ATTACHMENT A
DESCRIPTION OF COVERED SERVICES
BLUECHOICE PROGRAM OPTION

This Attachment A describes the medical services eligible for coverage under the BlueChoice Program Option. The coverage to which Members are entitled is subject to the limitations as stated in the Schedule of Benefits. For services covered by the BlueChoice Program Option, the Schedule of Benefits will state the payments the Program will make, the charges for which the Member will be responsible, and any specific limits on the number of services that will be covered.

	TABLE OF CONTENTS	PAGE
SECTION 1	GENERAL PROVISIONS	2
SECTION 2	OUTPATIENT AND OFFICE SERVICES	5
SECTION 3	INPATIENT HOSPITAL SERVICES	16
SECTION 4	SKILLED NURSING FACILITY SERVICES	19
SECTION 5	HOME HEALTH SERVICES	21
SECTION 6	HOSPICE CARE SERVICES	23
SECTION 7	MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	25
SECTION 8	EMERGENCY SERVICES AND URGENT CARE	27
SECTION 9	MEDICAL DEVICES AND SUPPLIES	30
SECTION 10	VISION CARE SERVICES	34
SECTION 11	REFERRALS	36
SECTION 12	EXCLUSIONS AND LIMITATIONS	40
SECTION 13	SCHEDULE OF BENEFITS	46

SECTION 1
GENERAL PROVISIONS

1.1 **Benefits Terms Defined**. In addition to the previously defined terms, this Attachment uses certain other defined terms. These are generally defined in the Section in which they first appear. The following general terms are also used:

Allowed Benefit means:

1. Contracted Health Care Provider: For a Health Care Provider that has contracted with CareFirst, the Allowed Benefit for a Covered Service is the lesser of the actual charge which, in some cases, will be a rate set by a regulatory agency; or the amount CareFirst allows for the service in effect on the date that the service is rendered. The benefit is payable to the Health Care Provider and is accepted as payment in full, except for any applicable Member payment amounts, as stated in the Schedule of Benefits.

2. a. Non-contracted health care practitioner: For a health care practitioner that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is determined in the same manner as the Allowed Benefit for a Health Care Provider that has contracted with CareFirst. The benefit is payable to the Subscriber or to the health care practitioner, at the discretion of CareFirst. If CareFirst pays the Subscriber, it is the Member's responsibility to pay the health care practitioner. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits, and for the difference between the Allowed Benefit and the health care practitioner's actual charge.

   b. Non-contracted hospital or health care facility: For a hospital or health care facility that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is based upon the lower of the provider's actual charge or the established fee schedule if one has been established for that type of eligible provider and service. If a fee schedule for the type of eligible provider and service has not been established, the Allowed Benefit will be based on facility reimbursement methodology. 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 Member payment amounts, as stated in the Schedule of Benefits. The benefit is payable to the Subscriber or to the hospital or health care facility, at the discretion of CareFirst. If CareFirst pays the Subscriber, it is the Member's responsibility to pay the hospital or health care facility. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits and, unless negotiated, for the difference between the Allowed Benefit and the hospital or health care facility's actual charge.

Ancillary Services means facility services that may be rendered on an inpatient and/or outpatient basis. These services include, but are not limited to, diagnostic and therapeutic services such as laboratory, radiology, operating room services, incremental nursing services, blood administration and handling, pharmaceutical services, Durable Medical Equipment and Medical Supplies. Ancillary Services do not include room and board services billed by a facility for inpatient care.

Benefit Period means the period of time during which Covered Services are eligible for payment. The Benefit Period for this Attachment A is on a contract year basis.

Contracting Physician means a licensed doctor who has entered into a contract with CareFirst BlueChoice to provide services to Members and who has been designated by CareFirst BlueChoice as a Contracting Physician.

Contracting Provider means any physician, health care professional or health care facility that has entered into a contract with CareFirst BlueChoice and has been designated by CareFirst BlueChoice to provide services to Members.

