takes effect

For employee coverage

Prompt enrollment is important. If you do so, your employee coverage under the plan will begin the first day of the month following the date:

- You are eligible for employee coverage; and
- You request enrollment, provided you submit your request within 30 calendar days from your hire or re-hire date (or date of status

change or qualifying event). You must submit your request on a form approved by FCPS and agree to pay the required contributions.

If you do not enroll when first eligible, you must wait until the next open enrollment period to enroll, unless you have a status change or qualifying event as defined by IRS regulations for cafeteria plans.

For dependent coverage

If you do not enroll dependents when first eligible, you will not be permitted to enroll them in the plan until the next open enrollment except for the following:

- Loss of coverage (you must add dependents within 30 calendar days)
- A new spouse (you must add a new spouse within 30 calendar days of the date of marriage)
- A newborn or adopted child (see below)
- HIPAA Special Enrollment Rights

Qualified changes

It is important that you inform the FCPS Office of Benefit Services within 30 calendar days of the date that:

- You first acquire a qualified dependent, such as through birth or adoption
- A new qualified dependent becomes eligible, such as through marriage
- A qualified dependent becomes ineligible, such as through divorce or reaching the maximum age limit

For additional information, review the FCPS Employee Benefits Handbook and/or the FCPS Retiree Benefits Handbook.

Continuing your group health coverage under COBRA

Employees and their eligible spouse and children who are covered under this plan have the right to COBRA continuation coverage, which is a temporary extension of coverage. The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA can become available to you and to other members of your family who are covered under the plan when you and/or they would otherwise lose group health coverage. For more detailed information about your rights and obligations under the plan and under federal law, see the FCPS Employee Benefits Handbook. For questions, you may contact the Fairfax County Public Schools Human Resources Client Services at 571-423-3000.

A dependent child covered by the group health plan has the right to continuation of coverage if group health coverage under the group health plan is lost for any of the following four reasons:

- Death of a parent
- Termination of a parent's employment
- Parent's divorce
- The dependent child ceases to be a "Dependent Child" under the group health plan

Notification requirements

The employee or a family member has the responsibility to inform the group health plan administrator (hereafter referred as "plan administrator") of a divorce, or a child losing dependent status under the group health plan within 30 days of the event. The employer has the responsibility to notify the plan administrator of the employee's death, termination, reduction in hours of employment, or Medicare entitlement. Similar rights may apply to certain retirees, spouses, and dependent children if your employer commences a bankruptcy proceeding and these individuals lose coverage.

When the plan administrator is notified that one of these events has happened, the plan administrator will in turn notify you that you have the right to choose continuation coverage. You have at least 60 days from the date you lose coverage (or date you receive your notice of continuation rights, whichever is later) because of one of the events described above to inform the plan administrator that you want continuation coverage. Your group health insurance will end until you notify the plan that you wish to continue coverage and pay the required premiums.

Refer to the FCPS website (**www.fcps.edu**) for more details about continuation coverage.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects workers who change jobs or lose jobs, limits pre-existing condition exclusion periods, eliminated permanent health exclusions in the group market, prohibits discrimination against employees and dependents based on health status, and guarantees renewability of health coverage to small employers and to individual Members. The following are answers to some commonly asked questions concerning HIPAA.

Notice of enrollment rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 calendar days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 calendar days after the marriage, birth, adoption or placement for adoption.

HIPAA questions and answers

Who is covered by HIPAA?

HIPAA primarily applies to members who have health coverage through a group health plan. It affects employees when they leave one employer group and go to another. It also affects some employees when they leave their group and take individual coverage.

Does COBRA count toward creditable coverage?

Yes.

See page 70 for the FCPS HIPAA Privacy Notice.

Member Services

Member Services is dedicated to educating and assisting you with your health care benefits. Trained Member Services Representatives are available to help you with any questions or concerns.

Member Services Representatives can assist you with questions concerning:

- Benefits and provisions of the BlueChoice Advantage plan
- Information on network providers
- Verification of BlueChoice Advantage doctors and services
- Claims status and appeals
- Member ID card replacement

Member Services Representatives are available Monday through Friday from 8 a.m. to 9 p.m. (EST) at 800-296-0724. The Member Services telephone number is also listed on the back of your member ID card or visit **carefirst.com/fcps**.

You can write for information

In addition to calling, you can also write for information. Please include your BlueChoice Advantage plan identification number and group number on all correspondence. If your question involves a claim, be sure to include all information regarding the claim, such as:

- The claim number
- The date of service(s)
- Type of service(s)
- Who provided the service(s)
- The charges involved

Address your letter to the mailing address indicated on the back of your member ID card.

Your BlueChoice Advantage member identification card

When you enroll, you and each eligible dependent will each receive your own member ID card. Show the card to the hospital, physician, or other health care professionals when you need to use your benefits.

On the back of your member ID card are the numbers to call when you need additional information. The 800-296-0724 toll-free number at the top of the card is the number for Member Services. You should call Member Services when you have questions about your benefits or to inquire about the status of claims. For questions regarding your vision benefits, call Davis Vision at 888-343-3462.

Your benefit plan also includes access to the 24-Hour Nurse Advice Line. When you can't reach your doctor, call 800-535-9700 to speak with a registered nurse for health care advice.

The Hospital Precertification Admission telephone number on the back of your member ID card must be called at least five business days prior to an elective or scheduled admission to a hospital. Before certain services can be covered, they will be subject to review and approval under the Utilization Management program.

If you lose your card

If you lose your card, we'll be glad to send you a new one. Simply call Member Services at 800-296-0724. When you call, we'll need to know your name and your identification number. You can expect to receive your card within seven to ten days from the date Member Services receives your request. You can also request a new card through *My Account*.

From the CareFirst mobile app, you can view, print or email your member ID card.

CareFirst Mobile

We're with you wherever you go

Whether you are traveling for work, family vacation or just taking a road trip, you always have access to your personalized coverage information. Set up your CareFirst BlueCross BlueShield (CareFirst) mobile access today.

1. Register for *My Account*
2. Download the CareFirst app or add **carefirst.com/myaccount** to your mobile favorites

It's that easy. Then, log in and conveniently,

- Find in-network doctors, urgent care centers and other care—nationwide
- View, order or email member ID cards
- Check claims and deductible status
- Update communication preferences and password
- Plus, more

Visit your favorite online store to download the CareFirst app.

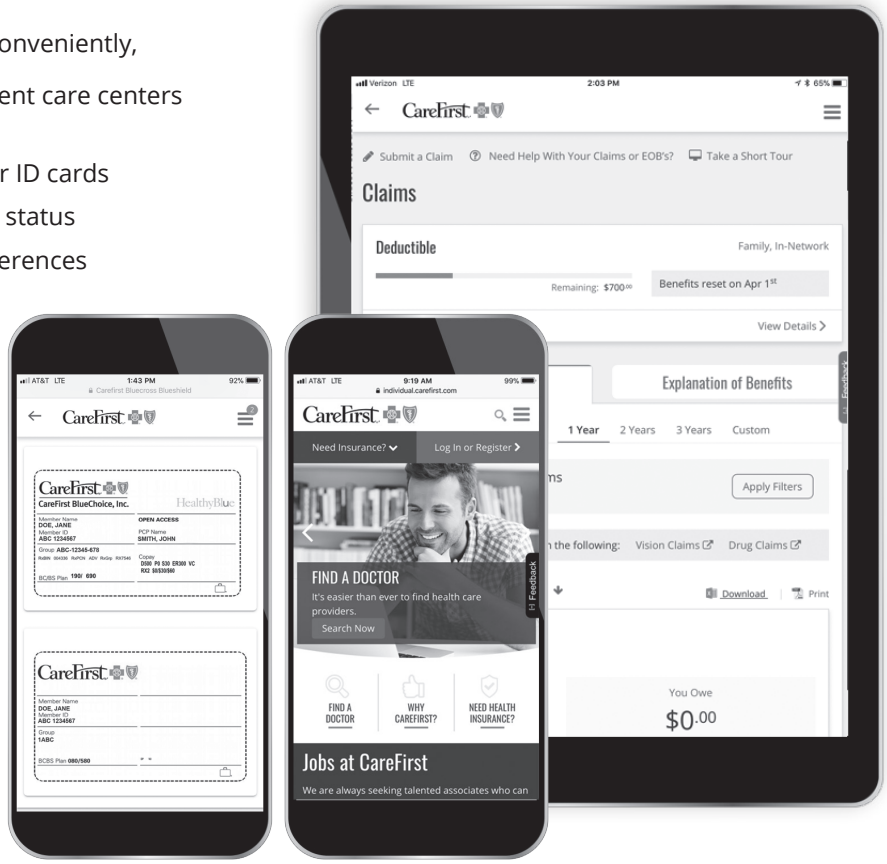
Available on the App Store

Google play

Download other helpful apps from CareFirst

CareFirst Video Visit

With CareFirst Video Visit you can connect with a board-certified* doctor whenever and wherever you want—without an appointment—from your computer or mobile device! To learn more visit **carefirstvideovisit.com** or download the app.



* The doctors accessed via this website are independent providers making their own medical determinations and are not employed by CareFirst. CareFirst does not direct the action of participating providers or provide medical advice.

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My Account

Your complete online resource

For members of CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all corporate affiliates (CareFirst), *My Account* makes it easy to understand and manage your health plan and benefits.

By setting up an account, you'll have password-protected access to:

- Find and select in-network doctors, specialists, dentists and behavioral health providers—including hospitals, urgent care centers, labs and imaging facilities
- Read and write reviews of providers and facilities
- Choose or change your primary care provider (PCP) as applicable
- View, order or print your member ID card
- Check the status of claims, remaining deductibles and out-of-pocket totals
- Calculate costs for treatment and services from specific providers—based on your plan's benefits*
- Review your Explanation of Benefits (EOBs)
- Locate nearby pharmacies or access the mail service pharmacy
- View copays and identify other expenses for which you may be responsible
- Research drug and pharmacy information, including
  - Drug pricing
  - Drug savings opportunities
  - Important drug interactions and side effects
- Compare hospitals to determine which is best for the care you need
- Download forms for claim submissions, drug requests, authorizations and more
- Confirm if a referral or preauthorization is required for a specific service**
- Access your wellness program
- Send a secure message or question via the Message Center

*The estimated cost information provided is intended to be used as a reference tool for your convenience and is not a substitute for medical advice or treatment by a medical professional.

**If applicable for your plan.

Register for *My Account*

Signing up is quick and easy. It only takes a few minutes!

Go to **carefirst.com/myaccount** and select *Register Now*. Then, follow the steps to complete your registration.

With *My Account,* you'll have secure online access to tools and information personalized just for you, day or night.

To register, you'll need:

- Your member ID number
- The last four digits of your social security number (SSN) or taxpayer identification number (TIN)

Know Before You Go

Your money, your health, your decision

Choosing the right setting for your care—from allergies to X-rays—is key to getting the best treatment with the lowest out-of-pocket costs. It's important to understand your options so you can make the best decision when you or your family members need care.*

Primary care provider (PCP)

Establishing a relationship with a primary care provider is the best way to receive consistent, quality care. Except for emergencies, your PCP should be your first call when you require medical attention. Your PCP may be able to provide advice over the phone or fit you in for a visit right away.

24-Hour Nurse Advice Line

Call 800-535-9700 anytime to speak with a registered nurse. Nurses will discuss your symptoms with you and recommend the most appropriate care. **The service is personal, confidential and available at no cost.**

CareFirst Video Visit

See a doctor 24/7/365 without an appointment! You can consult with a board-certified doctor on your smartphone, tablet or computer. Doctors can treat a number of common health issues like flu and pink eye. Visit **carefirstvideovisit.com** for more information.

Convenience care centers (retail health clinics)

These are typically located inside a pharmacy or retail store (like CVS MinuteClinic or Walgreens Healthcare Clinic) and offer accessible care with extended hours. Visit a convenience care center for help with minor concerns like cold symptoms and ear infections.

Urgent care centers

Urgent care centers (such as Patient First or ExpressCare) have a doctor on staff and are another option when you need care on weekends or after hours.

Emergency room (ER)

An emergency room provides treatment for acute illnesses and trauma. You should call 911 or go straight to the ER if you have a life-threatening injury, illness or emergency. Prior authorization is not needed for emergency room services.

To determine your specific benefits and associated costs:

- Log in to *My Account* at **carefirst.com/fcps**
- Check your Evidence of Coverage or benefit summary
- Ask your benefit administrator, or
- Call Member Services at the telephone number on the back of your member ID card

For more information and frequently asked questions, visit **carefirst.com/fcps**.

* The medical providers mentioned in this document are independent providers making their own medical determinations and are not employed by CareFirst. CareFirst does not direct the action of participating providers or provide medical advice.

When you need care

When your PCP isn't available, being familiar with your options will help you locate the most appropriate and cost-effective medical care. The chart below shows how costs[1] may vary depending on where you choose to get care.

	Member Cost In-Network[1,2]	Sample symptoms	Available 24/7	Prescriptions
CareFirst Video Visit	Urgent Care $20 PCP / $40 Specialist	■ Cough, cold and flu ■ Pink eye	✔	✔
	Breastfeeding Support $0 Member cost	■ Breastfeeding issues		
	Therapy & Psychiatry $20 PCP / $40 Specialist	■ Anxiety/Depression		
	Diet & Nutrition $20 PCP / $40 Specialist	■ Food allergies		
Convenience Care *(e.g., CVS MinuteClinic or Walgreens Healthcare Clinic)*	$20 per visit	■ Cough, cold and flu ■ Pink eye ■ Ear pain	✘	✔
Urgent Care[3] *(e.g., Patient First or ExpressCare)*	$40 per visit	■ Sprains ■ Cut requiring stitches ■ Minor burns	✘	✔
Emergency Room[4]	Deductible, then 10% of Allowed Benefit plus $250 per visit	■ Chest pain ■ Difficulty breathing ■ Abdominal pain	✔	✔
24-Hour Nurse Advice Line	$0	Support and guidance for any non-emergency situation	✔	✘

[1] Refer to this SPD for complete details.

[2] Does not include cost of prescription(s)

[3] Services must be of an urgent nature to use out-of-network urgent care centers. You may be required to pay up front and file for reimbursement.

[4] Bona fide emergency must exist for emergency room services to be covered.

Did you know that where you choose to get lab work, X-rays and surgical procedures can have a big impact on your wallet? Typically, services performed in a hospital cost more than non-hospital settings like LabCorp, Advanced Radiology or ambulatory surgery centers.

PLEASE READ: The information provided in this document regarding various care options is meant to be helpful when you are seeking care and is not intended as medical advice. Only a medical provider can offer medical advice. The choice of provider or place to seek medical treatment belongs entirely to you.

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Treatment Cost Estimator

Estimate your costs for care with our easy-to-use online tool

Our Treatment Cost Estimator* is designed to help you estimate your personal cost for procedures, doctor's office visits, lab tests and surgery beforehand.

With Treatment Cost Estimator, you can:

- Receive personalized estimates based on your healthcare plan and factor in your remaining deductible, benefit maximums, copayments and coinsurance.
- Avoid surprises and save money by comparing costs from different doctors and facilities.
- Plan ahead to keep health costs under control and make the best care decisions for you.

Get started by logging in to *My Account* at **carefirst.com/myaccount**. If you haven't registered for *My Account* yet, it just takes your member ID card and a few minutes to sign up.

* The cost information provided is intended to be used as a reference tool for your convenience and is not a substitute for medical advice from, or treatment by, a medical professional.

CareFirst Video Visit

When your primary care provider (PCP) isn't available and you need urgent care services, Video Visit securely connects you with a doctor*, day or night, through your smartphone, tablet or computer. In addition, you can get care for other needs such as behavioral health support from a therapist or psychiatrist, guidance from a certified nutritionist or breastfeeding support from a lactation consultant. It's a convenient and easy way to get the care you need, wherever you are.

Get treatment for common health issues 24/7

Use Video Visit when you're facing uncomplicated, non-emergency issues such as allergies, a sinus infection, a cold or the flu and more. Video Visit doctors will provide you a consultation, diagnosis and even prescriptions (when available and appropriate). They are all U.S. board-certified, licensed and credentialed medical professionals.

Schedule visits for additional services

- **Therapy/Psychiatry**—Talk with a therapist or psychiatrist for help managing mental health issues including anxiety, depression and grief.
- **Diet/Nutrition**—Connect with a registered dietitian to get support with dietary and nutrition needs, from weight loss to food allergies and more.
- **Breastfeeding Support**—Speak with a lactation consultant who can advise you on breastfeeding topics like latching issues, milk supply and others.

The cost for Video Visit varies based on your benefits, but your specific cost information will be shown to you before your visit begins. Take advantage of this great benefit and register today!

Register today so you'll be ready when you need care! Visit **carefirstvideovisit.com** *or download the CareFirst Video Visit app from your favorite app store.*

* The doctors accessed via this website are independent providers making their own medical determinations and are not employed by CareFirst. CareFirst does not direct the action of participating providers or provide medical advice.

In the case of a life-threatening emergency, you should always call 911 or your local emergency services. CareFirst Video Visit does not replace these services.

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Emergency Care

Knowing where to go when you have an urgent health issue is the key to getting the best treatment possible. In general, except for medical emergencies, your primary care provider (PCP) should be your first call for help with a situation requiring medical attention. Your PCP is most familiar with your medical history and may be able to see you right away, or direct you to further medical care if necessary.

When should you go to the ER?

When in doubt, seek emergency care

A medical emergency is a sudden serious illness or injury that, without immediate medical attention, could result in:

- Serious jeopardy to the patient's health
- Serious impairment to bodily functions
- Serious dysfunction of a body part or organ
- Serious health risks for a pregnant woman's fetus

If the situation is a medical emergency; call 911 or go directly to the nearest emergency care facility.

Some examples of possible medical emergency situations include:

- Difficulty breathing, shortness of breath
- Chest pain or upper abdominal pain or pressure lasting two minutes or more
- Fainting, sudden dizziness, weakness
- Change in vision
- Difficulty speaking
- Confusion or changes in mental status, unusual behavior, difficulty walking
- Any sudden and severe pain
- Severe or persistent vomiting or diarrhea
- Coughing or vomiting blood
- Suicidal or homicidal thoughts
- Unusual abdominal pain
- Severe headache or vomiting after a head injury, unconsciousness, uncontrolled bleeding

Prior authorization is not needed for emergency room services.

Do your homework now before you need immediate care. Find out where the closest ER, urgent care and convenience care centers are in your area. Then learn the differences between them so you know where to go.

In an emergency:

In a medical emergency (life, limb or sight-threatening), go to the nearest medical facility for emergency treatment.

If using a participating hospital or provider:

If you are admitted, you or your provider must call the Hospital Precertification Admission telephone number listed on the back of your member ID card within two business days of hospital admission, or as soon as reasonably possible. You should also call your provider so he or she can coordinate your care. If you are unable to call, another person can make the call for you.

If using a non-participating hospital or provider:

If you are admitted, you are responsible for contacting the Hospital Precertification Admission number listed on the back of your member ID card. If you do not call the Hospital Precertification Admission telephone number listed on the back of your member ID card within two business days of your treatment or hospital admission (or as soon as reasonably possible), benefits for covered services may be provided at the out-of-network allowed benefit.

If you are away from home when you have a medical emergency:

Go to the nearest medical emergency facility. If you are admitted, you (or someone on your behalf) must call the Hospital Precertification Admission telephone number on the back of your member ID card within two business days of receiving the emergency care in order for in-network benefits to be considered.

If you cannot call the Hospital Precertification Admission telephone number within two business days of receiving care:

You should always keep your member ID card with you so if you cannot call for precertification, the hospital can call for you. If you are unconscious or unable to call within two business days, and nobody can call on your behalf, you should call within two business days of regaining consciousness.

If you are admitted in an emergency to a hospital that is not an in-network hospital:

After you have notified your provider, he or she will review and monitor your medical care. If appropriate, your provider may arrange to transfer you to an in-network hospital when your condition stabilizes.

If you receive emergency care at a non-network hospital and follow-up treatment is necessary:

Sometimes, after hospitalization, you need follow-up care, like short-term rehabilitation or removal of stitches. Call your provider; he or she will review your situation with you.

When possible, you should receive follow-up care from an in-network provider to receive the highest level of benefits. Follow-up care provided by a non-network provider may be paid at the lower out-of-network level.

Questions?

If you have questions about your benefits or health plan requirements, there are several ways to find the information you need:

- Visit **carefirst.com/fcps** and log on to *My Account* to get personalized benefit information
- Email Member Services securely, through *My Account* at **carefirst.com/fcps**
- Call the Member Services phone number on your member ID card
- Refer to your Evidence of Coverage or the contract you received when you enrolled
- Speak with your benefits office

International emergency assistance program

The BlueChoice Advantage plan provides you and your covered family members with 24-hour protection when traveling outside the United States through our International Emergency Assistance Program. Benefits for inpatient care in an international participating hospital are the same as benefits for services out-of-network.

24-hour hotline when you need care overseas

A 24-hour hotline is provided for you to call in the event of a medical emergency abroad. Depending on your needs, the multi-lingual emergency coordinators will:

- Refer you to an appropriate overseas doctor or hospital
- Provide interpretation service to aid communication between you and foreign-speaking hospital personnel and doctors
- Relay benefits and eligibility to the provider, attempt to arrange assignment of benefits
- Distribute a participating international hospital listing

To receive round-the-clock help with a medical emergency abroad:

- Dial 800-810-BLUE (2583) from the United States; or
- Dial the local operator and reverse charges or call collect: (country code*) 804-673-1177 when traveling internationally.

*When calling from outside the United States, please consult the local telephone or telex operator for the correct code.

When you call, please be ready to tell us your name, your BlueChoice Advantage plan identification number, the fact that you are enrolled with Blue Cross and Blue Shield, your location, and/or telex number.

Listing of international participating hospitals

For a current listing of international participating hospitals, call 800-522-2855.

Claims for overseas care

When you use one of the international participating hospitals, your claims for inpatient hospital services are processed quickly and accurately. You don't have to worry about making advance payments, getting itemized bills or translations, or submitting claims.

You will owe the international participating hospital for any deductibles and coinsurance required under your coverage, and for any services not covered under your contract. The international participating hospital may request payment of these amounts at the time you receive services. If you receive non-emergency inpatient services at a hospital that does not participate with us or emergency medical assistance that is not coordinated through the International Assistance Center, you are responsible for submitting your claim directly to the FCPS plan.

Other options for care

Urgent care centers and convenience care clinics (also known as retail health clinics) are walk-in clinics that can treat minor injuries and illness when you can't get in to see your PCP. You don't need a written referral or an appointment.

If you can't reach your PCP, or are unsure about the seriousness of your symptoms, you can also call our 24-hour Nurse Advice Line at 800-535-9700 for medical advice.

Urgent care centers:

- Offer prompt medical attention
- Have a medical doctor on-site
- Offer evening and weekend hours
- Treat non-life or limb-threatening injuries

Convenience care centers:

- Are typically located in a pharmacy or retail store
- Offer convenient, accessible care and extended evening/weekend hours
- Treat minor concerns like cold symptoms, ear and eye infections

For a detailed chart of symptoms that an urgent care or convenience care center can assist you and your family members with, visit **carefirst.com/needcare**.

For a list of participating urgent and convenience care centers, visit our provider directory at **carefirst.com/doctor**.

Remember, urgent and convenience care centers don't take the place of your PCP. Your PCP should be your first contact whenever you need medical care that isn't an emergency situation.

BlueCard & Blue Cross Blue Shield Global® Core

Wherever you go, your health care coverage goes with you

With your Blue Cross and Blue Shield member ID card, you have access to doctors and hospitals almost anywhere. BlueCard gives you the peace of mind that you'll always have the care you need when you're away from home, from coast to coast. And with Blue Cross Blue Shield Global® Core (BCBS Global® Core) you have access to care outside of the U.S.

As always, go directly to the nearest hospital in an emergency.

Your membership gives you a world of choices. More than 93% of all doctors and hospitals throughout the U.S. contract with Blue Cross and Blue Shield plans. Whether you need care here in the United States or abroad, you'll have access to health care in more than 190 countries.

When you're outside of the CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. service area (Maryland, Washington, D.C., and Northern Virginia), you'll have access to the local Blue Cross Blue Shield Plan and their negotiated rates with doctors and hospitals in that area. You shouldn't have to pay any amount above these negotiated rates. Also, you shouldn't have to complete a claim form or pay up front for your health care services, except for those out-of-pocket expenses (like non-covered services, deductibles, copayments, and coinsurance) that you'd pay anyway.

Within the U.S.

1. Always carry your current member ID card for easy reference and access to service.
2. To find names and addresses of nearby doctors and hospitals, visit the National Doctor and Hospital Finder at **www.bcbs.com**, or call BlueCard Access at 800-810-BLUE (2583).
3. Call the Customer Service number on the back of your member ID card to verify benefits or find out if pre-certification or prior authorization is required.
4. When you arrive at the participating doctor's office or hospital, simply present your ID card.
5. After you receive care, you shouldn't have to complete any claim forms or have to pay up front for medical services other than the usual out-of-pocket expenses. CareFirst will send you a complete explanation of benefits.

Around the world

Like your passport, you should always carry your ID card when you travel or live outside the U.S. The Blue Cross Blue Shield Global® Core program (BCBS Global® Core) provides medical assistance services and access to doctors, hospitals and other health care professionals around the world. Follow the same process as if you were in the U.S. with the following exceptions:

- At hospitals in the BCBS Global Core Network, you shouldn't have to pay up front for inpatient care, in most cases. You're responsible for the usual out-of-pocket expenses. And, the hospital should submit your claim.
- At hospitals outside the BCBS Global Core Network, you pay the doctor or hospital for inpatient care, outpatient hospital care, and other medical services. Then, complete an international claim form and send it to the BCBS Global Core Service Center. The claim form is available online at **bcbs.globalcore.com**.
- To find a BlueCard provider outside of the U.S. visit **bcbs.com**, select *Find a Doctor or Hospital.*

Members of Maryland Small Group Reform (MSGR) groups have access to emergency coverage only outside of the U.S.

Medical assistance when outside the U.S.

Call 800-810-BLUE (2583) toll-free or 804-673-1177, 24 hours a day, 7 days a week for information on doctors, hospitals, other health care professionals or to receive medical assistance services. A medical assistance coordinator, in conjunction with a medical professional, will make an appointment with a doctor or arrange hospitalization if necessary.

Visit **bcbs.com** to find providers within the U.S. and around the world.

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BlueChoice Advantage Covered Providers

A covered provider must be licensed or certified in the area where the services are rendered and acting within the scope of his/her license.

Providers covered under this plan include:

Hospital

Any hospital which is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and operates in accordance with the laws of the jurisdiction in which it is located pertaining to institutions identified as hospitals. This includes Veterans Administration Hospitals and Department of Defense Hospitals.

Alcohol and drug treatment facility

Any hospital, quarterway house, or rehabilitation home, licensed and certified by the area in which it is located, and which operates a program for the rehabilitation of individuals dependent on alcohol or drugs.

Intermediate care facility

A residential public or private facility that is operated primarily for the purpose of providing a continuous, structured 24-hour per day program, approved by the state or by the Blue Cross and Blue Shield plan, for inpatient substance abuse services. The facility must be licensed or certified as such by the proper authority in the area in which it is located. These include:

- Residential substance abuse treatment facility
- Psychiatric halfway house
- Inpatient freestanding substance abuse facility
- Freestanding substance abuse treatment facility

Mental health treatment center

A treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a licensed physician, clinical psychologist, or psychiatrist. The facility must be licensed or certified as such by the proper authority in the area where it is located, funded, or eligible for funding under federal or state law, or affiliated with a hospital under a contractual agreement with an established system for patient referral.

Practitioners

Any professional provider licensed in the area where the services were rendered and acting within the scope of their licenses. These include:

- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Doctor of Dental Surgery (D.D.S. or D.M.D.)
- Doctor of Surgical Chiropody (D.S.C.)
- Podiatrist (D.P.M.)
- Clinical Psychologist (Ph.D.)—Services are covered when rendered in connection with psychotherapy only.

Certified nurse midwife

Must be a licensed Registered Nurse (R.N.) and certified as a nurse midwife by the American College of Nurse Midwives.

Private duty nurse

Must be a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.).

Psychiatric social worker

Must be a certified or licensed social worker (L.C.S.W.) in the area where services are rendered. Services are covered only when rendered in connection with psychotherapy.

Audiologist

Must be licensed or certified in the area where the services are rendered.

Christian Science care

- A Christian Science Sanitarium will be considered a Hospital. A service or treatment given to a patient in such a Sanitarium according to healing practices of Christian Science will be considered as if given for medical care. But to stay in a Christian Science Sanitarium will not be considered a Hospital stay unless it is for a condition that would require a person who is not a Christian Scientist to have a hospital stay in other than a Christian Science Sanitarium. A Christian Science Sanitarium is one that is accredited as such by the Department of Care of the First Church of Christ, Scientist, Boston, Massachusetts.
- A Christian Science Practitioner will be considered a Doctor, and treatment of a patient by a Christian Science Practitioner includes what is commonly called absent treatment. A communications charge, such as a charge for a telephone call, incidental to absent treatment, is not considered an eligible charge. A Christian Science Practitioner is a person who is listed as such in the *Christian Science Journal.*
- A Christian Science Nurse will be considered a registered graduate nurse. A Christian Science Nurse is a person who is listed as such in the *Christian Science Journal.*

Other covered providers

The following providers must be licensed or certified in the area where services are rendered and acting within the scope of their licenses:

- Ambulatory Surgical Facility
- Certified Addiction Counselor
- Certified Registered Nurse Anesthetist
- Chiropractor
- Clinical Nurse Specialist
- Extended Care Facility/Skilled Nursing Facility
- Freestanding Dialysis Center
- Home Health Agency
- Hospice
- Licensed Professional Counselor
- Occupational Therapist
- Optician
- Optometrist
- Pharmacist
- Physiotherapist
- Registered Nurse Clinical Specialist
- Registered Physical Therapist
- Respiratory Therapist
- Speech Therapist

Take the Call

You know that CareFirst BlueCross BlueShield (CareFirst) provides your health benefits and processes claims, but that's not all we do. We're there for you at every step of care—and every stage, even when life throws you a curveball.

Whether you are faced with an unexpected medical emergency, managing a chronic condition like diabetes, or looking for help with a health goal such as losing weight, we offer one-on-one coaching and support programs. You may receive a letter or postcard in the mail, or a call from a nurse or health coach explaining the programs and inviting you to participate.

These programs are confidential and part of your medical benefit. They can also play a huge role in helping you through an illness or keeping you healthy. Once you decide to participate, you can choose how involved you want to be. We encourage you to connect with the CareFirst team so you can take advantage of this personal support.

CareFirst may call you to offer one-on-one support programs concerning WellBeing, Care Management or Behavioral Health

carefirst.com/fcps

Take the Call

Here are a few examples of when we may contact you about these programs.
Visit **carefirst.com/fcps** to learn more.

	Program name	Overview	Why it's important	Communication
	**Health & Wellness**	Personal coaching support to help you achieve your health goals	Health coaching can help you manage stress, eat healthier, quit smoking, lose weight and much more	Letter or phone call from a ***Sharecare coach***
	**Complex Care Coordination**	Support for a variety of critical health concerns or chronic conditions	Connecting you with a nurse who works closely with your primary care provider (PCP) to help you understand your doctor's recommendations, medications and treatment plans	Introduction by your PCP or a phone call from a ***CareFirst care coordinator (nurse)***
	**Hospital Transition of Care**	Supporting transition from hospital to home	Help plan for your recovery after you leave the hospital, answer your questions and, based on your needs, connect you to additional services	Onsite visit or phone call from a ***CareFirst nurse***
	**Behavioral Health and Substance Use Disorder**	Support for mental health and/or addiction issues	Confidential, one-on-one support to help schedule appointments, explain treatment options, collaborate with doctors and identify additional resources	Phone call from a ***CareFirst behavioral health care coordinator***

This wellness program is administered by Sharecare, Inc., an independent company that provides health improvement management services to CareFirst members. Sharecare, Inc. does not provide CareFirst BlueCross BlueShield products or services and is solely responsible for the health improvement management services it provides.

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Find a Doctor, Hospital or Urgent Care

carefirst.com/fcps

It's easy to find the most up-to-date information on health care providers and facilities who participate with CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst).

Whether you need a doctor or a facility, **carefirst.com/fcps** can help you find what you're looking for based on your specific needs. We make it easy for you to find the doctors you need. The site is updated weekly, so you always have the most up-to-date information available.

The most up-to-date information:

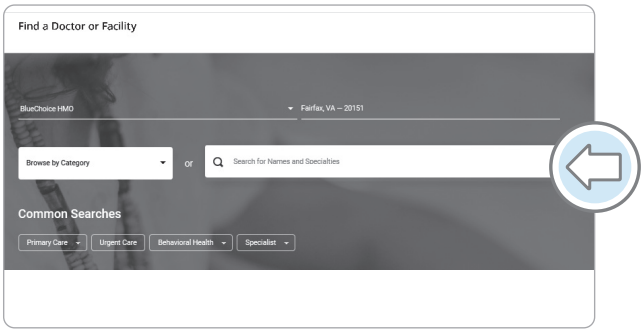
Go to **carefirst.com/fcps**. From here you can:

- Find a doctor or provider in your plan
- Search for a doctor by name

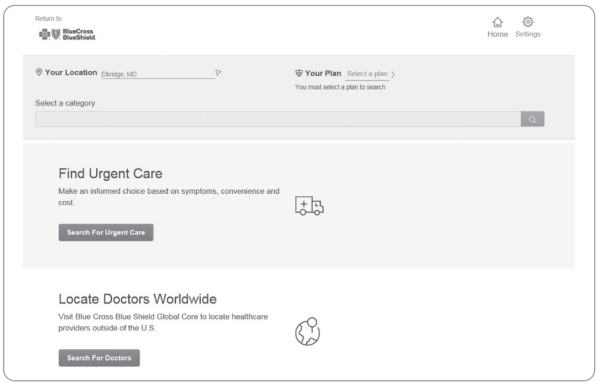
Select *Find a Doctor* tab to:

- Learn more about our directory
- Research a doctor or a hospital
- Learn about specialists

To locate a provider inside the CareFirst service area—search both BlueChoice HMO and BluePreferred (PPO).



To locate a BlueCard PPO provider outside the CareFirst service area, search the National Provider Directory at BCBS.com. Search by Plan Name and select BlueCard PPO/EPO.



BlueChoice Advantage

Offers you the freedom to choose

BlueChoice Advantage provides you with choices that offer control over your out-of-pocket costs. There's no need to select a primary care provider (PCP) or to obtain a referral to see a specialist with this plan. You have the freedom to visit any provider and your choice will determine your out-of-pocket costs.

Benefits of BlueChoice Advantage

- Choose from a network of almost 40,000 CareFirst BlueChoice providers, specialists and hospitals in Maryland, Washington, D.C. and Northern Virginia
- Access to more than 960,000 PPO providers through the national BlueCard PPO network and CareFirst's local BluePreferred PPO network
- No PCP selection required
- No PCP referral required to see a specialist
- Predictable copays when you receive care from an in-network provider

How your plan works

The BlueChoice Advantage plan offers you the flexibility and freedom to choose from both in- and out-of-network providers.

Receiving care inside the CareFirst service area

In-network benefits

When care is rendered inside the CareFirst service area (Maryland, Washington, D.C., and Northern Virginia), use the CareFirst BlueChoice HMO or BluePreferred PPO provider network to receive the highest level of coverage and pay lower out-of-pocket costs.

Receiving care outside the CareFirst service area

In-network benefits

When care is rendered outside the CareFirst service area, use the national BlueCard PPO provider network to receive the highest level of coverage and pay lower out-of-pocket costs.

Using out-of-network benefits

Member will still have the option to opt-out of using in-network providers, but will pay a higher out-of-pocket expense.

If you receive services from a provider outside of the BlueChoice HMO, BluePreferred PPO, and BlueCard PPO networks, you will have to:

- Pay the provider's actual charge at the time you receive care
- File a claim for reimbursement
- Satisfy a deductible and coinsurance

The choice is entirely yours. That's the advantage of this plan.

Hospital Authorization/Utilization Management

If you are receiving care from an In-Network CareFirst BlueChoice HMO, BluePreferred PPO or BlueCard PPO provider, your In-Network provider will obtain any necessary admission authorizations for covered services.

If you are receiving care from an Out-of-Network provider, you'll be responsible for obtaining authorization for services. Call toll-free at 866 PREAUTH (733-2884) for authorization.

Laboratory services

Participating BlueChoice providers and outpatient facilities must use LabCorp® facilities for laboratory services to be covered in-network.

For BlueChoice providers who refer you to a lab, you must use a Labcorp facility for laboratory services to be covered under your in-network coverage.

LabCorp has approximately 100 locations throughout Maryland, Washington, D.C. and Northern Virginia. To locate the LabCorp patient service center near you, call 888-LAB-CORP (522-2677) or visit **labcorp.com**. Any lab work performed in an outpatient hospital setting will require a prior authorization.

You may also use a participating BlueCard PPO laboratory and receive in-network benefits if the ordering physician and/or outpatient facility is not a BlueChoice participating provider.

How BlueChoice Advantage works

	In-network (you pay)	Out-of-network (you pay)
Provider	Care received by a BlueChoice, BluePreferred, or BlueCard PPO provider	Care received by a non-participating provider
Deductible (per calendar year)	$250 Individual/$500 Family	$500 Individual/$1,000 Family
Out-of-Pocket Maximum (per calendar year)	$2,000 Individual (applies to deductibles, coinsurance, and copays) Combined in- and out-of-network $4,000 Family (applies to deductibles, coinsurance, and copays) Combined in- and out-of-network	
Coinsurance	10% of allowed benefit after deductible	40% of allowed benefit after deductible
Preventive Services	No charge (no copayment or coinsurance)	40% of allowed benefit after deductible
Office Visits	Deductible, then $20 PCP/$40 Specialist copay per visit	40% of allowed benefit after deductible
Inpatient Hospitalization		
▪ Facility	$150 per admission copay, $100 copay per day (maximum 5 daily copays) after deductible	$150 per admission copay and 40% allowed benefit after deductible
▪ Physician	$20 PCP/$40 Specialist copay per provider per day	40% of allowed benefit after deductible per provider per day
Emergency Room*	$250 copay and 10% of allowed benefit after deductible per visit	$250 copay and 10% of allowed benefit after deductible per visit

* Bona fide emergency must exist for emergency room services to be covered.

Patient-Centered Medical Home

Supporting the relationship between you and your doctor

Whether you're trying to get healthy or stay healthy, you need the best care. That's why CareFirst[1] created the Patient-Centered Medical Home (PCMH) program to focus on the relationship between you and your primary care provider (PCP).

The program is designed to provide your PCP with a more complete view of your health needs. Your PCP will be able to use information to better manage and coordinate your care with all your health care providers including specialists, labs, pharmacies and others to ensure you get access to, and receive the most appropriate care in the most affordable settings.

Extra care for certain health conditions

If you have certain health conditions, your PCMH PCP will partner with a care coordinator, a registered nurse, to:

- Create a care plan based on your health needs with specific follow up activities
- Check in with you to make sure you're following your treatment plan
- Assist you in obtaining services and equipment necessary to manage your health condition(s)

A PCP is important to your health

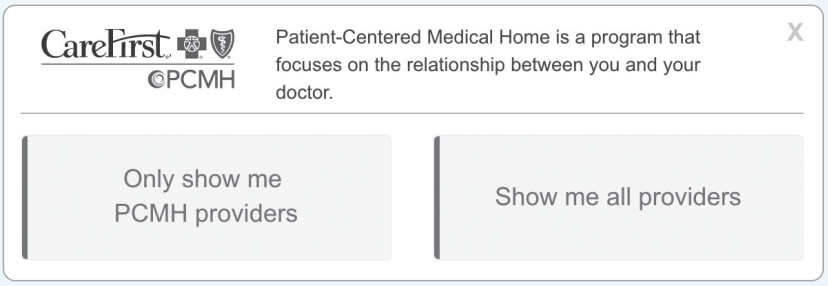
By visiting your PCP for routine visits, you build a relationship, and your PCP will get to know you and your medical history.

If you have an urgent health issue, having a PCP who knows your history often makes it easier and faster to get the care you need.

Even if you are young and healthy, or don't visit the doctor often, choosing a PCP is key to maintaining good health.

PCPs play a huge role in keeping you healthy for the long run. If you don't already have a relationship with a doctor, you can begin researching one today!

- To find a PCMH PCP, look for the PCMH logo when searching for primary care providers in our Provider Directory.



[1] All references to CareFirst refer to CareFirst BlueCross BlueShield and CareFirst, BlueChoice, Inc., collectively.