Convenience Item means any item that increases physical comfort or convenience without serving a Medically Necessary purpose, e.g. elevators, hoyer/stair lifts, ramps, shower/bath bench, items available without a prescription.

Cosmetic means the use of a service or supply which is provided with the primary intent of improving appearance, not restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention, as determined by CareFirst BlueChoice.

Covered Service means a Medically Necessary service or supply provided in accordance with the terms of this Attachment A.

Habilitative means the process of educating or training persons with a disadvantage or disability caused by a medical condition or injury to improve their ability to function in society, where such ability did not exist, or was severely limited, prior to the habilitative education or training.

Health Care Provider means a Hospital, health care facility, or health care practitioner licensed or otherwise authorized by law to provide Covered Services.

Over-the-Counter means any item or supply, as determined by CareFirst BlueChoice, that is available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions.

Primary Care Physician means a Contracting Physician or Contracting Provider selected by a Member to provide and manage the Member's health care.

Rehabilitation Services include Physical Therapy, Occupational Therapy, and Speech Therapy for the treatment of individuals who have sustained an illness or injury. The goal of Rehabilitative Services is to return the individual to his/her prior skill and functional level.

1.2 Selection of a Primary Care Physician.

A. A Member must select a Primary Care Physician and may select any Primary Care Physician from CareFirst BlueChoice's current list of Contracting Physicians. If the Primary Care Physician is not available, the CareFirst BlueChoice will assist the Member in making another selection.

If a Member has selected a Primary Care Physician and receives services from:

1. Another Primary Care Physician, (with or without a referral) the Member is charged the Primary Care Physician copayment;

2. A Provider that is not a Primary Care Physician, (with a referral) the Member is charged the specialist copayment.

If a Member has not selected a Primary Care Physician and receives services from a Contracting Provider who is a Primary Care Physician:

1. If there is room on their panel and will accept the Member, the Member will be assigned to this Primary Care Physician and charged the Primary Care Physician copayment;

2. If there is no room on their panel and/or will not accept the Member as a patient, there is no coverage .

Except for that noted in Section, 11.4, Conditions for a Referral to a Non-Contracting Specialist or Non-Contracting Nonphysician Specialist, if a Member receives services from:

1. A Contracting Provider that is not a Primary Care Physician, (without a referral) there is no coverage

2. Any Non-Contracting Provider,there is no coverage .

B. Members may change their Primary Care Physician at any time by notifying the Member Service Representative in writing. If the Member notifies CareFirst BlueChoice by the 20th day of the month, CareFirst BlueChoice will make the change effective the first day of the next month. If the Member notifies CareFirst BlueChoice after the 20th day of the month, CareFirst BlueChoice will make the change effective the first day of the second month following the notice.

C. CareFirst BlueChoice may require a Member to change to a different Primary Care Physician if:

1. The Member's Primary Care Physician is no longer available as a Primary Care Physician under the coverage provided by the Program; or

2. CareFirst BlueChoice determines that the furnishing of adequate medical care is jeopardized by a seriously impaired physician-patient relationship between the Member and Primary Care Physician, due to any of the following:

   a. The Member refuses to follow a treatment procedure recommended by the Primary Care Physician and the Primary Care Physician believes that no professionally acceptable alternative exists;

   b. The Member engages in threatening or abusive behavior toward the physician, the physician's staff, or other patients in the office; or

   c. The Member attempts to take unauthorized controlled substances from the Primary Care Physician's office, or to obtain these substances through fraud, misrepresentation, forgery, or by altering the physician's prescription order.

3. If a change in Primary Care Physicians is required under Section 1.2.A, CareFirst BlueChoice will notify the Member in advance. If a change is required under Section 1.2.C, the action is effective upon written notice to the Member. If a Member is required to change to another Primary Care Physician due to any of the circumstances described in Section 1.2.C, and there is a recurrence of the same or a similar situation with another Primary Care Physician, CareFirst BlueChoice may terminate the Member's coverage upon 31 days written notice.