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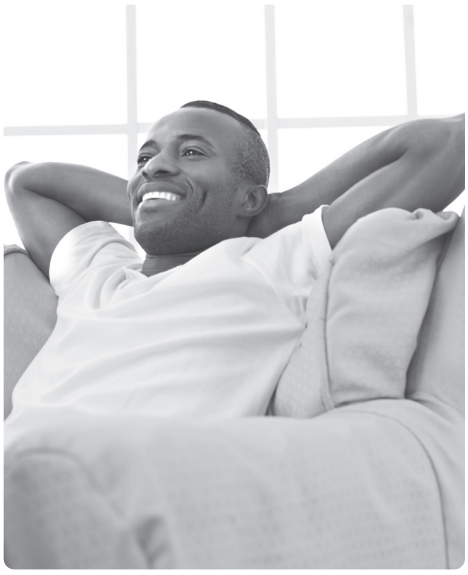
Plan Summary of Benefits

This section contains a summary of the BlueChoice Advantage plan benefits and provides basic information on the plans including copayments, deductibles, out-of-pockets limits, and maximums.

Calendar year deductible

In-network

Before the plan pays in-network benefits for covered services, you must satisfy a calendar year deductible. This means that each calendar year when you receive medical care for which benefits are available under the in-network component, you pay a portion of the cost before the plan pays any of the cost.



Out-of-network

Through the out-of-network component of the plan, you can choose to receive your care from any covered provider that is not considered in-network. However, your out-of-pocket expenses will be higher than if you receive services from an in-network provider.

Before the plan pays out-of-network benefits for covered services, you must satisfy a calendar year deductible. This means that each calendar year when you receive medical care for which benefits are available under the out-of-network component, you pay a portion of the cost before the plan pays any of the cost.

	Individual Deductible (per calendar year)	Family Deductible (per calendar year)
In-network (not combined with out-of-network)	$250	$500
Out-of-network (not combined with in-network)	$500	$1,000

NOTE: Charges that exceed the allowed benefit do not contribute toward meeting the deductible. Once an individual meets their calendar year deductible, the plan begins to pay. Under Family coverage, the eligible expenses of all covered family members may be combined toward the family out-of-network deductible. Note that under Minifamily coverage, each individual must satisfy the individual deductible.

Copayments, coinsurance and per confinement copayment

In-network

A copayment is the amount you pay at the time you seek certain types of care and depends on the medical service you receive. Generally, these payments are $20 for a PCP and $40 for a Specialist office visit after the calendar year deductible has been satisfied. For inpatient hospital, there is a $150 per admission copay, plus an additional $100 copay per day (maximum 5 daily copays) after the deductible has been satisfied for the facility, and $20 PCP/$40 Specialist copay per provider per day after deductible for physician services. Inpatient diagnostic services are also subject to a $40 Specialist copay after deductible, per provider, per day if billed by the practitioner.

Out-of-network

Most out-of-network covered services are reimbursed at 60 percent of the allowed benefit once you have met the individual or family calendar year deductible. The remaining 40 percent of the allowed benefit is called your coinsurance amount. You may also be responsible for any remaining amount above the allowed benefit, up to the provider's charge, when you receive care out-of-network from non-participating providers.

Hospital admissions are subject to a $150 per confinement copayment. Note that all related admissions will be considered as one period of confinement. Separate admissions are considered related unless the stays (1) result from wholly unrelated causes; or, (2) are separated by 60 consecutive days during which the patient had no other hospital stays.

Reaching your out-of-pocket maximum

In-network

Your in-network benefits for the most part are covered at 100 percent of the allowed benefit once you have met the calendar year deductible and paid the applicable copays and coinsurance. However, there is a limit on the amount of money you will spend out of your own pocket during any calendar year. This is called your out-of-pocket maximum. This maximum includes deductibles, coinsurance and copays you paid out of your pocket. It does not include any amount over the allowed benefit or non-covered services. Once you reach the out-of-pocket maximum in a calendar year, the plan will begin to pay 100 percent of the allowed benefit for your eligible covered medical expenses for the rest of that calendar year.

Out-of-pocket Maximum (per calendar year)	In-network	Out-of-network
Medical Plan: Copays, Deductible, Coinsurance	$2,000 Individual $4,000 Family	
Pharmacy: Out-of-pocket Maximum	$1,500 Individual $3,000 Family	
Total: Out-of-pocket Maximum	The combined out-of-pocket maximum for medical and pharmacy copays, deductible and coinsurance is $3,500 person/$7,000 family. Applies to covered/allowable charges.	

NOTE: You are responsible for all medical copays, coinsurance and deductibles until the medical out-of-pocket maximum is reached.

Your out-of-pocket maximum (combined in- and out-of-network) for medical copays, coinsurance and deductible is $2,000 Individual/$4,000 Family per year. The combined out-of-pocket limit for medical and pharmacy copays, deductibles and coinsurance is $3,500 Individual/$7,000 Family. This applies to covered/allowable charges.

Once an individual meets their out-of-pocket maximum for copays, coinsurance and deductible, then the copays, coinsurance and deductible will no longer apply in- and out-of-network. Under Family coverage, the eligible expenses of all covered family members may be combined to satisfy the family out-of-pocket maximum. Note that under Minifamily (2-Party) coverage, each individual must satisfy their own out-of-pocket maximum.

Out-of-network

If you or a covered family member gets seriously hurt or sick, your medical expenses could be quite high. However, since out-of-network benefits are generally provided at 60 percent of the allowed benefit, there is a limit on the amount of money you will spend out of your own pocket in a calendar year for covered out-of-network services. This is called your out-of-pocket maximum. Once you reach the out-of-pocket maximum in a calendar year, the plan will begin to pay 100 percent of the allowed benefit for your eligible covered medical expenses for the rest of that calendar year. You will be responsible for amounts in excess of the allowed benefit.

The following items DO NOT contribute toward the annual out-of-pocket expense maximum:

- Penalties for failure to comply with Utilization Management Program requirements
- Non-covered services
- Amounts in excess of the allowed benefit

Out-of-pocket Maximum (per calendar year)	In-network	Out-of-network
Individual	$2,000 (applies to deductibles, coinsurance and copays) Combined in- and out-of-network	
Family	$4,000 (applies to deductibles, coinsurance and copays) Combined in- and out-of-network	

NOTE: Your out-of-pocket maximum is $2,000 per individual per calendar year. Under Family coverage, the eligible expenses of all covered family members may be combined to satisfy the family out-of-pocket maximum of $4,000. Note that under Minifamily coverage, each individual must satisfy the $2,000 out-of-pocket maximum.

BlueVision Plus (Davis Vision)

A plan for healthy eyes, healthy lives

Professional vision services including routine eye examinations, eyeglasses and contact lenses offered by CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., through the Davis Vision, Inc. national network of providers.

Healthy vision—an important asset

Healthy eyes are an important part of your overall health. Routine eye examinations not only keep your eyewear current; they can also detect high-risk health issues such as diabetes and glaucoma before symptoms occur. Whether you have 20/20 vision or 20/200 vision, you should have a routine eye examination on a regular basis to keep your eyes healthy.

That's why we are pleased to offer BlueVision Plus, giving you complete eye health as part of your medical plan. BlueVision Plus makes eye health easy, offering a large network of optometrists, ophthalmologists and opticians from which to choose.

To administer your group's vision benefits, CareFirst and CareFirst BlueChoice have selected Davis Vision, Inc.—one of the nation's leading managed vision and eye care providers.

Need more information? Please visit **carefirst.com/fcps** or call 888-343-3462.

How the plan works

How do I find a provider?

BlueVision *Plus* offers a national network consisting of optometrists, ophthalmologists and opticians. To find a provider, go to **carefirst.com/fcps** and utilize the *Find a Doctor* feature or call Davis Vision at 888-343-3462 for a list of network providers closest to you. Be sure to ask your provider if he or she participates with the Davis Vision network before you receive care.

How do I receive care from a network provider?

BlueVision *Plus* is as easy to use as it is effective. Simply call your provider and schedule an appointment. Identify yourself as a CareFirst BlueCross BlueShield or CareFirst BlueChoice member and provide the doctor with your identification number, as well as your date of birth. Then go to the provider to receive your service. There are no claim forms to file.

BlueVision Plus (Davis Vision)

In-network	You Pay
EYE EXAMINATIONS (Once per calendar year)	
Routine Eye Examination with dilation	$20 copay
FRAMES (Once every other calendar year)	
Davis Vision Frame Collection	
Fashion level	No copay
Designer level	No copay
Premier level	$25 copay
Non-Collection Frame	Plan pays up to $130, you pay balance minus 20% discount
SPECTACLE LENSES (Once per calendar year)	
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any Rx)	No copay
CONTACT LENSES (Initial supply) (Once per calendar year, in lieu of spectacle lenses)	
Davis Vision Contact Lens Collection (see details below)	No copay
Medically Necessary Contact Lenses	No copay with prior approval
Other (Non-Collection) Contact Lenses	Plan pays up to $125, you pay balance minus 15% discount
CONTACT LENS EVALUATION, FITTING AND FOLLOW-UP CARE (Once per calendar year)	
Davis Vision Collection	No copay
Standard Contact Lenses	15% discount
Medically Necessary Contact Lenses	No copay
Specialty Contact Lenses that are non-collection, including, but not limited to, toric, multifocal and gas permeable lenses	15% discount
LENS OPTIONS[1] (Add to spectacle lens prices above)	
Standard Progressive Lenses	$50
Premium Progressive Lenses (Varilux®, etc.)	$90
Ultra Progressives[2]	$150
Polarized Lenses	$75
High Index Lenses	$55
Blended Segment Lenses	$20
Polycarbonate Lenses for children, monocular and high prescription	No copay
Polycarbonate Lenses for all other patients	$30
Transition Lenses	$65
Intermediate Vision Lenses	$30
Photochromic Lenses	$20
Scratch-Resistant Coating	No copay
Standard Anti-Reflective Coating (ARC)	$35
Premium Glare Resistant Anti-Reflective Coating (ARC)	$48
Ultra Anti-Reflective Coating (ARC)	$60
Ultraviolet (UV) Coating	$12
Tinting	No copay
Oversize Lenses	No copay
Plastic Photosensitive Lenses	$65

In-network	You Pay
CONTACT LENSES (MAIL ORDER)[1]	
DavisVisionContacts.com Mail Order Contact Lens Replacement Program	Up to 40% off Retail Prices
LASER VISION CORRECTION	
Laser Vision Correction[1]	Up to 25% off allowed amount or 5% off any advertised special[3]

Out-of-network	You Pay
Routine Eye Examination with dilation (per calendar year)	Plan pays $40, you pay balance
Frames	Plan pays $45, you pay balance
Single Lenses	Plan pays $40, you pay balance
Bifocal Lenses	Plan pays $60, you pay balance
Trifocal Lenses	Plan pays $80, you pay balance
Lenticular (post-cataract) Eyeglass Lenses	Plan pays $80, you pay balance
Medically Necessary Contacts	Plan pays $225, you pay balance
Elective Contact Lenses	Plan pays $125, you pay balance
Elective Bifocal Contact Lenses	Plan pays $125, you pay balance

[1] These services or supplies are not considered covered benefits under the Plan. This portion of the Plan is not an insurance product.

[2] Includes digital free-form progressive lenses.

[3] Please note that some providers have flat fees that are equivalent to these discounts.

Davis Vision Contact Lens Collection (additional information)

- The Davis Vision Contact Lens Collection offers a wide variety of covered-in-full contact lenses from today's top manufacturers, including CooperVision® and Vistakon®, in both traditional and silicone hydrogel materials. The collection is inclusive of disposable, planned replacement and select torics and multifocals. The collection is updated regularly to reflect industry trends.
- Contact your provider or Davis Vision for the latest contact lens collection.
- Members can receive up to 4 boxes of disposable contact lenses or two boxes of planned replacement contact lenses in lieu of glasses each calendar year.

Exclusions

The following services are excluded from coverage:

- Diagnostic services, except as may be necessary for a vision exam
- Medical care or surgery
- Prescription Drugs, except as may be necessary for a vision exam
- Orthoptics, vision training and low vision aids
- Except as otherwise provided, vision care services for Cosmetic use
- Replacement, within the same calendar year/24-month period, of frames, lenses or contact lenses that were lost or broken
- Non-prescription glasses, sunglasses or contact lenses
- Services or supplies for which prior authorization is required but not obtained

Benefits issued under policy form numbers: Non-rider/Freestanding:

MD CFMI: CFMI/51+/GC (R. 7/10) • CFMI/EOC/D-V (R. 10/11) • CFMI/VISION DOCS (R. 10/11) • CFMI/VISION SOB (R. 10/11) • CFMI/ELIG/D-V (7/09) • and any amendments.

MD GHMSI: MD/CF/GC (R. 7/10) • MD/CF/EOC/D-V (R. 10/11) • MD/CF/DOCS-V (R. 10/11) • MD/CF/SOB-V (R. 10/11) • MD/CF/ELIG (R. 1/08) • and any amendments.

Ridered: CFMI/VISION RIDER (10/11) • MD/BCOO/VISION (R. 10/11) • MD/CF/VISION (R. 10/11).

CST1821-1P (3/18)

What if I go out-of-network?

Staying in-network gives you the best benefit, but BlueVision Plus does offer an out-of-network allowance schedule as well. In this case, you may see any provider you wish, but you will be responsible for all payments up-front. You will also be responsible for filing the claim with Davis Vision for reimbursement and paying any balances over the allowed benefit to the non-participating provider. You can find the claim form by going to **carefirst.com/fcps**, locate *Plan Information,* then select *Vision Claim Form* under *Member Forms.*

May I use my benefit at different times?

Of course there will be times when you choose not to select your eyeglasses at the same time you receive your examination. You may "split" your benefits by getting your examination and your eyewear at different times. You don't even need to go to the same provider, but your care will be most effective when you stay with the same provider. When bringing an outside prescription to any provider, please confirm in advance that the provider will fill an outside prescription.

Can I get contacts and eyeglasses in the same benefit period?

With BlueVision Plus, the benefit covers one pair of eyeglasses **or** a supply of contact lenses per benefit period.

Mail order replacement contact lenses

Free membership and access to a mail order replacement contact lens service, Davis Vision Contacts provides a fast and convenient way to purchase replacement contact lenses at significant savings. For more information, please call 855-589-7911 or visit **davisvisioncontacts.com**.

Covered Services

Service	In-network, You Pay:[1,2]	Out-of-network, You Pay:[1,3]
Provider	Care received by a BlueChoice, BluePreferred, or BlueCard PPO provider	Care received by a non-participating provider
24-HOUR NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **carefirst.com/fcps** to learn more about your options for care.	When your doctor is not available, call the 24-Hour Nurse Advice Line at 800-535-9700 to speak with a registered nurse about your health questions and treatment options.	
ANNUAL DEDUCTIBLE[4]		
Individual	$250	$500
Family	$500	$1,000
INPATIENT HOSPITAL SERVICES		
Hospital Admission (facility charges)** **See page 34 for information on maternity admissions**	$150 per admission copay, then $100 copay per day (maximum 5 daily copays) after deductible	$150 per admission copay, then 40% of allowed benefit after deductible
Rehabilitative Facility *(Not related to Alcohol and Drug Abuse Treatment Rehabilitation)* (see below for more information on covered hospital services while inpatient such as Physician Services, Diagnostic (Non-Routine) Services, and Therapeutic Services (Hospital and Physician Billed).	$150 per admission copay, then $100 copay per day (maximum 5 daily copays) after deductible Benefit limited to 90 days per calendar year in a rehabilitative hospital if medically necessary and preauthorized. **Note:** If admission immediately follows a related hospital confinement, a separate $150 per confinement copayment will not apply nor the $100 copay per day (maximum 5 daily copays).	$150 per admission copay, then 40% allowed benefit for covered services after deductible Benefit limited to 90 days (combined in- and out- of-network per calendar year in a rehabilitative hospital if medically necessary and preauthorized). **Note:** If admission immediately follows a related hospital confinement, a separate $150 per confinement copayment will not apply.
****NOTE:** Hospital services covered in-network and out-of-network include: ▪ Room and Board—room with 2 or more beds, average semi-private room ▪ Hospital services, including ▪ meals, including special diets ▪ drugs and medicines provided by the hospital while you are a patient in the hospital, including intravenous solutions and injections ▪ oxygen, including the use of equipment for its administration ▪ artificial limbs and orthopedic braces ▪ diagnostic services such as laboratory and radiology ▪ operating room services ▪ incremental nursing services ▪ blood administration and handling ▪ pharmaceutical services ▪ durable medical equipment and medical supplies		
Physician Services While Inpatient ▪ Physicians visits ▪ Surgeon ▪ Surgical Assistants ▪ Radiologist ▪ Anesthesiologists ▪ Pathologists	$20 PCP/$40 Specialist copay after deductible per provider per day	40% of allowed benefit after deductible
NOTE: Inpatient physician visit services covered in-network and out-of-network include: ▪ Any medically necessary physician visit during an approved admission ▪ Intensive care which requires a physician's attendance ▪ Consultation by another physician when additional skilled care is required due to the complexity of the condition and the consultation is requested by the attending provider Benefits for physician inpatient visits are not paid during hospital admissions for the following purposes: convalescent care, custodial or institutional care, rest, occupational, speech, or physical therapy. Also, benefits are not provided for physician hospital visits when a claim for hospitalization has been denied.		

Authorization must be obtained for any inpatient hospitalization. See page 47 for details.

Service	In-network, You Pay:[1,2]	Out-of-network, You Pay:[1,3]
Provider	Care received by a BlueChoice, BluePreferred, or BlueCard PPO provider	Care received by a non-participating provider
INPATIENT HOSPITAL SERVICES (CONTINUED)		
Diagnostic (Non-Routine) Services While Inpatient ▪ Laboratory ▪ X-rays ▪ Machine test	$40 Specialist copay after deductible per provider per day if billed by the practitioner	40% of allowed benefit after deductible
NOTE: The following services are not covered when billed in connection with laboratory services: laboratory handling fees when billed alone; or with medical care and/or laboratory studies.		
Therapeutic Services (Hospital and Physician Billed) While Inpatient ▪ Radiation therapy ▪ Chemotherapy ▪ Respiratory (Inhalation) therapy ▪ Physical, occupational, and speech therapy ▪ Dialysis ▪ Infusion and nutritional therapies	No charge* after deductible for facility. If billed by a practitioner, $40 copay per provider per day.	40% of allowed benefit after deductible
EMERGENCY ROOM AND URGENT CARE SERVICES		
Emergency Room Care Care provided in the hospital emergency room related to a medical emergency or accidental injury.	10% of allowed benefit after $250 copayment per visit after deductible ($250 copayment is waived if you are admitted to the hospital directly from the emergency room). Emergency Room Practitioner is 10% allowed benefit after deductible. Related laboratory and diagnostic services are covered at 10% after the deductible.	10% of allowed benefit after $250 copayment per visit after in-network deductible ($250 copayment is waived if you are admitted to the hospital directly from the emergency room). Emergency Room Practitioner is 10% allowed benefit after in-network deductible. Related laboratory and diagnostic services are covered at 10% after the in-network deductible.
Air and Ground Ambulance Service to a Hospital for Emergency Services	10% of allowed benefit after deductible for a bona fide emergency	10% of allowed benefit after in-network deductible for a bona fide emergency
NOTE: See page 40 for medically necessary non-emergency Air Ambulance Services.		
Urgent Care Center—Emergency Care	$40 copay per visit	$40 copay per visit NOTE: Non-network urgent care centers may request payment in full at the time of service
Urgent Care Center — Non-Emergency Care	$40 copay per visit	$40 copay per visit NOTE: Non-network urgent care centers may request payment in full at the time of service
Emergency Care—Provider's Office	$20 PCP/$40 Specialist copay after deductible per visit Copay applies to office exam only; surgical services are paid as surgery (page 35)	$20 PCP/$40 Specialist copay after in-network deductible per visit Copay applies to office exam only; surgical services are paid as surgery (page 35)
Emergency Services means those health care services that are rendered after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in: ▪ Serious jeopardy to the mental or physical health of the individual ▪ Danger of serious impairment of the individual's bodily functions ▪ Serious dysfunction of any of the individual's bodily organs ▪ In the case of a pregnant woman, serious jeopardy to the health of the fetus Examples might include, but are not limited to, heart attacks, uncontrollable bleeding, inability to breathe, loss of consciousness, poisonings, and other acute conditions as CareFirst determines. **Note:** All follow-up care is paid the same as other outpatient services.		

*No copayment or coinsurance

Service	In-network, You Pay:[1,2]	Out-of-network, You Pay:[1,3]
Provider	Care received by a BlueChoice, BluePreferred, or BlueCard PPO provider	Care received by a non-participating provider
MATERNITY CARE AND FAMILY PLANNING SERVICES†		
Inpatient Hospital (see page 32 for more information on covered hospital services)	$150 per admission copay, then $100 copay per day (maximum 5 daily copays) after deductible	$150 per admission copay, then 40% allowed benefit after deductible
Inpatient Hospital Practitioner Services	$20 PCP/$40 Specialist copay after deductible	40% of allowed benefit after deductible
Physician Services Pre and Postnatal Office Visits	No charge*	40% of allowed benefit after deductible
Nurse Midwife Pre and Postnatal Office Visits	No charge*	40% of allowed benefit after deductible
Birthing Center Facility	$100 copay after deductible	40% of allowed benefit after deductible
Birthing Center Practitioner Services	$40 copay after deductible	40% of allowed benefit after deductible
Lactation Support and Counseling; Breastfeeding Supplies and Equipment	No charge*	40% of allowed benefit after deductible

NOTE: The following maternity care services are covered in-network and out-of-network under the FCPS Plan; these services are available to Employees/Members, Dependent Spouses, and Dependent Children.†
▪ Obstetrical care for a normal pregnancy including prenatal care, delivery, and postnatal care as well as for cesarean section, if medically indicated
▪ Treatment of an ectopic pregnancy or miscarriage
▪ Abortion
▪ Routine newborn nursery visits are covered when the mother's hospital stay is covered
▪ Circumcision, but only when infant is eligible for coverage
▪ Two postpartum home visits per delivery when the mother and child are discharged from the hospital as follows:
  ▪ In less than 48 hours following an uncomplicated vaginal delivery
  ▪ In less than 96 hours following an uncomplicated cesarean delivery
  ▪ The postpartum home visit will be subject to coinsurance or copayments, but not the deductible. Does not apply to home health maximum.
▪ Newborn hearing screening
† There are no benefits for newborns of dependent children following discharge of the mother from the hospital or birthing center.		

FAMILY PLANNING SERVICES		
Contraceptive Counseling (contraceptive counseling and devices)	No charge*	40% of allowed benefit after deductible
Artificial Insemination† ▪ Facility ▪ Practitioner services	 $100 copay, after deductible $40 Specialist copay after deductible per provider per day	 40% of allowed benefit after deductible 40% of allowed benefit after deductible per provider per day
In Vitro Fertilization† ▪ Facility ▪ Practitioner services	 $100 copay, after deductible $40 Specialist copay after deductible per provider per day	 40% of allowed benefit after deductible 40% of allowed benefit after deductible per provider per day
† Artificial Insemination and In Vitro Fertilization subject to a lifetime maximum benefit of $100,000 combined in- and out-of-network and across all plans. The member does not have to be married to receive IVF services, but must meet the definition of infertile. See CareFirst Medical Policy for covered benefits and limitations at **https://provider.carefirst.com/providers/medical/medical-policy.page?** and click on *Medical Policies* tab. Utilization Management Approval is required. CVS Caremark, a subcontractor of CareFirst, will coordinate medication requirements with the physician and CareFirst. If CVS Caremark approves, the medication can be dispensed.		
Female Elective Sterilization	No charge*	40% of allowed benefit after deductible
Male Elective Sterilization ▪ Outpatient Facility ▪ Practitioner Services	 $100 copay after deductible $40 Specialist copay after deductible per provider per day	 40% of allowed benefit after deductible 40% of allowed benefit after deductible per provider per day

*No copayment or coinsurance

Service	In-network, You Pay:[1,2]	Out-of-network, You Pay:[1,3]
Provider	Care received by a BlueChoice, BluePreferred, or BlueCard PPO provider	Care received by a non-participating provider
OUTPATIENT HOSPITAL SERVICES		
Facility Charges ▪ Ambulatory Surgical Facility or Outpatient Hospital	$100 copay after deductible per visit	40% of allowed benefit after deductible per visit
Physician Services, including ▪ Physician ▪ Surgeon ▪ Assistant Surgeon ▪ Anesthesia billed by: physician or nurse anesthetist, acupuncture provided by a physician (used for anesthetic purpose only as part of covered surgical services) ▪ Medical and surgical consultations	$20 PCP/$40 Specialist copay after deductible per provider per day	40% of allowed benefit after deductible per provider per day
NOTE: Surgical services covered in-network and out-of-network: ▪ The treatment of fractured and dislocated bones ▪ Operations necessary for the treatment of disease or injury ▪ Sterilization ▪ Endoscopic procedures where a tube is inserted to examine internal organs ▪ Oral surgery, limited to the following: ▪ The reduction of, dislocation of, or excision of temporomandibular joints (see CareFirst medical policy for more details) ▪ Procedures involving accessary sinuses, salivary glands or ducts ▪ Excision of tumors and cysts of the jaw, cheeks, roof and floor of 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 If two surgical procedures are performed at the same time, your FCPS Plan will usually pay the normal benefit (in-network or out-of-network) for the primary procedure and a reduced benefit for the other procedures. Each procedure must be medically necessary.		
Diagnostic Services (including pre-admission testing performed in an outpatient hospital setting)† ▪ Laboratory ▪ X-rays ▪ Machine tests	No charge* after deductible	40% of allowed benefit after deductible
▪ Imaging (MRI, MRA/MRS, PET and CAT Scans)	$100 copay after deductible if provided in physician's office or approved network facility	40% of allowed benefit after deductible
†Prior authorization required for diagnostic and screening services performed in the outpatient department of a hospital Participating BlueChoice providers and outpatient facilities must use LabCorp® facilities for laboratory services to be covered in-network. For BlueChoice providers who refer you to a lab, you must use a LabCorp® facility for laboratory services to be covered under your in-network coverage. You may also use a participating BlueCard PPO laboratory and receive in-network benefits if the ordering physician and/or outpatient facility is not a BlueChoice participating provider. The following services are not covered when billed in connection with laboratory services: laboratory handling fees when billed alone; or with medical care and/or laboratory studies. **NOTE:** These services are covered at a higher level when performed in a physician's office or freestanding network provider.		
Therapeutic Services (provided in outpatient hospital setting, including) ▪ Radiation therapy ▪ Chemotherapy ▪ Inhalation therapy ▪ Physical therapy ▪ Occupational therapy ▪ Speech therapy	No charge* after deductible for the facility. $40 copay after deductible per provider per day	40% of allowed benefit after deductible for both the facility and facility practitioner
NOTE: In-network and out-of-network physical, occupational and speech therapy benefits are limited to a 90-visit maximum combined per condition per calendar year and combined between in- and out-of-network.		

*No copayment or coinsurance

Service	In-network, You Pay:[1,2]	Out-of-network, You Pay:[1,3]
Provider	Care received by a BlueChoice, BluePreferred, or BlueCard PPO provider	Care received by a non-participating provider
Nutritional Counseling (see exclusions and limitations)	$20 PCP/$40 Specialist copay after deductible per visit	40% of allowed benefit after deductible per provider per day
Outpatient Cardiac Rehabilitation Program Hospital Outpatient or Approved Outpatient Facility	No charge* after deductible for the facility. $40 copay after deductible for the facility practitioner per day	40% of allowed benefit after deductible per provider per day
PHYSICIAN AND PROFESSIONAL SERVICES—OFFICE SETTING OR FREESTANDING FACILITY		
Physician Services (office, home, and provider-sponsored telemedicine visits)	$20 PCP/$40 Specialist copay after deductible per visit	40% of allowed benefit after deductible
CareFirst Video Visit (CareFirst sponsored telemedicine visits)	See Benefit information on page 11 and Registration information on page 13	Not covered
Convenience Care Center	$20 copay per visit	40% of allowed benefit after deductible
Allergy Treatment ▪ Injections	Injections only—No charge* after deductible. Office visit billed along with an allergy injection is subject to the $20 PCP/$40 Specialist office visit copayment after deductible	40% of allowed benefit after deductible
▪ Allergy Testing	$20 PCP/$40 Specialist copay after deductible	40% of allowed benefit after deductible
▪ Allergy Serum and Biological Sera and Other Injections	No charge* after deductible	40% of allowed benefit after deductible
Diagnostic Testing (provided in physician's office or freestanding facility)† ▪ Laboratory ▪ X-rays ▪ Machine tests	No charge* after deductible if provided in physician's office or approved network facility	40% of allowed benefit after deductible
▪ Imaging (MRI, MRA/MRS, PET, CAT scans)	$75 copay after deductible if provided in physician's office or approved network facility	40% of allowed benefit after deductible
Participating BlueChoice providers and outpatient facilities must use LabCorp® facilities for laboratory services to be covered in-network. For BlueChoice providers who refer you to a lab, you must use a LabCorp® facility for laboratory services to be covered under your in-network coverage. You may also use a participating BlueCard PPO laboratory and receive in-network benefits if the ordering physician and/or outpatient facility is not a BlueChoice participating provider. †The following services are not covered when billed in connection with laboratory services: laboratory handling fees when billed alone; or with medical care and/or laboratory studies.		
Therapeutic Services (provided in physician's office or freestanding facility) ▪ Radiation therapy ▪ Chemotherapy ▪ Respiratory therapy ▪ Speech, physical or occupational therapist ▪ Chiropractor	$40 copay after deductible per visit	40% of allowed benefit after deductible per visit
NOTE: In-network and out-of-network physical, occupational and speech therapy benefits are limited to a 90-visit maximum combined per condition per calendar year and combined between in- and out-of-network.		
Nutritional Counseling (by approved provider – see exclusions and limitations)	$20 PCP/$40 Specialist copay after deductible per visit	40% of allowed benefit after deductible
Dialysis ▪ Facility charges (Outpatient Hospital-billed or Freestanding Dialysis Facility)	No charge* after deductible at approved facilities	40% of allowed benefit after deductible
▪ Physician-billed services	$40 copay after deductible per visit	40% of allowed benefit after deductible per visit

*No copayment or coinsurance

Service	In-network, You Pay:[1,2]	Out-of-network, You Pay:[1,3]
Provider	Care received by a BlueChoice, BluePreferred, or BlueCard PPO provider	Care received by a non-participating provider
PREVENTIVE SERVICES		
Preventive (routine) Physicals, including: ▪ Related laboratory and other routine diagnostic tests ▪ Routine immunizations	No charge*	40% of allowed benefit after deductible
NOTE: Preventive (routine) examinations may include screenings for prostate cancer, osteoporosis prevention, chlamydia, human papillomavirus (HPV), colorectal cancer, syphilis infection in non-pregnant adults and adolescents, and depression if appropriate. Access the following link for a full list of adult and children's immunizations: **http://www.cdc.gov/vaccines/schedules/hcp/index.html**. Preventive (routine) tests provided at outpatient facilities or freestanding facilities are covered in full when using network providers. Access the following link for list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations: **https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/**. For colorectal screening recommendations see CareFirst Medical Policy at **https://provider.carefirst.com/providers/medical/medical-policy.page?** and click on *Medical Policy* tab.		
PREVENTIVE SERVICES (CONTINUED)		
Well Woman Exams ▪ Preventive (routine) Gynecological exam (including screening PAP Tests or Thin Prep)	No charge*	40% of allowed benefit after deductible
▪ Screening Mammography	No charge* at network radiology centers	40% of allowed benefit after deductible
NOTE: Women may self-refer to a network OB/GYN for preventive obstetrical and gynecological care—no Primary Care Provider referral is needed. Benefits are allowed for one well woman visit per calendar year.		
Well Child Exams, including ▪ Routine immunizations ▪ Related diagnostic services	No charge*	40% of allowed benefit after deductible
NOTE: In-network Well Child Care benefits consist of preventive care services that monitor a child's physical and mental development. Covered services include: ▪ All visits for and of childhood and adolescent immunization recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control ▪ All newborn visits and screenings ▪ All visits for age-appropriate screening tests for tuberculosis, anemia, lead toxicity, Autism Spectrum Disorder, depression, hearing and vision, as determined by the American Academy of Pediatrics Well Child Care benefits are available for covered services rendered from birth through the day before a child's 18th birthday. The actual scheduling for covered services is determined by your family physician and is based on a schedule recommended by the American Academy of Pediatrics, the Center for Disease Control, and/or the United States Public Health Service.		
SKILLED NURSING, HOME HEALTH CARE AND HOSPICE CARE		
Extended Care Facility/ Skilled Nursing Facility (see pages 32 and 33 for more information on covered hospital services while inpatient such as Physician Services, Diagnostic (Non-Routine) Services, and Therapeutic Services (Hospital and Physician Billed).	$150 per admission copay, then $100 copay per day (maximum 5 daily copays) after deductible up to 120-day maximum per confinement (care received out-of-network also counts toward this maximum). **Note:** If admission immediately follows a related hospital confinement, a separate $150 per confinement copay will not apply nor the $100 copay per day (maximum 5 daily copays). Days are renewed when you have been out of the facility for 60 consecutive days. Benefits limited to services meeting specific guidelines and receiving prior approval through the Utilization Management Program.	$150 per admission copay, then 40% of allowed benefit for covered services after deductible for up to 120-day maximum per confinement (care received in-network also counts toward this maximum). **Note:** If admission immediately follows a related hospital confinement, a separate $150 per confinement copayment will not apply. Days are renewed when you have been out of the facility for 60 consecutive days. Benefits limited to services meeting specific guidelines and receiving prior approval through the Utilization Management Program.
Home Health Care	$40 copay after deductible up to 90 visits per calendar year (care received out-of-network also counts toward this maximum). Benefits limited to services meeting specific guidelines and receiving prior approval through the Utilization Management Program.	40% of allowed benefit after deductible for up to 90 visits per calendar year (care received in-network also counts toward this maximum). Benefits limited to services meeting specific guidelines and receiving prior approval through the Utilization Management Program.

*No copayment or coinsurance

Service	In-network, You Pay:[1,2]	Out-of-network, You Pay:[1,3]
Provider	Care received by a BlueChoice, BluePreferred, or BlueCard PPO provider	Care received by a non-participating provider
NOTE: To be eligible for Home Health Care benefits in-network and out-of-network, your condition must be such that confinement in a hospital or care in an Extended Care Facility/Skilled Nursing Facility would be required if the Home Health Care benefits were not available. That is, your condition and the care to be rendered at home must be such that if you received the same care in a hospital, that hospitalization or confinement would be considered medically necessary by the plan. Your attending physician must prescribe an approved treatment plan defining the health care services you are to receive at home. Covered services include: ▪ Physicians' visit (usually one per week) ▪ Nursing services (part-time intermittent nursing services only) ▪ Physical, respiratory, speech, and occupational therapy ▪ Home health aide services (if incidental to skilled nursing services) ▪ Rental of durable medical equipment ▪ Medical and surgical supplies (rendered in the course of a Home Health Care Visit) ▪ Drugs prescribed by a physician and provided and billed for by the Home Health Care provider		
SKILLED NURSING, HOME HEALTH CARE AND HOSPICE CARE (CONTINUED)		
Hospice Facility (see pages 32 and 33 for more information on covered hospital services while inpatient such as Physician Services, Diagnostic (Non-Routine) Services, and Therapeutic Services (Hospital and Physician Billed).	$150 per admission copay, then $100 copay per day (maximum 5 daily copays) after deductible for inpatient facility or $40 copay after deductible for alternative setting. **Note:** If admission immediately follows a related hospital confinement, a separate $150 per confinement copayment will not apply nor the $100 copay per day (maximum 5 daily copays). Benefits limited to services meeting specific guidelines and receiving prior approval through the Utilization Management Program.	$150 per admission copay, then 40% of allowed benefit for covered services after deductible. 40% of allowed benefit after deductible for alternative setting. **Note:** If admission immediately follows a related hospital confinement, a separate $150 per confinement copayment will not apply. Benefits limited to services meeting specific guidelines and receiving prior approval through the Utilization Management Program.
NOTE: Hospice Care is an alternative to traditional inpatient hospitalization which provides supportive care to terminally ill patients and their families. To be eligible for in-network and out-of-network hospice care benefits, the patient must: 1. Have a confirmed diagnosis of terminal illness; and 2. Sign an informed consent form indicating an understanding and acceptance of hospice care (a responsible family member may sign the form only if the patient is incapable of doing so). Covered services include: ▪ All covered inpatient and outpatient hospice service (treatment must be under a physician's direction) ▪ Nursing services ▪ Physical, respiratory, speech, and occupational therapy ▪ Home health aide services ▪ Nutritional guidance by a registered dietitian ▪ Medications (rendered in the course of a covered hospice stay) ▪ Outpatient radiation therapy and chemotherapy		
Private Duty Nursing (RN or LPN) Outpatient (120 days per plan year combined In-Network and Out-of-Network)	$40 copay after deductible per provider per day	40% of allowed benefit after deductible
BEHAVIORAL HEALTH SERVICES AND SUBSTANCE ABUSE TREATMENT (ALSO SEE PAGES 49 AND 50)		
Inpatient Services (Hospital Billed) ▪ Inpatient mental health services ▪ Alcohol and drug detoxification ▪ Alcohol and drug rehabilitation (includes psychotherapy, counseling, family therapy, drug and behavior therapy)	Facility Charges—$150 per admission copay, then $100 copay per day (maximum 5 daily copays) after deductible Physician Charges—No charge* after $20 PCP/$40 Specialist copay after deductible per provider per day	Facility Charges—Subject to $150 per admission copayment; then 40% of allowed benefit after deductible Physician Charges—40% of allowed benefit after deductible per provider per day
Outpatient Hospital ▪ Facility ▪ Partial hospitalization ▪ Outpatient treatment facility ▪ Intermediate care facility ▪ Physician services	Facility Charges—$100 copay after deductible Physician Charges—$40 copay after deductible	40% of allowed benefit after deductible

*No copayment or coinsurance

Covered Services

Service	In-network, You Pay:[1,2]	Out-of-network, You Pay:[1,3]
Provider	Care received by a BlueChoice, BluePreferred, or BlueCard PPO provider	Care received by a non-participating provider
Office Visits and Professional Services ▪ Psychologist ▪ Social Worker ▪ Clinical Nurse Specialist ▪ Licensed Professional Counselor	Physician Office—$20 copay after deductible per visit	40% of allowed benefit after deductible
Psychiatric Testing (to determine diagnosis; educational testing excluded)	Physician Office—$20 copay after deductible	40% of allowed benefit after deductible
Laboratory Services	Radiology or Laboratory Centers—No charge* after deductible (prior authorization required for diagnostic and screening services performed in the outpatient department of a hospital)	40% of allowed benefit after deductible
OTHER HEALTH CARE SERVICES		
Accidental Dental Injury	$40 copay after deductible per visit	40% of allowed benefit after deductible
NOTE: Charges for the following dental services or supplies are covered if they are required to correct an accidental injury: dental X-rays; the initial placement of a bridge or denture; and any dental services or supplies necessary for the performance of a surgical service to correct injuries of the jaw, cheek, lips, tongue, or roof and floor of the mouth. Treatment must be received within 6 months of the accidental injury.		
Air Ambulance Service for Medically Necessary Non-Emergency Services	10% of Allowed Benefit after deductible	40% of Allowed Benefit after deductible
NOTE: Prior authorization is required for medically necessary non-emergency Air Ambulance Services.		
Autism Spectrum Disorder ▪ Office Visit	$40 copay after deductible per visit	40% of allowed benefit after deductible
▪ Outpatient	Outpatient Facility—$100 copay after deductible Outpatient Facility Practitioner—$20 PCP/$40 Specialist copay after deductible	40% of allowed benefit after deductible
NOTE: Coverage is provided for the diagnosis and treatment of autism spectrum disorder and evidence-based, medically necessary treatment in individuals of any age; subject to Utilization Management. Coverage includes habilitative services; subject to prior authorization. Benefits for Applied Behavioral Analysis are covered when services are provided or supervised by a board-certified behavioral analyst who is licensed by the Board of Medicine.		
Blood and Blood Products (if not replaced by or for the patient, including blood storage)	No charge* after deductible. Includes blood products, as well as blood handling and administrative charges (including storage), and receipted blood plasma and blood expanders	40% of allowed benefit after deductible
Christian Science Care (includes Sanitarium, Practitioner/ Healer, and Nurse—benefits not available for reading rooms)	$20 PCP/$40 Specialist copay after deductible	40% of allowed benefit after deductible
Early Intervention Services (limited to members from birth to age 3)	$40 copay after deductible	40% of allowed benefit after deductible
NOTE: Benefits include habilitative services; subject to prior authorization.		
Hearing Aid Evaluation	$20 PCP/$40 Specialist copay after deductible per visit	40% of allowed benefit after deductible
Hearing Aids (only when required as a result of accidental injury)	$40 copay after deductible	40% of allowed benefit after deductible
Organ Transplants	Coverage is provided for all Medically Necessary, non-Experimental/Investigational bone marrow, solid organ transplant, and other non-solid organ transplant procedures. Medical Necessity is determined by CareFirst. Organ and Tissue Transplants: Limited to kidney; cornea; skin (for skin grafting or other medically necessary purposes); heart; combined heart and lung; single lung; double lung; pancreas, (when performed simultaneously with a kidney transplant); liver; autologous or allogenic bone marrow non-experimental and non-investigational procedures.	