SECTION 2
OUTPATIENT AND OFFICE SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
In Contracting Physicians' offices or in other Contracting Provider facilities when provided by or upon written referral from a PCP. Coverage for the services listed below.	The coverage is subject to the limitations, if any, stated in this Attachment or in the Schedule of Benefits.	Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

MOST CARE MUST BE PROVIDED BY, OR UPON WRITTEN REFERRAL OF THE MEMBER'S PCP.

2.1 **Covered Outpatient Medical Services**. Members are entitled to benefits for the Covered Services listed below when provided by Contracting Providers.

A. Office visits, medical care, urgent care, surgery and consultations, with a PCP and other Contracting Providers. This includes a history and baseline examination after enrollment.

B. Diagnostic Procedures.

C. Laboratory Tests and X-ray Services rendered by designated Contracting Providers, whether ordered by a Contracting Provider or a non-Contracting Provider.

D. Cancer Screening. Benefits are provided for cancer screening, including:

1. Prostate-specific antigen (PSA) tests and digital rectal exams are covered:

   a) For men who are between 40 and 75 years of age;

   b) When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment;

   c) When used for staging in determining the need for a bone scan for patients with prostate cancer; or,

   d) When used for male Members who are at high risk for prostate cancer.

2. Pap smears, at intervals appropriate to the Member's age and health status, as determined by CareFirst BlueChoice, including tests performed using FDA approved gynecological cytology screening technologies.

3. Breast cancer screening benefits provided accordance with the latest screening guidelines issued by the American Cancer Society.

4. Colorectal cancer screening. Benefits are available for colorectal cancer screening in accordance with the most current guidelines issued by the American Cancer Society.

E. Health Exams. Health exams and other services for the prevention and detection of disease, at intervals appropriate to age, sex and health status as determined by CareFirst BlueChoice. These services are not covered if required solely for:

1. Employment;

2. Insurance;

3. Travel;

4. School;

5. Camp admissions; or

6. Participation in sports activities.

F. Immunizations. Coverage is provided in accordance with accepted medical practice. Immunizations required solely for travel are not covered.

G. Allergy Testing and Treatment. Benefits include allergy testing and treatment, including administration of injections and allergy serum.

H. Obstetric and Gynecological Care. Except for infertility services, a female Member can self-refer to a Contracting Provider obstetrician-gynecologist. Benefits include health care services incidental to and rendered during an annual visit. The obstetrician-gynecologist may need to contact the Member's PCP to arrange referrals for additional services from another specialist. Consultation with the PCP may be by telephone or electronically.

A Member who is pregnant may self refer to a Contracting Provider obstetrician-gynecologist. Thereafter, the obstetrician-gynecologist may assume responsibility for the primary management of the Member's pregnancy, including the issuance of referrals in accordance with CareFirst BlueChoice's policies and procedures, through the postpartum period.

A female Member may receive Medically Necessary and routine obstetric and gynecological care from a Contracting Provider who is a certified nurse midwife or other health care practitioner authorized under state law to provide obstetric and gynecological services without a referral from her Primary Care Physician.

A certified nurse midwife or other health care practitioner shall consult with an obstetrician/gynecologist with whom the certified nurse midwife or other health care practitioner has a collaborative agreement, in accordance with the collaborative agreement, regarding any care rendered for the Member under this paragraph.

I. Well Child Preventive Care and pediatric services in accordance with the most recent guidelines of the American Academy of Pediatrics.

J. Eye Examinations. Eye examinations for the diagnosis and treatment of a medical condition.

K. Routine Hearing Screenings.

L. Rehabilitation Services. Coverage shall include Occupational Therapy, Physical Therapy and Speech Therapy as defined below subject to any limitations as stated in the Schedule of Benefits.