*No copayment or coinsurance

Service	In-network, You Pay:[1,2]	Out-of-network, You Pay:[1,3]
Provider	Care received by a BlueChoice, BluePreferred, or BlueCard PPO provider	Care received by a non-participating provider
NOTE: Organ and Tissue Transplant Services: All services must be Medically Necessary as determined by CareFirst in order to be covered. I. Covered Benefits A. Benefits will be provided for Medically Necessary organ transplants that are performed for reasons that are not considered experimental or investigational, as determined by CareFirst. B. Covered services include the following: 1. The expenses related to registration at transplant facilities. The place of registry is subject to review and determination by CareFirst. 2. Organ procurement charges including harvesting, recovery, preservation, and transportation of the donated organ. 3. Cost of hotel lodging and air transportation for the recipient Member and a companion (or the recipient Member and two companions if the recipient Member is under the age of 18 years) to and from the site of the transplant, if approved by CareFirst. 4. There is no limit on the number of re-transplants that are covered. 5. If you are the recipient of a covered organ/tissue transplant, we will cover the Donor Services (as defined below) to the extent that the services are not covered under any other health insurance plan or contract. Donor Services consist of services covered under your Agreement or Contract which are related to the transplant surgery, including evaluation and preparing the actual donor, regardless of whether the transplant is attempted which are directly related to donating the organ or tissue.		
DURABLE MEDICAL EQUIPMENT AND SUPPLIES		
Durable Medical Equipment (rental or purchase of wheel chair, hospital bed, mechanical ventilation or other medically necessary equipment; colostomy bags, hair prosthesis)	$40 copay after deductible Covered only when deemed to be medically necessary and authorized under the Utilization Management Program.	40% of allowed benefit after deductible
NOTE: Hair prosthesis combined in- and out-of-network not to exceed $500 per benefit period.		
Medical Foods, Nutritional Substances, Low Protein Modified Foods	$40 copay after deductible	40% of allowed benefit after deductible
Prosthetic and Orthopedic Devices (including orthotics)	Surgically implanted prosthetic devices covered at $40 copay after deductible. Orthopedic and other prosthetic devices are covered at $40 copay after deductible deemed to be medically necessary.	40% of allowed benefit after deductible
Diabetic Equipment (such as insulin pumps)	$40 copay after deductible	40% of allowed benefit after deductible.
NOTE: Insulin, needles and syringes, test strips, lancets, and glucometers are covered through CVS Caremark/SilverScript.		

[1] When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.

[2] In-Network: When covered services are rendered in Maryland, Washington D.C. and/or Northern Virginia, collectively known as the CareFirst service area, by a provider in the CareFirst BlueChoice or PPO Provider network, care is reimbursed at the in-network level. In-network benefits are based on the CareFirst BlueChoice or PPO allowed benefit. The CareFirst BlueChoice and PPO allowed benefit is generally the contracted rates or fee schedules that CareFirst and PPO providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueChoice, Inc., however, in certain circumstances, an allowance may be established by law. Outside of the CareFirst service area, when covered services are rendered by a provider in the preferred provider network, care is also covered at the in-network level. These in-network benefits are based on the contracted rates or fee schedules that preferred providers have agreed to accept as payment for covered services that are established by the local Blue Cross and Blue Shield plan, however, in certain circumstances, an allowance may be established by law.

[3] Out-of-Network: When covered services are rendered by a provider that is not in the CareFirst BlueChoice or PPO network in Maryland, Washington D.C. or Northern Virginia, or is not in the preferred provider network outside of the CareFirst service area, the care is reimbursed as out-of-network. Out-of-network benefits are based on the allowed benefit. The allowed benefit is generally the contracted rates or fee schedules that are established by CareFirst, or the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.

[4] For family coverage only: When one family member meets the individual deductible, they can start receiving benefits as indicated above. Each family member cannot contribute more than the individual deductible amount. The family deductible must be met before the remaining family members can start receiving benefits.

Covered Services Index

BlueChoice Advantage Plan Exclusions

What is not covered

BlueChoice Advantage plan general exclusions

Coverage is not provided for the following:

- Any service, test, procedure, supply, or item which CareFirst determines not necessary for the prevention, diagnosis or treatment of the Member's illness, injury, or condition. Although a service may be listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in the Member's particular case.
- Any treatment, procedure, facility, equipment, drug, drug usage, device, or supply which, in the judgment of CareFirst, 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.
- Services that are not described as covered in this book 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.
- The cost of services that are furnished without charge or are normally furnished without charge if a Member was not covered by the plan, or any charge or any portion of a charge which by law the provider is not permitted to bill or collect from the Member directly.
- Any service, supply, or procedure that is not specifically listed as a covered benefit or that does not meet all other conditions and criteria for coverage as determined by CareFirst.
- Services that are beyond the scope of the license of the provider performing the service.
- Routine foot care, including services related to hygiene or 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 CareFirst determines that medical attention was needed because of a medical condition affecting the feet, such as diabetes and, that all other conditions for coverage have been met.
- Any type of dental care (except treatment of accidental injuries, oral surgery not related to dental services listed below, and cleft lip, cleft palate, or ectodermal dysplasia,) 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. All other procedures involving the teeth or areas surrounding the teeth, including shortening of the mandible or maxillae for Cosmetic purposes or for correction of malocclusion unrelated to a functional impairment are excluded.
- 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.
- 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.
- Any prescription drugs, unless administered to the Member in the course of covered outpatient or inpatient treatment or unless the prescription drug is specifically identified as covered. 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, even though they may be dispensed or administered in a physician or provider office or facility, unless the take-home prescription or medication is specifically identified as covered.

- All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies routinely obtained and self administered by the Member.
- Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment unless indicated as medically appropriate in the CareFirst medical policy.
- 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, except for diabetes outpatient self-management training and educational services. Cardiac rehabilitation programs are covered as described in this Summary Plan Description.
- Medical and surgical treatment for obesity and weight reduction, except in the instance of morbid obesity (subject to CareFirst medical policy and approval by Utilization Management).
- Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof.
- Services solely based on a court order or as a condition of parole or probation, unless approved by CareFirst.
- Health education classes, self-help programs, and birthing classes, other than those for the treatment of diabetes.
- Acupuncture services, except when approved or authorized by CareFirst when used for anesthesia.
- 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 Practitioner.
- 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.)
- Private duty nursing, except as described in the table of covered services
- Non-medical, provider services, including but not limited to:
  1. Telephone consultations, failure to keep a scheduled visit, completion of forms, copying charges, or other administrative services provided by the Health Care Practitioner or the Health Care Practitioner's staff.
  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 this Summary Plan Description are available for covered services rendered to the Member by a health care provider.
- Speech therapy, occupational therapy, or physical therapy, unless CareFirst determines that the condition is subject to improvement. Coverage does not include non-medical Ancillary Services such as vocational rehabilitation, employment counseling, or educational therapy.
- 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.
- Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst, and services listed under Transplants Section), whether or not recommended by an Eligible Provider.

BlueChoice Advantage Plan Exclusions

- 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.
- Contraceptive drugs, unless surgically implanted.
- Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.
- Services, drugs, or supplies the Member receives without charge while in active military service.
- Habilitative services delivered through school services.
- Custodial care.
- Services or supplies received before the effective date of the Member's coverage under this Evidence of Coverage.
- Durable medical equipment or supplies associated or used in conjunction with non-covered items or services.
- Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.
- Work Hardening Programs. Work Hardening Program means a highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.
- Christian Science Reading Rooms.
- Habilitative services—refer to medical policy.
- Services furnished as a result of a referral prohibited by law.

Transplants

Benefits will not be provided for the following:

- Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary non-Experimental/Investigational skin grafts.
- Any hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.
- Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst.
- Services for a Member who is an organ donor when the recipient is not a Member.
- Benefits will not be provided for donor search services.
- Any service, supply, or device related to a transplant that is not listed as a benefit in the Description of covered services.

Inpatient hospital services

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

- Private room, unless Medically Necessary and 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.
- Non-medical items and convenience items, such as television and phone rentals, guest trays, and laundry charges.
- Except for covered emergency services and maternity care, a hospital admission or any portion of a hospital 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.
- Private duty nursing, except as described in covered services

Home health services

Coverage is not provided for:

- Inpatient private duty nursing is not covered
- Outpatient private duty nursing is covered with a limitation of 120 days
- Custodial care

Hospice services

Benefits will not be provided for the following:

- Services, visits, medical equipment, or supplies not authorized by CareFirst
- Financial and legal counseling
- Any services for which a Qualified Hospice Program does not customarily charge the patient or his or her family
- Reimbursement for volunteer services
- Chemotherapy or radiation therapy, unless used for symptom control

- Services, visits, medical equipment, or supplies that are not required to maintain the comfort and manage the pain of the terminally ill Member
- Custodial Care, domestic, or housekeeping services
- Meal on Wheels or similar food service arrangements
- Rental or purchase of renal dialysis equipment and supplies

Outpatient mental health and substance abuse. Benefits will not be provided for:

- Psychological testing, unless Medically Necessary, as determined by the Plan, and appropriate within the scope of covered services
- Services solely on court order or as a condition of parole or probation unless approved or authorized by the Plan's Medical Director
- Mental retardation, after diagnosis
- Psychoanalysis

Inpatient mental health and substance abuse. The following services are excluded:

- 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
- Custodial Care
- Observation or isolation

Emergency services. Benefits will not be provided for:

- Non-emergency services if the condition does not meet the prudent layperson rule. (See glossary on page 78 for complete description).
- Charges for services when the claim filing and notice procedures as stated on pages 16, 17 and 60 have not been followed by the Member.
- Except for covered ambulance services, travel, whether or not recommended by a Plan Provider.

Medical Devices and Supplies

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

- 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, shower/bath bench).
- 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).
- 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).
- 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).
- 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.
- Eyeglasses or contact lenses (except when used as a prosthetic lens replacement for aphakic patients as in this Evidence of Coverage), dental prostheses or appliances (except for Medically Necessary treatment of Temporomandibular Joint Syndrome (TMJ) or treatment of an accidental injury.
- Corrective shoes (unless required to be attached to a leg brace), shoe lifts, or special shoe accessories.
- Medical equipment/supplies of an expendable nature. Non-covered supplies include incontinence pads or ace bandages.

Special maternity benefits exclusions and limitations

- Benefits for artificial insemination and in vitro fertilization are covered up to a maximum of $100,000 per member per lifetime across all FCPS self-insured plans. Coverage is subject to approval by Utilization Management and CareFirst medical policy.
- Benefits are not available for cryopreservation, thawing or storage of sperm, donor sperm, egg(s), or embryo(s).

- Benefits are not available for donor monitoring, cycle monitoring, administrative fees or medication for donor.
- Benefits and services are not available for gestational carrier or surrogacy programs.
- Donor eggs may only be used when (a) the patient egg cannot be retrieved or (b) patient has non-functioning or absent ovaries or (c) the patient's oocytes are genetically defective.
- Donor sperm may only be used when medical criteria is met. The member's marital status is not a factor in the determination.
- Elective reversal of male/female sterility is not covered. Following the reversal of an elective sterilization (to include vasectomy and/or tubal ligation), the patient must have a one-year history of infertility.

Professional nutritional counseling

Professional nutritional counseling is defined as individualized advice and guidance given to people at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness, and about options and methods for improving nutritional status. This counseling is provided by a registered licensed dietitian or other health professional functioning within their legal scope of practice. This includes diabetes education.

Counseling for the following medical conditions is covered when rendered by a registered licensed dietitian or other health professional functioning within their legal scope of practice:

- Diabetes, all types, including gestational
- Malnutrition
- Cancer
- Kidney disease
- Cardio- and/or cerebrovascular disease
- Eating disorders
- Hypertension
- Gastrointestinal disorders
- Seizure disorders
- Hyperlipidemia
- Endocrine/metabolic disorders amenable to dietary therapy
- Morbid obesity

Nutritional counseling benefits are not provided for obesity/weight loss, (e.g., Weight loss centers, including, but not limited to: Diet Center, Jenny Craig, Nutri-System, Optifast, Weight Watchers, Diet Workshop, Health Focus, Physicians' Weight Loss Centers, Healthy Options, Medifast, Healthfast, and Baltimore Better Life). Nutritional counseling benefits are not provided for conditions which have not been shown to be nutritionally related, including but not limited to chronic fatigue syndrome and hyperactivity.

Eligible practitioners of nutritional counseling include:*

- Medical Doctor (M.D.)
- Doctor of Osteopathy (D.O.)
- Registered dietician or nutritionist licensed by the state.
- Board of Dietetic Practice of that practitioner's location of practice
- Certified Diabetes Educator

*Institutional providers (e.g. Hospitals) may provide services for nutritional counseling in the facility setting.

Organ and tissue transplants

Coverage is provided for all Medically Necessary, non-Experimental/Investigational bone marrow, solid organ transplant, and other non-solid organ transplant procedures. Medical Necessity is determined by CareFirst.

Utilization Management Program

The plan is designed to assure you that the care you receive is appropriate and necessary. The Utilization Management Program monitors the use of your health care benefits in a sensitive and efficient manner. The purpose of this program is to reduce costs by encouraging necessary and appropriate treatment, while assuring that quality services are provided, and in the patient's best interest.

Before certain services will be covered, they will be subject to review and approval under the Utilization Management Program. Through Utilization Management, CareFirst reviews a Member's care and evaluates the medical necessity for services, the appropriateness of the hospital or facility requested, and the appropriate length of confinement or the course of treatment. Utilization Management may include second surgical opinion and preadmission testing requirements, concurrent review, discharge planning and case management. If you or your provider fail to obtain precertification, your claim will reject until precertification is obtained.

The Utilization Management Program includes hospital inpatient services

All hospitalizations require precertification. The Hospital Precertification Admission telephone number on the back of your member ID card must be contacted at least five business days prior to an elective or scheduled admission to a hospital. If the admission cannot be scheduled in advance because it is not medically feasible to delay the admission for five business days due to your medical condition, notification of the admission must be received as soon as possible (but in any event within two business days following the beginning of the admission).

Hospital precertification admission telephone numbers

The Precertification Admission telephone number is listed below. The number is also listed on the back of your member ID card.

Toll-free: 866-773-2884, 866-PRE-AUTH

Provider and member responsibility

When you receive care from in-network providers, the provisions of the Utilization Management Program will be arranged for you. When you receive care from out-of-network providers, you will need to arrange for your own certifications under the Utilization Management Program. It is your responsibility to assure that hospitals, physicians and other providers associated with the Member's care cooperate with Utilization Management requirements. This includes initial notification in a timely manner, responding to CareFirst's

inquiries, and, if requested, allowing CareFirst representatives to review medical records on-site or in its offices. If CareFirst is unable to conduct utilization reviews, benefits may be reduced. If you or your provider fail to obtain precertification, your claim will reject until precertification is obtained.

Medical services

To receive in-network benefits for any of the following services, the Hospital Precertification Admission staff (telephone number is on the back of your member ID card) must be contacted five business days prior to the anticipated date upon which the admission or treatment will commence:

- All hospital admissions, including inpatient mental health/substance abuse
- Home health care
- Extended care facility/skilled nursing facility care
- Treatment of infertility
- Hospice
- Out-patient private duty nursing
- Early intervention for children
- Clinical trials
- Transplants

How does the Utilization Management Program work?

To obtain necessary certifications, call the Hospital Precertification Admission telephone number on the back of your member ID card. Office hours are 8 a.m. to 8 p.m. (EST) Monday through Friday. However, if you have questions about your benefits or coverage, please contact Member Services at the 800-296-0724 telephone number listed on the back of your member ID card.

When you call the Hospital Precertification Admission telephone number to obtain certifications, you will be asked for the following information:

- Your name and identification number
- The patient's name and relationship to the Fairfax County Public Schools employee or retiree
- The name of your employer and the group number (found on your member ID card)
- The doctor's name and phone number
- The hospital's name and the date of the planned admission
- The reason for hospitalization

Who makes the call?

In-network, the process is started by your doctor, hospital, or other health care professional.

Exception: Members seeking inpatient Mental Health Care and Substance Abuse Treatment should call CareFirst at 800-245-7013.

Out-of-network, the process may be started by you, a family member, your physician, or a hospital representative. Once notified, a Utilization Management Program nurse will obtain the necessary information from you and your physician and notify the provider promptly.

In most cases, you or your doctor, and the hospital will be notified of the decision to certify the admission within one business day. You, your physician, and the hospital will also receive written notice regarding this decision.

When you need extra hospital days

After your hospital admission has been certified, the Utilization Management Program nurse will review your admission to determine if additional inpatient hospital days are medically necessary. This type of review is known as Continued Stay Review.

Retrospective review

Retrospective Review is conducted to determine the medical necessity of all care and appropriateness of treatment for which preauthorization was not issued and a claim for medical services has been received.

Case Management

Case Management is an extension of the Utilization Management Program. Case Management is designed to identify patients, as early as possible, with catastrophic or chronic illnesses who require continuing care. A Case Manager will work closely with you, your family members, your physician, and our in-network providers to coordinate the skilled care you may need. Our goal is to manage your health care benefits to assure you receive quality care at a reasonable cost.

Appealing a decision

In the event your admissions or extension of additional days is not certified, you may appeal the decision. For more information on the appeal process, please call Member Services at 800-296-0724.

Your family needs to know

Share this information with a family member or other responsible person who could arrange for your Utilization Management Program certifications in case you are unable to do so yourself.

Mental health substance abuse service and admission authorization telephone number

Members call the telephone number below for CareFirst Mental Health/Substance Abuse Service and Admission Authorization.

Toll-free: 800-245-7013
This number is also listed on the back of your member ID card.

All requests for inpatient admissions require prior authorization at the time admission is being sought. CareFirst will need to speak with someone at the admitting facility who can provide clinical information during the prior authorization review process. Requests for inpatient prior authorizations and emergencies are handled 24/7. All other requests are managed during regular business hours Monday–Friday, 8 a.m.–6 p.m. EST.

Outpatient mental health and substance abuse treatment

Outpatient services do not require prior authorization; however, in order to receive the highest level of benefits, BlueChoice Advantage members must see participating providers in the CareFirst BlueChoice or BluePreferred PPO network while inside the CareFirst service area. Outside the service area, members should utilize participating BlueCard PPO Providers.

Quick Reference Chart for BlueChoice Advantage

Utilization Management Program

Utilization Management Program Question	In-Network	Out-of-Network
Who calls to precertify required inpatient and outpatient hospitalization and procedures?	Your network provider will make the call to arrange for any necessary certifications.	You are responsible for making the call to the Hospital Precertification Admissions telephone number to arrange for the required certifications. Failure to do so may result in a benefits reduction or denial.
When must the Utilization Management Program be notified of an admission?	Planned/Elective procedures or admissions—within 5 business days prior to the procedure/admission; Emergencies—within 2 business days after an admission.	
What must be certified?	Your network provider will arrange for any required certifications. All inpatient admissions and the procedures listed under the *Medical Services* heading earlier in this section.	Your network provider will arrange for any required certifications. All inpatient admissions and the procedures listed under the *Medical Services* heading earlier in this section.
Are there any penalties if precertification is NOT obtained?	The claim will not pay until precertification is obtained.	
May I refer myself to any covered provider?	You may self-refer to any covered provider.	You may self-refer to any covered provider.
What if I need extra days in the hospital?	All arrangements would be coordinated by your network physician, the network hospital, and a Utilization Management Program nurse.	In most instances, a Utilization Management Program nurse will make arrangements with your physician. If the nurse is unable to make contact with your physician, you will be notified.
What if the extra days are not medically necessary?	All arrangements would be coordinated by your network physician, the network hospital, and a Utilization Management Program nurse. The physician and hospital will be notified in writing of any non-covered hospital days. The hospital is also notified by phone, fax or log. You will be notified in writing of any non-covered hospital days.	You will be notified in writing of any non-covered hospital days. You will be responsible for any non-covered payments.
What are my responsibilities for Mental Health Care and Substance Abuse Treatment?	You and/or your provider are responsible for handling all admission certifications both in-network and out-of-network by calling the Mental Health Substance Abuse Service & Admission Authorization telephone number on the back of your member ID card.	