1. Definitions.

a. **Occupational Therapy (OT)** means the use of purposeful activity or interventions designed to achieve functional outcomes that promote health, prevent injury or disability, and that develop, improve, sustain or restore the highest possible level of independence of an individual who has an injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, developmental or learning disability, physical disability, loss of a body part, or other disorder or condition. Occupational Therapy services do not include the adjustment or manipulation of any of the osseous structures of the body or spine.

b. **Speech Therapy (ST)** means the treatment of communication impairment and swallowing disorders. Speech Therapy services facilitate the development and maintenance of human communication and swallowing through assessment, diagnosis, and rehabilitation, including cognitive rehabilitation.

c. **Physical Therapy (PT)** means the short-term treatment described below that can be expected to result in an improvement of a condition. Physical Therapy is the treatment of disease or injury through the use of therapeutic exercise and other interventions that focus on improving a person's ability to go through the functional activities of daily living, to develop and/or restore maximum potential function, and to reduce disability following an illness, injury, or loss of a body part. These may include improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and alleviating pain.

M. Radiation Therapy.

N. Chemotherapy.

O. Family Planning Services. Coverage includes but is not limited to:

1. Contraceptive counseling;

2. Depo-Provera, Norplant, intra-uterine devices and any Medically Necessary insertion, removal, or examination associated with the use of any contraceptive drug or device that is approved by the FDA for use as a contraceptive.

P. Renal Dialysis (Hemodialysis and Peritoneal dialysis for Chronic Kidney Conditions). Coverage will be provided for Medically Necessary services including equipment, training and Medical Supplies, required for home dialysis.

1. Benefits will not be provided for any furniture, plumbing, electrical or other fixtures, Convenience Items or for professional assistance needed to perform the dialysis treatment in the home.

2. If it is determined that a Member no longer meets the criteria for Medical Necessity, CareFirst BlueChoice's obligation is limited to paying for services up to the date that determination is communicated to the Member.

Q. Spinal Manipulation Services.

1. Spinal manipulation, limited to Medically Necessary spinal manipulation, evaluation and treatment for the musculoskeletal conditions of the spine when provided by a qualified chiropractor or doctor of osteopathy (D.O.). Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine.

2.2 Outpatient Surgical Care. Benefits are available for the following services in a Hospital or in an ambulatory surgical facility, in connection with a covered surgical procedure. Services provided to the Member as an outpatient in a Hospital must receive prior authorization from CareFirst BlueChoice.

A. Use of operating room and recovery room.

B. Use of special procedure rooms.

C. Anesthesia services and supplies.

D. Diagnostic procedures, laboratory tests and x-ray services.

E. Drugs, medications, solutions, biological preparations, and services associated with the administration of the same.

F. Medical and surgical supplies.

G. Blood, blood plasma and blood products, and related donor processing fees that are not replaced by or on behalf of the Member. Administrations of infusions are covered.

2.3 Coverage for Infertility Services.

Benefits are available for the diagnosis and treatment of infertility including Medically Necessary, non-Experimental/Investigational artificial insemination/intrauterine insemination and in-vitro fertilization. The oocytes (eggs) must be naturally produced by the Subscriber or spouse and fertilized with sperm naturally produced by the Subscriber or spouse. Prior authorization is required.

Subject to the Exclusions and Limitations, in-vitro fertilization benefits are available when each of the following are present:

A. The Member has had a fertility examination that resulted in a qualified physician's diagnosis of infertility including, but not limited to, any of the following medical conditions:

1. Endometriosis;

2. Exposure in utero to diethylstilbestrol, commonly known as DES;

3. Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy), or,

4. Abnormal male factors, including oligospermia, contributing to the infertility.

B. The Member has not been able to attain a successful pregnancy through a less costly infertility treatment for which coverage is available.

2.4 Organ and Tissue Transplants

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 BlueChoice.

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 BlueChoice.

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. Benefits are limited to $150 per day up to $10,000 maximum.

4. There is no limit on the number of re-transplants that are covered.

5. If the Member is a 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 evaluating and preparing the actual donor, regardless of whether the transplant is attempted or completed, and recovery services after the donor procedure which are directly related to donating the organ or tissue.