Your Wellness and Incentive Program

Personalized solutions for a healthier you

Welcome to your CareFirst BlueCross BlueShield (CareFirst) wellness program! Brought to you in partnership with Sharecare, Inc.*, a digital health company, the program is designed to help you live a healthier life, reach your wellness goals and earn rewards.

Your program delivers a wealth of resources customized to your interests and needs. It all starts with the RealAge® test, a unique health assessment that helps you determine the physical age of your body compared to your calendar age. You also get:

- **A personalized health timeline:** Receive recommendations, content and services tailored to you.
- **Trackers:** Connect your wearable devices or enter your own data to monitor daily habits like sleep, steps, nutrition and more.
- **Challenges:** Having trouble staying motivated? Join a challenge to make achieving your health goals more entertaining.
- **A health profile:** Access your important health data like biometric information, vaccine history, lab results and medications all in one place.
- **Blue Rewards for Active FCPS Employees:** Earn a $100 incentive for completing the RealAge health assessment.

You can access your wellness program resources anytime, anywhere!

For more information on completing the steps required for your Blue Rewards, visit **carefirst.com/fcps** and select the tab labeled *Plan Year 2022.*

* This wellness program is administered by Sharecare, Inc., an independent company that provides health improvement management services to CareFirst members. Sharecare, Inc. does not provide CareFirst BlueCross BlueShield products or services and is solely responsible for the health improvement management services it provides.

How to earn your $100 incentive

The Blue Rewards incentive program is available to Active Fairfax County Public Schools employees who are the primary cardholder enrolled in the CareFirst medical plan. Earn the $100 incentive by completing the RealAge test **before November 18, 2022**.

RealAge takes a few minutes to complete and gives you a better understanding of your current health status along with recommendations to improve or maintain your RealAge. You will learn what lifestyle behaviors are helping you stay younger or making you age faster.

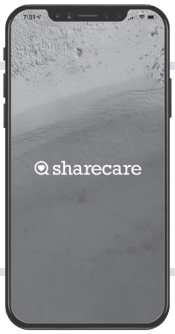
Incentives are only available to active employees who are the primary cardholder enrolled in the CareFirst medical plan.

Specialized programs for extra support

The following programs can help you focus on specific wellness goals.

- **Health coaching**—provided by registered nurses and trained professionals.
- **Weight management program**—available for members age 18 or older with a body mass index (BMI) of 30 or greater.
- **Tobacco cessation program**—access expert guidance, support and wealth of tools.
- **Financial well-being program**—learn the small steps that add up to big financial improvements.

To get started, visit **carefirst.com/sharecare**. You'll need to enter your CareFirst account username and password and complete the one-time registration with Sharecare to link your CareFirst account information. This will help personalize your experience.



Mental Health Support

Well-being for mind and body

Living your best life involves good physical and mental health. Emotional well-being is important at every stage in life, from adolescence through adulthood.

It's common to face some form of mental health challenge during your life. CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) are here to help. Our support team is made up of specially trained service representatives, registered nurses and licensed behavioral health clinicians, ready to:

- Help you find the right mental health provider(s) and schedule appointments
- Connect you with a care coordinator who will work with your doctor to create a tailored action plan
- Find support groups and resources to help you stay on track

When mental health difficulties arise for you or a loved one, remember you are not alone. Help is available and feeling better is possible.

CareFirst members have access to specialized services and programs for depression, anxiety, drug or alcohol dependence, eating disorders, and other mental health conditions.

If you are in crisis, help is available 24/7 at 800-245-7013.

Like the privacy and convenience of CareFirst Video Visit? You can now see providers for therapy and psychiatry services. These special services have fees associated with them, and your specific cost will be shown before the visit begins.

If you or someone close to you needs support or help making an appointment, call our support team at 800-245-7013, Monday-Friday 8 a.m.–6 p.m. ET. Or for more information, visit **carefirst.com/mentalhealth.**

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Prenatal Care Management Program

At no additional cost, our Prenatal Care Management Program helps expectant mothers have a healthy pregnancy and deliver healthy babies.

Pregnancy support

Studies show that proper prenatal care is essential for the delivery of healthy, full-term babies. This is even true for women who have had healthy babies in the past. Our Prenatal Care Management Program is designed to promote good health for mothers and newborns by helping expecting women receive education, prenatal care and professional support services during their pregnancy and following the delivery.

Program cost

There is no cost to participate.

How the program works

Our Case Managers strive to help you and your baby stay healthy during pregnancy. To speak with a Case Manager, call 866-773-2884. During this call, a Registered Nurse Case Manager who is trained in obstetrics will ask you questions about your health. The information obtained from this confidential questionnaire is used to identify any special needs you may have during your pregnancy (such as a history of high blood pressure). Based on your evaluation, you will receive a packet of helpful information on any special needs you may have.

If you have a medical condition that may put you at risk for a complicated pregnancy, your case will be referred to a Case Manager. The Case Manager will work directly with you and your obstetrician to help you follow a plan specific to your needs. This plan may be as basic as a special diet, or it may be related to a medical condition requiring a greater level of care such as monitoring by a skilled nurse. In the event follow-up home care is required for either you or your baby, your Case Manager will continue to coordinate that care with you and your obstetrician. For more information, call 866-773-2884.

To speak with a Case Manager, call **866-773-2884**, 8 a.m.–6 p.m. Monday–Friday.

Healthy Pregnancy Services	Contact
Online pregnancy center—Access interactive tools and a wealth of information about pregnancy, labor and delivery and newborn care.	**carefirst.com/pregnancy**
24-hour health care advice line—Unable to reach your doctor? Call the 24-Hour Nurse Advice Line and speak to a registered nurse who can help answer your clinical questions or guide you to the most appropriate care.	**800-535-9700**
Text4baby messages—Receive health tips and information throughout your pregnancy and your baby's first year through text messages.	**text4baby.org**
High-risk pregnancy support—If your provider determines you might be at risk for premature delivery or medical complications, a CareFirst nurse care coordinator, specialized in obstetrics, will work with you and your doctor to help you have the healthiest delivery possible.	**866-773-2884** **8 a.m.–6 p.m., Monday–Friday**
Behavioral health support—For parents who may experience loss, depression, anxiety, or addiction, there are resources available to support you.	**Call the Mental Health/Substance Abuse number listed on the back of your ID card**

Inter-Plan Arrangements Disclosure

Out-of-area services

CareFirst BlueCross BlueShield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Members access health care services outside the geographic area CareFirst serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to CareFirst for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this Group Contract are described generally below.

Typically, Members, when accessing care outside the geographic area CareFirst serves, obtain care from health care providers that have a contractual agreement (i.e., are "PPO/Participating") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from Non-participating providers. CareFirst payment practices in both instances are described below.

A Member will be entitled to benefits for covered services accessed either inside or outside the geographic area CareFirst serves.

Due to variations in Host Blue network protocols, a Member may also be entitled to benefits for some health care services obtained outside the geographic area CareFirst serves, even though the Member might not otherwise have been entitled to benefits if he or she had received those health care services inside the geographic area CareFirst serves. But in no event will a Member be entitled to benefits for health care services, wherever he or she received them, that are specifically excluded from, or in excess of the limits of, coverage provided by this Group Contract.

A. Definitions

For purposes of Inter-Plan Programs, the underlined terms, when capitalized, are defined as follows:

Allowed Benefit, unless otherwise stated, or required by federal law, means the amount the Host Blue allows for a covered service regardless of whether the amount the Host Blue allows is greater or lesser than CareFirst's allowed benefit and is deemed a final amount.

BlueCard PPO Network Provider (PPO Provider) means a health care provider who contracts with a Host Blue as part of its Preferred Provider Organization (PPO) network.

BlueCard Traditional Network Provider (participating provider) means a health care provider who contracts with a Host Blue to be paid directly for rendering covered services to Members.

Non-participating provider means any health care provider that does not contract with a Host Blue.

Preferred Provider Organization (PPO) means a health care benefit arrangement designed to supply services at a discounted cost by providing incentives for Members to use designated health care providers (who contract with the PPO at a discount), but which also provides coverage for services rendered by health care providers who are not part of the PPO network.

B. Negotiated national account arrangements

Claims for covered services may be processed through a negotiated national account arrangement with a Host Blue.

The amount the Member pays for covered services, if not a flat dollar copayment, will be calculated based on the "price" made available to CareFirst. The "price" may be either the:

- negotiated price/lower of either billed covered charges or negotiated price
- lower of either billed covered charges or negotiated price (refer to the description of negotiated price under paragraph C., BlueCard Program)

Under certain circumstances, if CareFirst pays the health care provider amounts that are the responsibility of the Member under this Group Contract CareFirst may collect such amounts from the Member.

C. BlueCard Program

Under the BlueCard Program, when Members access covered services from a PPO Provider or participating provider within the geographic area served by a Host Blue, CareFirst will remain responsible to FCPS for fulfilling CareFirst contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its PPO/participating providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

Whenever a Member accesses covered services outside the geographic area CareFirst serves and the claim is processed through the BlueCard Program, the amount the Member pays for covered services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed covered charges for the covered services; or
- The negotiated price that the Host Blue makes available to CareFirst.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the health care provider. Sometimes, it is an estimated price that takes into account special arrangements with the health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price CareFirst uses for a claim because they will not be applied retroactively to claims already paid.

A small number of states require Host Blues either (i) to use a basis for determining Member liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should federal law or the state in which health care services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, CareFirst would then calculate Member liability and FCPS liability in accordance with applicable law.

Under certain circumstances, if CareFirst pays the health care provider amounts that are the responsibility of the Member under this Group Contract CareFirst may collect such amounts from the Member.

D. Non-participating providers outside the CareFirst service area

Member Liability Calculation

1. In General
   When covered services are provided outside of the CareFirst service area by Non-participating providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue's Non-participating provider local payment or the pricing arrangements required by applicable state/federal law. In these situations, the Member may be responsible for the difference between the amount that the Non-participating provider bills and the payment CareFirst will make for the covered services as set forth in this paragraph.
2. Exceptions
   In some exception cases, CareFirst may pay claims from Non-participating providers outside of CareFirst's service area based on the provider's billed charge, such as in situations where a Member did not have reasonable access to a PPO/participating provider, as determined by CareFirst in CareFirst's sole and absolute discretion or by applicable state/federal law. In other exception cases, CareFirst may pay such claims based on the payment it would make if CareFirst were paying a Non-Contracted Provider inside of its service area, as described elsewhere in this Group Contract, where the Host Blue's corresponding payment would be more than CareFirst's in-service

area Non-Contracted Provider payment, or in CareFirst's sole and absolute discretion, CareFirst may negotiate a payment with such a provider on an exception basis.

Finally, CareFirst may pay up to billed charges for FCPS designated covered services.

Unless otherwise stated, in any of these exception situations, the Member may be responsible for the difference between the amount that the Non-participating provider bills and the payment CareFirst will make for the covered services as set forth in this paragraph.

Inter-Plan Programs eligibility claim types

Unless otherwise stated, all claim types are eligible to be processed through the Inter-Plan Programs except for those Dental Care Benefits, Prescription Drug Benefits, or Vision Care Benefits that may be delivered by a third-party contracted by CareFirst to provide the specific service or services.

Inter-Plan Programs Ancillary Services

A. Definitions

Ancillary Services means, with respect to Inter-Plan Programs, the following covered services:

- Independent clinical laboratory tests (performed at non-hospital based labs)
- Medical Devices and Supplies
- Specialty Prescription Drugs (including non-routine, biological therapeutics such as injectables, infusion therapies, high-cost therapies, and therapies that require complex care)

Remote Provider means, with respect to Ancillary Services, an Ancillary Services provider located outside the geographic area a Blue Cross and/or Blue Shield plan serves, with which a Blue Cross and/or Blue Shield plan may contract under its Blue Cross and Blue Shield Association license agreement for Ancillary Services rendered in its service area and which are considered local providers.

B. Member payment

Member payment for Ancillary Services is determined by the relationship between the provider and the Local Plan (which may be CareFirst).

If an Ancillary Services Remote Provider contract is in place with the Local Plan, the Remote Provider is a Contracted Health Care provider/BlueCard PPO Network Provider/BlueCard Traditional Network Provider.

If an Ancillary Services Remote Provider contract is not in place with the Local Plan, the Remote Provider is a Non-Contracted health care provider/Non-participating provider.

The Member is responsible for the Member payment as stated in the How the Plan Works section or Inter-Plan Arrangements Disclosure section of this Group Contract, Program Description, Certificate of Coverage, Evidence of Coverage.

C. Determining the Local Plan

For Ancillary Services, the Local Plan is determined as follows:

Out-of-network Covered Ancillary Services	The Local Plan is the Blue Cross/Blue Shield plan in whose service area/state where the:	
Independent Clinical Laboratory	Specimen was drawn, if the referring provider is located in the same service area	Referring provider is located, if the provider is not located in the same service area where the specimen was drawn
Medical Devices and Supplies	Medical Devices and/or Supplies were either: ■ Shipped to a retail store ■ Purchased at a retail store	
Specialty Prescription Drugs	Ordering/prescribing physician is located	

Coordination of Benefits

Most group health care plans, including your FCPS plan, contain a coordination of benefits provision. This provision applies when you, your spouse, or your covered family members are eligible for benefits under more than one group health program. Coordination of benefits prevents duplicate payments for the same expenses, and helps to hold down the cost of health care coverage.

In-network: how coordination of benefits works

Whether the FCPS plan is primary or secondary, you would be responsible for no more than your in-network copayments and coinsurance.

Out-of-network: how coordination of benefits works

The FCPS plan provides benefits for non-participating providers up to the allowed benefit, but not to exceed the normal out-of-network benefits that would have been paid had you not had other insurance coverage. The plan payment is either the normal benefits or the allowed benefit minus what the other carrier paid, whichever amount is less.

Deciding which health plan is primary

It's important to know which of your plans is primary and which is secondary because your claims will be paid more quickly and accurately if you submit them in the right order. Please keep in mind that the primary/secondary order may be different for different family members. Here are the rules we use to determine which plan is primary for a Member with double coverage:

- When your other group coverage does not coordinate benefits, then that coverage pays first. You should submit your claims to the other carrier first. If the other group carrier does not pay the full claim, submit the balance to the FCPS plan. Claims payments will be made according to your FCPS plan terms.
- When the person who received care is covered as an employee under one group contract, and as a dependent under another group contract, then the employee's coverage pays first. Submit a claim first to the health plan for the patient's employer, and then submit any unpaid balance to the other plan.
- When a dependent child is covered under two group plans, the plan that will pay first for dependent children will be that of the parent with the earliest birth date (in other words, the earlier month and date, regardless of the birth year). If the parents are born on the same day, the contract that has been in force longer will pay first for dependent children. However, if the other carrier uses gender to determine who would pay first, then your FCPS plan will follow suit and use the gender rule and the father's plan will pay first. Submit your child's claim to whichever health coverage pays first and any unpaid balances to the other plan.
- When the parents are separated or divorced and the eligible child(ren) are covered by more than one health plan, then the following rules apply:
  - If the parent with custody of the child has not remarried, the coverage of the parent with custody pays first.
  - If the parent with custody of the child has remarried, the parent's coverage pays first. The step-parent's coverage pays second, and the coverage held by the parent without custody of the child pays third.
  - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.
  - When none of the above can be applied, the benefits of the plan that has covered the participant the longest pays first.

Coordination of Benefits

When the FCPS plan is primary

When the FCPS plan is your primary insurer, you or the provider of care should submit your claims to us first, in the same way you would if you had no other coverage. Then, if balances remain, you should submit a claim to your secondary plan.

When the FCPS plan is secondary

When the FCPS plan is your secondary health plan, you should submit your claims to your primary health plan first. Once the claim has been processed, you should receive a form—often called an Explanation of Benefits or Notice of Benefits—showing the amount paid, or if benefits were denied, the reason for the denial.

If your claim was not paid in full by your primary plan, you may then submit a claim for consideration of the balance to the FCPS plan. You or the provider should submit the claim to us in the same way you would have if we were the primary plan, with one difference: in addition to sending us the information required for a claim (date of service, provider's name, type of service and diagnosis), you should attach the Explanation of Benefits or Notice of Benefits you or the provider received explaining the other plan's payment. This information will enable us to process your claim quickly and accurately.

Workers' Compensation

If you are injured while at work or require medical care as a result of your work, you should obtain benefits for such injuries through Workers' Compensation. Your FCPS plan coverage does not provide benefits for expenses which are eligible under Workers' Compensation laws. To report a work-related injury, contact Sedgwick at 1-855-937-1387.

How to File a Claim

In-network

When you receive covered services from in-network providers, you will not have to file claims. Your in-network provider will file the claim for you.

Out-of-network

When services are rendered by non-participating providers (doctors, hospitals, and other health care professionals) you must submit your own claim forms.

After you have services rendered by a non-participating provider, be sure to obtain an itemized bill from your provider. Attach the bill to a completed "Health Benefits Claim Form." The address where the form should be sent, along with filing instructions, are on the back of the form.

Claim forms can be downloaded from **carefirst.com/fcps**.

Separate forms for each family member

A separate claim form must be completed for each family member (instructions are on the back of the form). Sign the claim form and attach all original itemized bills.

Time for filing claims

Claims must be submitted to the plan within 12 months after the date services are rendered or supplies received. The plan will only consider claims beyond the 12-month filing limit if you are legally incapacitated.

We suggest you keep copies of all bills for your records. Your original bills will not be returned.

Appealing a Denied Claim

CareFirst's Appeal procedure is designed to enable you to have your concerns regarding a denial of benefits, including any Rescission of coverage (whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time) or authorization for services heard and resolved. By following the steps below, you can ensure that your Appeal is quickly and responsively addressed.

Your concerns can often be handled and resolved through informal discussions and information gathering. If your question relates to our handling of a claim or other administrative action, call and discuss the matter with a CareFirst Member Services Representative. In many instances, the matter can be quickly resolved.

If your concern is not resolved through a discussion with a CareFirst representative, you or someone on your behalf may make a formal request for Appeal.

Glossary of appeals-related terms

Adverse Benefit Determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. This includes any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the FCPS plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental/investigational or not Medically Necessary or appropriate. An Adverse Benefit Determination also includes any Rescission of coverage (whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time).

Appeal (or Internal Appeal) means review by CareFirst of an Adverse Benefit Determination.

Claimant means an individual who makes a claim. References to claimant include a claimant's authorized representative.

External Review means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to the External Review process.

Final External Review Decision means a determination by an Independent Review Organization at the conclusion of an External Review.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by CareFirst at the completion of the Internal Appeals process (or an Adverse Benefit Determination with respect to which the Internal Appeals process has been exhausted under the deemed exhaustion rules explained below).

Independent Review Organization (or IRO) means an entity that conducts independent External Reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations.

Rescission means a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats coverage as void from the time of your enrollment or FCPS's enrollment is a Rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a Rescission. A cancellation or discontinuance of coverage is not a Rescission if:

1. The cancellation or discontinuance of coverage has only a prospective effect; or
2. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay charges when due, by FCPS.

Urgent health care claims

For conditions that could seriously jeopardize the life, health, or ability to regain maximum function; or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Rules for urgent health care claims

1. CareFirst has 72 hours after receiving your initial claim to notify you if your claim is approved or denied.
2. If denied, you have 180 days after receiving the Adverse Benefit Determination to Appeal CareFirst's decision.
3. CareFirst has 72 hours after receiving your Appeal to notify you of its Internal Appeal decision.
4. A Claimant may request an expedited External Review at the time the Claimant receives:
   - An Adverse Benefit Determination involving a medical condition for which the 72-hour timeframe for completion of an expedited Internal Appeal would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function.
   - A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function; or, if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

See the External Review section for additional information.

If the urgent health care claim is improper or incomplete, the following rules apply:

- CareFirst has 24 hours after receiving your initial claim to notify you that your claim is improper or incomplete. You have 48 hours after receiving notice from CareFirst to correct or complete your claim.
- CareFirst has 48 hours to notify you if your claim is approved or denied. CareFirst must do so within the earlier of 48 hours of:
  - Receiving your completed claim; or
  - Your deadline to complete the claim.

Pre-service health care claims

Where treatment must be pre-certified before it is performed.

Rules For Pre-Service Health Care Claims

1. CareFirst has 15 days after receiving your initial claim to notify you if your claim is approved or denied.
2. If denied, you have 180 days after receiving the Adverse Benefit Determination to Appeal CareFirst's decision.
3. CareFirst has 30 days after receiving your Appeal to notify you of its Final Internal Adverse Benefit Determination decision.
4. Request an External Review within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination.

See the External Review section for additional information.

If a pre-service health care claim is improper or incomplete, the following rules apply:

- CareFirst has five days after receiving your initial claim to notify you that your claim is improper or incomplete.
- CareFirst has 15 days after receiving your claim to notify you of its decision to approve or deny the claim. If CareFirst needs more information and provides an extension notice during the initial 15-day period, CareFirst has 30 days after receiving the claim to notify you of its decision. (The time CareFirst waits for information from you is not counted in totals.)
- You have 45 days after receiving the extension notice to provide additional information or complete the claim.

- If denied, you have 180 days after receiving the claim denial to Appeal CareFirst's decision.
- CareFirst has 30 days after receiving your Appeal to notify you of the decision.

Post-service health care claims

Where you request reimbursement after treatment has been performed.

Rules For Post-Service Health Care Claims

1. CareFirst has 30 days after receiving your initial claim to notify you if your claim is approved or denied.
2. If denied, you have 180 days after receiving the Adverse Benefit Determination to Appeal CareFirst's decision.
3. CareFirst has 60 days after receiving your Appeal to notify you of its Final Internal Adverse Benefit Determination decision.
4. Request an External Review within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination.

See the External Review section for additional information.

If CareFirst needs further information or an extension, the following rules apply:

- CareFirst has 30 days after receiving the initial claim to notify you if your claim is denied. If CareFirst needs more information and provides an extension notice during the initial 30-day period, CareFirst has 45 days after receiving the claim to notify you if your claim is denied. (The time CareFirst waits for information from you is not counted in totals.)
- You have 45 days after receiving the extension notice to provide additional information or complete your claim.
- If denied, you have 180 days after receiving the claim denial to Appeal CareFirst's decision.
- CareFirst has 60 days after receiving your Appeal to notify you of the decision.

Continued coverage will be provided pending the outcome of an Appeal

Deemed exhaustion of Internal Appeal process

In certain situations, a Claimant may initiate an External Review without first having exhausted the Internal Appeal process:

- If CareFirst fails to adhere to all the prior requirements with respect to a claim, the Claimant is deemed to have exhausted the Internal Appeal process, except as provided below. The Claimant is also entitled to pursue any available remedies under State law on the basis that CareFirst has failed to provide a reasonable Internal Appeal process that would yield a decision on the merits of the claim.
- However, the Internal Appeal process will not be deemed exhausted based on violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as CareFirst demonstrates that the violation was for good cause or due to matters beyond its control and that the violation occurred in the context of an ongoing, good faith exchange of information between CareFirst and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by CareFirst. The Claimant may request a written explanation of the violation from CareFirst, and CareFirst will provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the Internal Appeal process to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that CareFirst met the standards for the exception under this paragraph, the Claimant has the right to resubmit and pursue the Internal Appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), CareFirst will provide the Claimant with notice of the opportunity to resubmit and pursue the Internal Appeal of the claim. Time periods for re-filing the claim will begin to run upon Claimant's receipt of such notice.

Full and fair review

CareFirst allows a Claimant to review the claim file and to present evidence and testimony as part of the Internal Appeal process. Specifically:

- A Claimant will be provided free of charge with any new or additional evidence considered, relied upon or generated by CareFirst in connection with the Appeal request, and the rationale for the adverse determination prior to the Final Internal Adverse Benefit Determination. This provides an opportunity for a Claimant to respond in writing prior to CareFirst making the Final Internal Adverse Benefit Determination.
- The full and fair review notification is always sent via Federal Express. The full and fair review notification is also sent to the provider (via Federal Express) if the provider is the requestor of the Appeal.
- A Claimant and or the provider are given 30 days to respond to the full and fair review notification. Any new or additional information is reviewed and considered prior to making the Final Internal Adverse Benefit Determination.

Avoiding conflicts of interest

CareFirst ensures that all claims and Appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

Written notice requirements

If your claim is denied, you will receive a written explanation of the denial that will include the following:

- The specific reason why your claim was denied.
- Reference to the specific plan provisions on which the decision is based.
- A description of how to Appeal the denial.
- A description of CareFirst's review procedures and time limits.
- In the case of a claim denial, a statement that a copy of any internal rules, guidelines, or other similar criteria relied upon in denying the claim will be provided to you free of charge upon request.
- If a denial is based on a Medical Necessity, experimental treatment, or other similar exclusion or limit, a statement notifying you that an explanation of the scientific or clinical judgment for the denial that applies to the terms of the FCPS plan and to your medical circumstances will be provided to you free of charge upon request.
- In the case of a denial involving a claim for urgent care, a description of the expedited review process applicable to urgent care claims.

If you wish to have a denied claim reviewed, you must submit a written Appeal within 180 days after receiving the Adverse Benefit Determination. Submit your Appeal to:

Central Appeals and Analysis Unit
CareFirst BlueCross BlueShield
P.O. Box 17636
Baltimore, MD 21298-9375

You may also submit any comments, documents, or other information that you feel will support your Appeal. In addition, you may have access to all relevant documents that may help you with your Appeal, free of charge.

The review of the denied claim will consider all new information that was not present when the claim was initially decided. Also, the Appeal review will not be influenced by the initial claim decision.

Someone other than the person who denied the initial claim will conduct the Appeal review and the Appeal reviewer will not work under the authority of the person who denied the initial claim. If your claim was denied on the grounds of a medical judgment, CareFirst will consult with an appropriate health professional about the claim. This health professional will not be the person who processed the initial claim or work under his/her authority. If the advice of a medical or vocational expert was used to deny your initial claim, CareFirst will provide you with the name of this expert, even if his/her advice was not used.

If your claim involves urgent care, you may request

a rush Appeal. The rush Appeal and any necessary information may be made orally or in writing and may be transmitted by telephone, fax, or other similar method.

If your Appeal is denied, the Final Internal Adverse Benefit Determination will contain the following:

- The availability of translation assistance in eighteen languages (providing notices to you in a culturally and linguistically appropriate manner). See Notice of Nondiscrimination and Availability of Language Assistance Services on page 81.
- Identification of the claim under review including the date of service, the health care provider, and the claim amount, if applicable.
- A statement that the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, will be made available upon request.
- The denial code and its corresponding meaning.
- The specific reason why your claim was denied.
- The specific criteria, and if applicable, the interpretative guidelines on which the Final Internal Adverse Benefit Determination was based.
- Reference to the specific FCPS plan provisions on which the Final Internal Adverse Benefit Determination is based.
- If applicable, the physician specialty consulted in making the Final Internal Adverse Benefit Determination.
- The name, business address, and business telephone number of the Medical Director who made the Final Internal Adverse Benefit Determination.
- Statements that:
  - Tell you that you are entitled to receive – upon request and without charge – reasonable access or copies of any documents, records, or other relevant information.
  - Describe any voluntary Appeal procedures offered by FCPS and your right to get information about these procedures.
  - Provide information regarding criteria and initiation of an expedited External Review, a dedicated fax number, and expected timeframe for completion.
  - Provide information regarding the initiation of a standard External Review, mailing address, and time frame for completion.
  - Outline any internal rules, guidelines, or other similar criteria relied on when denying the claim (will be provided to you free of charge upon request).
  - Explain how the scientific or clinical judgment for the denial that applies to the terms of the FCPS plan and your medical circumstances will be provided to you free of charge upon request, if the denial is based on a Medical Necessity, experimental treatment, or other similar exclusion or limit.

External Review

Review by an Independent Review Organization (IRO)

When filing a request for an External Review, the Claimant will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the External Review.

If you wish to have an External Review, you must file a written complaint within four months after receiving the Final Internal Adverse Benefit Determination. Submit your External Review request to:

Central Appeals and Analysis Unit
CareFirst BlueCross BlueShield
P.O. Box 17636
Baltimore, MD 21298-9375

A denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of the FCPS plan is not eligible for External Review.

The External Review process applies only to:

1. An Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by CareFirst that involves medical judgment (including, but not limited to, those based on CareFirst's requirements for Medical Necessity,

appropriateness, health care setting, level of care, or effectiveness of a covered service; or its determination that a treatment is experimental/ investigational), as determined by the External Reviewer

2. A Rescission of coverage (whether or not the Rescission has any effect on any particular benefit at that time).

Rules For Expedited External Review

1. A Claimant may request an expedited External Review with CareFirst at the time the Claimant receives:
   - An Adverse Benefit Determination if it involves a medical condition for which the timeframe for completion of an expedited Internal Appeal would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited Internal Appeal.
   - A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.
2. Immediately upon receipt of the request for expedited External Review, an IRO will determine whether the request meets the reviewability requirements set forth above for standard External Review. The IRO will immediately send a notice that meets the requirements set forth above for standard External Review to the Claimant of its eligibility determination.
3. Referral to Independent Review Organization. Upon a determination that a request is eligible for External Review following the preliminary review, CareFirst will assign an IRO pursuant to the requirements set forth above for standard review. CareFirst will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other expeditious method.

   The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during CareFirst's internal claims and Appeals process.
4. The assigned IRO will provide notice as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the Claimant and CareFirst.
5. Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, CareFirst will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Rules for Standard External Review (External Review that is not considered expedited)

1. A Claimant may request an External Review within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination.
2. Within five business days following the date of receipt of the External Review request, an IRO will complete a preliminary review of the request to determine if the request is eligible for External Review.
3. Within one business day after completion of the preliminary review, the IRO will issue a notification in writing to the Claimant.

- If the request is not complete, the IRO's notice will describe the information or materials needed to make the request complete. The IRO will allow a Claimant to perfect the request for External Review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

4. The assigned IRO will provide written notice of the final External Review decision within 45 days after the IRO receives the request for the External Review. The IRO will deliver the notice of Final External Review Decision to the Claimant and CareFirst.
5. Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, CareFirst will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Preliminary review

The IRO's preliminary review of the request will determine whether:

- The Claimant is or was covered at the time the health care item or service was requested or, in the case of a retrospective review, was covered at the time the health care item or service was provided.
- The Adverse Benefit Determination or the Final Internal Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the FCPS plan (e.g., worker classification or similar determination).
- The Claimant has exhausted the Internal Appeal process unless the Claimant is not required to exhaust the Internal Appeals process as previously described.
- The Claimant has provided all the information and forms required to process an External Review.

Referral to Independent Review Organization

CareFirst will assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the External Review.

Moreover, CareFirst will take action against bias and to ensure independence. Accordingly, CareFirst will contract with at least three IROs for assignments under the FCPS plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

- The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the FCPS plan.
- The assigned IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for External Review. This notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.
- Within five business days after the date of assignment of the IRO, CareFirst will provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by CareFirst to timely provide the documents and information will not delay the conduct of the External Review. If CareFirst fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO will notify the Claimant and CareFirst.
- Upon receipt of any information submitted by the Claimant, the assigned IRO will within one business day forward the information to CareFirst. Upon receipt of any such information, CareFirst may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the External Review. Reconsideration by CareFirst will not delay the External Review. The External Review may be terminated as a result of the

reconsideration only if CareFirst decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, CareFirst will provide written notice of its decision to the Claimant and the assigned IRO. The assigned IRO will terminate the External Review upon receipt of the notice from CareFirst.

- The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during CareFirst's internal claims and Appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
  - The Claimant's medical records.
  - The attending health care professional's recommendation.
  - Reports from appropriate health care professionals and other documents submitted by CareFirst, Claimant, or the Claimant's treating provider.
  - The terms of the Claimant's FCPS plan to ensure that the IRO's decision is not contrary to the terms of the FCPS plan, unless the terms are inconsistent with applicable law.
  - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations.
  - Any applicable clinical review criteria developed and used by CareFirst, unless the criteria are inconsistent with the terms of the FCPS plan or with applicable law.
  - The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

Written notice requirements

- The assigned IRO will provide written notice of the Final External Review Decision within 45 days after the IRO receives the request for the External Review. The IRO will deliver the notice of Final External Review Decision to the Claimant and CareFirst.
- The assigned IRO's Final External Review Decision notice will contain:
  - A general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial).
  - The date the IRO received the assignment to conduct the External Review and the date of the IRO Final External Review Decision.
  - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its Final External Review Decision.
  - A discussion of the principal reason or reasons for its Final External Review Decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.
  - A statement that the Final External Review Decision is binding except to the extent that other remedies may be available under state or federal law to either the FCPS plan or to the Claimant.
  - A statement that judicial review may be available to the Claimant.
- After a Final External Review Decision, the IRO will maintain records of all claims and notices associated with the External Review process for six years. An IRO will make such records available for examination by the Claimant, FCPS plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

- Reversal of CareFirst's decision. Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, CareFirst will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Binding decision

An External Review decision is binding on CareFirst, as well as the Claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding will not preclude CareFirst from making payment on the claim or otherwise providing benefits at any time, including after a Final External Review Decision that denies the claim or otherwise fails to require such payment or benefits. For this purpose, CareFirst will provide any benefits (including by making payment on the claim) pursuant to the Final External Review Decision without delay, regardless of whether CareFirst intends to seek judicial review of the External Review decision and unless or until there is a judicial decision otherwise.

FCPS Group Health Plans' Commitment to Privacy

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Effective Date: April 14, 2003; Amended Date: April 18, 2005/July 13, 2012/May 21, 2013/ September 9, 2013/ February 25, 2015

This notice describes how medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

Fairfax County Public Schools (FCPS) Group Health Plan (the "Plan" or "we") is committed to protecting the privacy of your "protected health information (PHI)." Protected health information referred to as "medical information" in this Notice, is information that identifies you and relates to your physical or mental health or to the provision or payment of health services for you. We create, receive, and maintain your medical information when the Plan provides health benefits to you and your covered dependents. We are required to provide you with certain rights related to your medical information.

We have the following legal obligations under federal health privacy law—the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the related regulations to:

- Maintain the privacy of your medical information
- Provide you with this Notice of our legal duties and privacy practices with respect to your medical information
- Abide by the terms of this Notice currently in effect

This Notice becomes effective as of the effective date of your health coverage and will remain in effect unless and until we publish a revised Notice.

Who Will Follow This Notice

This Notice discusses the practices of the Plan regarding your medical information and the standards to which it will hold any third parties (such as health insurance companies) that assist in the administration of the Plan.

Information Subject to this Notice

This notice of Privacy Practices applies to FCPS' Health Plans covered by HIPAA regulations, for example, health benefits plans, dental plans, vision plan, pharmacy benefit programs, and flexible medical spending account, collectively the "Plan." We, as the Plan, create, receive, and maintain certain medical information about you to help provide health benefits to you, as well as to fulfill legal and regulatory requirements. We obtain this medical information from applications and other forms that you may complete, through conversations you may have with our benefits administrative staff and health care professionals, and from reports and data provided to us by health care service providers, insurance companies, and other third parties.

The medical information we have about you includes, among other things, your name, address, phone number, birth date, Social Security number, and health claims information. This is the information that is subject to the privacy practices described in this Notice. This Notice does not apply to medical information created, received, or maintained by FCPS on behalf of the non-health employee benefits that it sponsors, including disability benefits and life insurance benefits. This Notice also does not apply to medical information that FCPS requests, receives, and maintains about you for employment purposes, such as employment testing or determination of your eligibility for medical leave benefits or disability accommodations.

Summary of the Plan's Privacy Policies

The Plan's Uses and Disclosures of Your Medical Information

Generally, you must provide a written authorization to us in order for us to use or disclose your medical information. However, we may use and disclose your medical information without your authorization for administering the Plan and for processing claims. We also may disclose your medical information without your authorization for other purposes as permitted by the federal health privacy law, such as health and safety, law enforcement, or emergency purposes. The law also requires us to disclose medical information when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.

Your Federal Rights Under HIPAA Regarding Your Medical Information

Under 45 CFR Parts 160 and 164, (Standards for Privacy of Individually Identifiable Health Information) you have several rights regarding medical information. You have the right to:

- Inspect, access, and/or copy your medical information
- Request that your medical information be amended
- Request an accounting of certain disclosures of your medical information
- Request certain restrictions related to the use and disclosure of your health information
- Request to receive your medical information through alternative means or location for receiving confidential communications
- Request an electronic copy of your electronic medical records
- Request restriction of information sharing regarding services you pay for yourself
- Receive notification upon a breach of your unsecured Protected Health Information
- File a complaint with the Plan or the secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated or a breach has occurred
- Receive a paper copy of this Notice

Contact Information

If you have any questions or concerns about the Plan's privacy practices or about this Notice or if you want to obtain additional information about the Plan's privacy practices, contact:

HIPAA Compliance Officer

Fairfax County Public Schools
Department of Human Resources
Office of Equity & Employee Relations
8115 Gatehouse Road, Suite 2500
Falls Church, VA 22042
Phone: 571-423-3065 or 877-702-5137
Fax: 571-423-5058

Detailed Notice of the Plan's Privacy Practices

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information. Please Review it Carefully.

How the Plan May Use and Disclose Health Information About You

Except as described in this section, as provided for by federal health privacy law, or as you have otherwise authorized, we only use or disclose your health information for administering the Plan and processing health claims. The uses and disclosures that do not require your authorization are described below with specific examples of such disclosures.

Please note that most of the medical information about you will be handled by the insurance companies and business associates that administer the Plan, not the FCPS Office of Benefits Services. Occasionally, however, the Office of Benefits Services will receive or maintain such information. The Plan's contracts with these insurance companies require them to protect the privacy of your medical information. The purpose of this Notice is to advise you about how the Plan and the business associates that work for the Plan may use that information.

For Treatment

We are not aware of any circumstances under which FCPS will be providing treatment information about you to health care providers. In the event that such inquiries are made, however, we may use or disclose medical information about

you to facilitate medical treatment or services by providers. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

For Payment

We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate your coverage. Our business associates may confer with your health care provider to determine whether a particular treatment is medically necessary or to determine whether the Plan will cover the treatment. We may also share medical information with a utilization review or precertification service provider. Likewise, we may share medical information with another entity to assist with the adjudication or subrogation of health claims or with another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose medical information about you to run the Plan efficiently and in the best interests of all its participants. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; or conducting or arranging for medical reviews, legal services, audit services, and the fraud and abuse detection program.

Disclosures to Health Plan Sponsor

We do not disclose your medical information to the Plan Sponsor (FCPS). We may share de-identified aggregate information with the Plan Sponsor for plan administration purposes including, but not limited to quality assurance, monitoring, or auditing functions. FCPS will not use your medical information for non-Plan purposes or for purposes not covered by this Notice, such as employment decisions.

Disclosures to Business Associates

We may disclose certain medical information, without your authorization, to our "business associates." Business associates are third parties that assist us in the Plan's operations, such as insurance companies. For example, we may share your claims information with business associates that provide claims processing services to the Plan, and we may disclose your medical information to our business associates for actuarial and audit purposes and legal services. We enter into contracts with these business associates to ensure that they protect the privacy of your medical information.

As Required by Law: Lawsuits and Disputes

We may disclose medical information about you when required to do so by federal, state, or local law and by related judicial and administrative proceedings. For example, we may disclose your medical information in response to a subpoena, discovery request, court or administrative order, or other legal process.

Health or Safety

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or to the health and safety of the public or another person. We also may disclose your health information for public health activities such as preventing or controlling disease, injury, or disability; reporting births and deaths; or reporting child abuse or neglect.

Emergency Situations

We may use or disclose your medical information to a family member or close personal friend involved in your care in the event of an emergency or to a disaster relief entity in the event of a disaster.

Others Involved in Your Care

In limited circumstances, we may use or disclose your medical information to a family member, close personal friend, or others whom we have verified are involved in your care or payment for your care. For example, your medical information may be disclosed if you are seriously injured and unable to discuss your case with us. Also, in certain circumstances, we may advise a family member or close personal friend about your general condition, location (such as in the hospital), or death.

Personal Representatives

Your medical information may be disclosed to people whom you have authorized to act on your behalf or to people who have a relationship with you that gives them the right to act on your behalf. Examples of personal representatives are parents for minors and those who have power of attorney for adults.

Treatment and Health-Related Benefits Information

Our business associates and we may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services, and education.

Research

We do not use your medical information for research purposes.

Organ and Tissue Donation

If you are an organ donor, we may use or disclose your medical information to an organ donor or procurement organization to facilitate an organ or tissue donation transplantation.

Deceased Individuals

The medical information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

Military and Veterans

If you are a member of the armed forces or a veteran, we may release medical information about you in order to comply with laws and regulations related to military service or veterans' affairs. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We do not release your medical information for workers' compensation program without your authorization.

Health Oversight Activities

We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and licensure.

Data Breach Notification Purposes

We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Law Enforcement

- To help law enforcement officials in their law enforcement duties.
- To respond to a court order, subpoena, warrant, summons, or similar process.
- To identify or locate a suspect, fugitive, material witness, or missing person.
- To provide information about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement.
- To provide information about a death that may be the result of criminal conduct.
- To provide information about criminal conduct on FCPS property.
- In emergency circumstances, to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

National Security and Intelligence Activities

We may release medical information about you to authorized federal officials for intelligence, counterintelligence, protection of public officials, and other national security activities authorized by law.

Genetic Information Nondiscrimination Act (GINA)

We do not use or disclose genetic information for underwriting purposes or for any other reason.

Other Uses and Disclosures for Fundraising and Marketing Purposes

We do not use your medical information for fund-raising and marketing purposes.

Any Other Uses and Disclosures Require Your Express Written Authorization

Uses and disclosures of your medical information other than those described above will be made only with your express written authorization. You

may revoke your authorization in writing. If you do so, we will not disclose the medical information covered by the revoked authorization except to the extent the Plan has already relied on your authorization. You also should understand that insurance laws might affect your ability to revoke your authorization.

Once your medical information has been disclosed pursuant to your authorization, the federal health privacy protections may no longer apply to the disclosed medical information, and that information may be redisclosed by the recipient without your or our knowledge or authorization.

Your Federal Rights Under HIPAA Regarding Your Medical Information

Under 45 CFR Parts 160 and 164 (Standards for Privacy of Individually Identifiable Health Information), you have several rights regarding medical information that the Plan creates, receives, and maintains about you. You should address such requests to exercise your rights to:

HIPAA Compliance Officer

Fairfax County Public Schools
Department of Human Resources
Office of Equity & Employee Relations
8115 Gatehouse Road, Suite 2500
Falls Church, VA 22042
Phone: 571-423-3065 or 877-702-5137
Fax: 571-423-5058

Your Individual Rights

You have the following individual rights regarding medical information we maintain about you:

Right to Access

You have the right to request healthcare records. This right is not absolute. You have the right to obtain and review a copy of your protected health information in the Plan's or its Business Associates designated record set that may be used to make decisions about your Plan benefits. You must submit your request in writing to the Compliance Officer at the address above. If you request a copy of the information, we may charge a fee for the costs of copying and mailing that information.

We may deny your request to inspect and copy that health information in certain very limited circumstances, such as certain psychotherapy notes and information compiled for certain legal proceedings. If you are denied access to health information, we will inform you in writing, and in certain circumstances you may request that the denial be reviewed.

Right to Your Medical Records

If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you may request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format your request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable fee for the labor associated with transmitting the electronic medical record.

Right to Request That Your Medical Information Be Amended

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Compliance Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the medical information kept by or for the Plan.
- Was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the information that you would be permitted to inspect or copy.
- Is accurate and complete.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures" made by the Plan or its Business Associates. An accounting of disclosures is a list of disclosures of your medical information that we have made. The maximum accounting period is six years. The accounting that the Plan or its Business Associates provide will not include disclosures made before April 14, 2003; disclosures made for treatment, payment or health care operations; disclosures made earlier than six years before the date of your request; and disclosures made to you or pursuant to your written request. The accounting will tell you the person to whom your medical information was disclosed, the date of the disclosure, a description of the information disclosed, and the purpose of the disclosure.

To request an accounting of disclosures, you must submit your request in writing to the Compliance Officer. Your request must state a time period that may not be longer than six years and may not include dates before April 2003. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accountings. The Plan will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. We are under no obligation to agree to requests for restrictions. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Compliance Officer. You must include with your request: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse). We will notify you in writing as to whether we agree to your request for restrictions.

Right to Request a Restriction for Services Paid Out-of-Pocket

You have the right to request a restriction to share information about your treatment for services you pay for yourself.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain confidential way or at specific or certain agreed upon location. For example, you can ask that we contact you only at work or by mail.

To request confidential communications by alternative means or at an alternative location, you must make your request in writing to the Compliance Officer. Your request should state the reason(s) for your request and the alternative means by which or the location at which you would like to receive your health information. If you believe that the disclosure of all or part of your health information by non-confidential communications could endanger you, your request should state that. The Plan will accommodate reasonable requests and notify you appropriately.

Right to Receive Notice of a Breach

You have the right to be notified of a breach of any of your unsecured Protected Health Information.

Rights About Fundraising Communication

We do not use or disclosure your Protected Health Information for marketing and fundraising purposes. You have the right to opt out of fundraising communications, and your Protected Health Information cannot be sold without your permission.

Right to a Paper Copy of the Privacy Notice

You have the right to obtain a paper copy of this Notice of Privacy Practices at any time upon request. Even if you agree to receive this Notice electronically, you are still entitled to a paper copy of this Notice. To obtain a paper copy of this notice by mail, you should contact the Department of Human Resources, Office of Equity and Compliance at the below address. You may also obtain an electronic copy of this notice at the Plan's website.

HIPAA Compliance Officer

Fairfax County Public Schools
Department of Human Resources
Office of Equity & Employee Relations
8115 Gatehouse Road, Suite 2500
Falls Church, VA 22042
Phone: 571-423-3065 or 877-702-5137
Fax: 571-423-5058

Changes to this Notice

We reserve the right to change any of the privacy policies and related practices at any time, as allowed by federal and state law, and to make the change effective for all information that we maintain. The terms of the revised Notice may apply to medical information we already have about you as well as any information we receive in the future. If we materially change any of the privacy practices covered by this Notice, we will provide you with the revisions within 60 days and post the revised Notice on the Plan's website.

We will post a copy of the current Notice on the Plan's website at www.fcps.edu. That Notice will contain the effective date on the top right-hand corner. You should monitor the website for revisions. Copies of the revised Notice will be made available to you upon your written request.

Your Right to File a Complaint and Contact Information

The Plan provides a process as required by HIPAA for you to make complaints regarding the Plan's policies and procedures or compliance with policies and procedures related to protecting the privacy of your health information. If you believe your privacy rights have been violated, you may file a complaint with the HIPAA Compliance Officer or with the Secretary of the Department of Health and Human Services. To file a complaint you must submit it in writing to the following:

HIPAA Compliance Officer

Fairfax County Public Schools
Department of Human Resources
Office of Equity & Employee Relations
8115 Gatehouse Road, Suite 2500
Falls Church, VA 22042
Phone: 571-423-3065 or 877-702-5137
Fax: 571-423-5058

Office for Civil Rights

U.S. Department of Health & Human Services
150 S. Independence Mall West - Suite 372
Philadelphia, PA 19106-3499
Phone: 215-861-4441; 215-861-4440 (TDD)
Fax: 215-861-4431

Glossary of Terms

Allowed benefit (BlueChoice Provider definition)

For a plan physician or plan provider, the allowed benefit for a covered service is the lesser of:

a. the actual charge; or

b. the amount CareFirst BlueChoice allows for the service in effect on the date that the service is rendered.

The benefit payment is made directly to the plan physician or plan provider and is accepted as payment in full, except any applicable deductible, copayment or coinsurance as set forth in this booklet. The Member is responsible for any applicable deductible and copayment and the plan physician or plan provider may bill the Member directly for such amounts.

For a non-plan physician or a non-plan provider
For a non-plan physician or a non-plan provider, the allowed benefit for a covered service will be determined in the same manner as the allowed benefit to a plan physician or plan provider. Benefits may be paid to the Subscriber or to the non-plan physician or non-plan provider. The Member is responsible for the non-plan physician's or non-plan provider's total charge, and the non-plan physician or non-plan provider may bill the Member directly.

Allowed Benefit (PPO Provider definition)

1. For a preferred provider, the allowed benefit for a covered service will be the amount agreed upon between CareFirst and the preferred provider which, in some cases, will be a rate set by a regulatory agency. The benefit is payable to the provider and is accepted as payment in full, except for any applicable deductible, copayment and coinsurance amounts, for which the Member is responsible.

2. For a non-participating provider the benefit is payable to the Member or to the provider, at the discretion of CareFirst. The Member is responsible for any applicable deductible, copayment, and coinsurance amounts and for the difference between the allowed benefit and the practitioner's actual charge. It is the Member's responsibility to apply any CareFirst payments to the claim from the non-participating practitioner.

3. For a non-participating facility, the allowed benefit for a covered service is based upon the lower of the provider's actual charge or the established allowed benefit if one has been established for that type of Eligible Provider and service. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with an Eligible Provider. In that instance, the CareFirst payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable deductible, copayment and coinsurance amounts, for which the Member is responsible. The benefit is payable to the Member or to the Facility, at the discretion of CareFirst. The Member is responsible for any applicable deductible, copayment, and coinsurance amounts and, unless negotiated as stated above, for the difference between the allowed benefit and the practitioner's actual charge. It is the Member's responsibility to apply any CareFirst payments to the claim from the non-participating facility.

In-network benefits

Benefits are paid at a higher level when you use an in-network provider.

Out-of-network benefits

Benefits are paid at a lower level when you have care rendered by an out-of-network provider.

CareFirst service area

The CareFirst service area is defined as the entire State of Maryland, Washington, D.C., and Northern Virginia.

Coinsurance—Medical

The BlueChoice Advantage plan pays a percentage of certain in-network covered services, and a percentage of all of your out-of-network covered services (after you meet your out-of-network calendar year deductible). The percentage you pay is your coinsurance.

Glossary of Terms

Copayment
The amount of covered expenses you are responsible to pay in-network at the time you receive care. There is no out-of-pocket maximum for copayment amounts. All copayments will continue after the out-of-pocket maximum is reached.

Covered services
A service that is covered under the plan. To be a "covered service," the service must be rendered by a covered provider.

Deductible
The amount you pay for covered health care services before the plan begins paying a percentage of your covered in-network and out-of-network expenses.

Emergency care
The first treatment given in a hospital's emergency room right after either sudden and unexpected onset of symptoms or an accident causing injuries which are severe enough to require immediate hospital-level care.

Explanation of Benefits (EOB)
A statement of payments or denials you receive.

Medically Necessary or Medical Necessity
Health care services or supplies that a health care provider, exercising prudent clinical judgment, renders to or recommends for, a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. These health care services or supplies are:

1. In accordance with generally accepted standards of medical practice.
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's illness, injury or disease.
3. Not primarily for the convenience of a patient or health care provider.
4. Not more costly than an alternative service or frequency of services at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and views of health care providers practicing in relevant clinical areas, and any other relevant factors.

Open Access
No referrals required.

Out-of-Pocket Maximum
The most you will pay out of your pocket in coinsurance in a calendar year before the Plan pays 100% of the allowed benefit for your covered expenses.

Per admission copayment
The amount you are responsible for paying for your hospital admissions in addition to your coinsurance.

PPO
Preferred Provider Organization

Precertification (or Pre-authorization)
An administrative procedure whereby certifications are obtained before treatment begins.

Prudent layperson
The prudent layperson definition of an emergency medical condition commonly in practice is any medical or behavioral condition of recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in placing the patient's health in serious jeopardy, cause serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy. This prudent layperson definition of emergency medical condition focuses on the patient's presenting symptoms rather than the final diagnosis when determining whether to pay emergency medical claims.

Controlled Clinical Trial Patient

Controlled Clinical Trial Patient Cost benefits are available as follows:

A. Definitions

Controlled Clinical Trial means a treatment that is:

1. Approved by an institutional review board.
2. Conducted for the primary purpose of determining whether or not a particular treatment is safe and efficacious.
3. Is approved by:
   a. The National Institutes of Health (NIH) or a Cooperative Group.
   b. The Centers for Disease Control and Prevention.
   c. The Agency for Health Care Research and Quality.
   d. The Centers for Medicare & Medicaid Services.
   e. Cooperative group or center of any of the entities described in clauses 3.a) through 3.d) above or the Department of Defense or the Department of Veterans Affairs.
   f. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.
   g. The Department of Veterans Affairs, the Department of Defense or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that has been determined:
      1) To be comparable to the system of peer review of studies and investigations used by the NIH.
      2) Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
   h. The FDA in the form of an investigational new drug application.
   i. An institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the NIH.

Cooperative Group means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. Cooperative Group includes the National Cancer Institute Clinical Cooperative Group; the National Cancer Institute Community Clinical Oncology Program; the Aids Clinical Trials Group; and the Community Programs For Clinical Research in Aids.

Multiple Project Assurance Contract means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the United States Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

NIH means the National Institutes of Health.

Patient Cost means the cost of a Medically Necessary health care service that is incurred as a result of the treatment being provided to the Member for purposes of the clinical trial. Patient Cost does not include the cost of an Investigational drug or device, the cost of non-health care services that a Member may be required to receive as a result of the treatment being provided for purposes of the clinical trial, costs associated with managing the research associated with the clinical trial, or costs that would not be covered under this contract for non-Investigational treatments.

B. Covered services

1. Benefits will be provided to a Member in a Controlled Clinical Trial if the Member's participation in the Controlled Clinical Trial is the result of either:
   a. Treatment provided for a life-threatening condition
   b. Prevention, early detection, and treatment studies on cancer
2. Coverage will be provided only if:
   a. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV Controlled Clinical Trial for cancer.

b. The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV Controlled Clinical Trial for any other life-threatening condition.

c. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.

d. There is no clearly superior, non-Experimental/Investigational treatment alternative.

e. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-Experimental/Investigational alternative.

f. Prior authorization has been obtained from CareFirst.

3. Coverage is provided for the Patient Cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the Member's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 8/5/19)

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., CareFirst Diversified Benefits and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call 855-258-6518.

If you believe CareFirst has failed to provide these services, or discriminated in another way, on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues, or other documentation to this office.

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 8894 Baltimore, Maryland 21224
Email Address	**civilrightscoordinator@carefirst.com**
Telephone Number	410-528-7820
Fax Number	410-505-2011

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Foreign Language Assistance

Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their member identification card. All others may call 855-258-6518 *and wait through the dialogue until prompted to push* 0*. When an agent answers, state the language you need and you will be connected to an interpreter.*

አማርኛ (Amharic) ማሳሰቢያ፦ ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀነ-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኽን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ እገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

Èdè Yorùbá (Yoruba) Ìtẹ́tíléko: Àkíyèsí yìí ní ìwífún nípa ìṣẹ́ adójútòfò rẹ. Ó le ní àwọn déètì pàtó o sì le ní láti gbé ìgbésẹ̀ ní àwọn ọjọ́ gbèdéke kan. O ni ẹ̀tọ́ láti gba ìwífún yìí àti ìrànlọ́wọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Àwọn ọmọ-ẹgbẹ́ gbọ́dọ̀ pe nọ́mbà fóònù tó wà lẹ́yìn káàdì ìdánimọ̀ wọn. Àwọn míràn le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò títí a ó fi sọ fún ọ láti tẹ 0. Nígbàtí aṣojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì so ọ́ pọ̀ mọ́ ògbufọ̀ kan.

Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.

Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawan ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.

Español (Spanish) Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.

Русский (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.

Notice of Nondiscrimination and Availability of Language Assistance Services

हिन्दी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

Bǎsɔ́ɔ̀-wùdù (Bassa) Tò Đùǔ Cáo! Bɔ̃ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fûà-fǔá-tìǐn nyɛɛ jè dyí. Bɔ̃ nìà kɛ ɓéɖé wé jéɛ́ ɓě ɓɛ́ m̀ ké ɖɛ wa mɔ́ m̀ ké nyuɛɛ nyu hwè ɓɛ́ wé ɓěa ké zi. Ɔ mɔ̀ nì kpé ɓɛ́ m̀ ké ɓɔ̃ nìà kɛ kè gbo-kpá-kpá m̀ mɔ́ɛɛ dyé ɖé nì ɓíɖí-wùdù mú ɓɛ́ m̀ ké se wídí ɖò péɛ̀. Kpooɔ̀ nyɔ ɓě mɛ ɖá fǔùn-nɔ̀ɓà nìà ɖé waà I.D. káàɔ̀ ɖeín nyɛ. Nyɔ tɔ̀ɔ̀ séín mɛ ɖá nɔ̀ɓà nìà kɛ: 855-258-6518, ké m̀ mɛ fò tee ɓɛ́ wa kéɛ m̀ gbo cɛ̃ ɓɛ́ m̀ ké nɔ̀ɓà mɔ̀à 0 kɛɛ dyi pàɖàìn hwè. Ɔ jǔ ké nyɔ ɖò dyi m̀ gɔ̃ jǔǐn, po wuɖu m̀ mɔ́ poɛ dyiɛ, ké nyɔ ɖò mu ɓó nììn ɓé ɔ ké nì wuɖuɔ̀ mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যেরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

اردو (Urdu) توجہ :یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہ کیے اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ ممبران کو اپنے شناختی کارڈ کی پشت پر موجود فون نمبر پر کال کرنی چاہیے۔ سبھی دیگر لوگ 855-258-6518پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں۔ ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبان بتائیں اور مترجم سے مربوط ہو جائیں گے۔

فارسی (Farsi) توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و لازم است تا تاریخ مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی را به صورت رایگان به زبان خودتان دریافت کنید.
اعضا باید با شماره درج شده در پشت کارت شناسایی‌شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518تماس بگیرند و منتظر بمانند تا از آنها خواسته شود عدد 0 را فشار دهند. بعد از پاسخگویی توسط یکی از اپراتورها، زبان مورد نیاز را تنظیم کنید تا به مترجم مربوطه وصل شوید.

اللغة العربية (Arabic) تنبيه :يحتوي هذا الإخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد نهائية محددة .يحق لك الحصول على هذه المساعدة والمعلومات بلغتك بدون تحمل أي تكلفة .ينبغي على الأعضاء الاتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم .يمكن للآخرين الاتصال على الرقم 855-258-6518 والانتظار خلال المحادثة حتى يطلب منهم الضغط على رقم .0 عند إجابة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحد المترجمين الفوريين.

中文繁体 (Traditional Chinese) 注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。

Notice of Nondiscrimination and Availability of Language Assistance Services

Igbo (Igbo) Nrụbama: Ọkwa a nwere ozi gbasara mkpuchi nchekwa onwe gị. Ọ nwere ike ịnwe ụbọchị ndị dị mkpa, ị nwere ike ịme ihe tupu ụfọdụ ụbọchị njedebe. Ị nwere ikike ịnweta ozi na enyemaka a n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ndị otu kwesịrị ịkpọ akara ekwentị dị n'azụ nke kaadị njirimara ha. Ndị ọzọ niile nwere ike ịkpọ 855-258-6518 wee chere ụbụbọ ahụ ruo mgbe amanyere ịpị 0. Mgbe onye nnọchite anya zara, kwuo asụsụ ị chọrọ, a ga-ejikọ gị na onye ọkọwa okwu.

Deutsch (German) Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

Français (French) Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

한국어(Korean) 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아니신 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Diné Bizaad *(Navajo)* Ge': Díí bee ił hane'ígíí bii' dahólǫ bee éédahózin béeso ách'ą́ąh naanil ník'ist'i'ígíí bá. Bii' dahólǫ́ǫ doo íiyisíí yoolkáálígíí dóó t'áádoo le'é ádadoolyíįlígíí da yókeedgo t'áá doo bee e'e'aahí ájiil'įįh. Bee ná ahóót'i' díí bee ił hane' dóó nikáádoowoł t'áá nínizaad bee t'áá jiik'é. Atah danilínígíí béésh bee hane'é bee wółta'ígíí nitł'izgo bee nee hódolzinígíí bikéédęę' bikáá' bich'į' hodoonihjį'. Aadóó náánáła' éí kojį' dahódoolnih 855-258-6518 dóó yii diiłts'įįł yałtí'ígíí t'áá níléíjį ádóó éí bikéé'dóó naasbąąs bił adidiilchił. Ákáa'ánidaalwó'ígíí neidiitą́ągo, saad bee yáníłt'i'ígíí yii diikił dóó ata' halne'é lá níká'ádoolwoł.

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