6. Immunosuppressant maintenance drugs are covered when prescribed for a covered transplant.

2.5 High Dose Chemotherapy/ Bone Marrow or Stem Cell Transplant. Benefits will be provided for high dose chemotherapy bone marrow or stem cell transplant treatment that is not Experimental or Investigational as determined by CareFirst BlueChoice.

2.6 Clinical Trials. Benefits for Patient Cost to a Member in a Clinical Trial will be provided in accordance with the terms below. Prior authorization from CareFirst BlueChoice is required for all services.

A. Definitions.

Cooperative Group is 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:

1. The National Cancer Institute Clinical Cooperative Group;

2. The National Cancer Institute Community Clinical Oncology Program;

3. The Aids Clinical Trials Group; and,

4. 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 federal 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 is the National Institutes of Health.

Patient Cost means the cost of a Medically Necessary service that is incurred as a result of the treatment being provided under the Clinical Trial. Patient Cost does not include:

1. The cost of an Experimental-Investigational drug or device;

2. The cost of non-health care services that a Member may be required to receive under the Clinical Trial;

3. Costs associated with managing the research associated with the Clinical Trial; or

4. Costs that would not be covered under the Contract for non-Investigational treatments.

B. Patient Cost related to a Clinical Trial will be covered if the Member's participation in the Clinical Trial is the result of:

1. Treatment studies provided for a life-threatening condition; or

2. Prevention, early detection, and treatment studies on cancer.

C. Coverage for Patient Cost for treatment being provided will be evaluated on a case-by-case basis. Coverage for Patient Cost will be provided only if:

1. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV Clinical Trial for treatment, prevention and early detection of cancer; or

2. The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV Clinical Trial for treatment, prevention and early detection of any other life threatening condition;

3. The treatment is being provided in a Clinical Trial approved by:

   a. One of the National Institutes of Health, such as the National Cancer Institute (NCI); or

   b. An NIH Cooperative Group or an NIH Center; or

   c. The FDA in the form of an Experimental-Investigational new drug application; or

   d. The federal Department of Veterans Affairs; or,

   e. 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;

4. The facility and personnel providing the treatment are capable of doing so by virtue of their:

   a. Experience;

   b. Training; and,

   c. Volume of patients treated to maintain expertise;

5. There is no clearly superior, non-Investigational treatment alternative; and,

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

D. Coverage is provided for 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.

2.7 Maternity Benefits.

A. Maternity Services. Benefits are provided for all female Members including:

1. Obstetrical care, prenatal, delivery, postnatal care;

2. Coverage for a Hospital stay;

3. Coverage for care rendered by a CareFirst BlueChoice approved licensed birthing center;

4. Collection of adequate samples for hereditary and metabolic newborn screening and follow-up; and,

5. Newborn hearing screening prior to discharge.

B. Postpartum Home Visits. Home visits following delivery are covered in accordance with the most current standards published by the American College of Obstetricians and Gynecologists.

1. For a mother and newborn child who have a shorter Hospital stay than that provided under Section 3.2.D, Number of Inpatient Hospital Days Covered, benefits will be provided for:

   a. one home visit scheduled to occur within 24 hours after Hospital discharge; and

   b. an additional home visit if prescribed by the attending provider

2. For a mother and newborn child who remain in the Hospital for at least the length of time provided under Section 3.2.D, Number of Hospital Days Covered, benefits will be provided for a home visit if prescribed by the attending provider

C. Birthing Classes. Birthing classes are covered, one course, per pregnancy at a CareFirst BlueChoice approved facility.

2.8 Morbid Obesity.

A. Benefits are available for the surgical treatment of Morbid Obesity. The procedures must be recognized by the National Institutes of Health as effective for the long-term reversal of Morbid Obesity and are consistent with guidelines approved by the National Institutes of Health.

B. Morbid Obesity means a body mass index that is:

1. Greater than 40 kilograms per meter squared; or

2. Equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

C. As used above, body mass index (BMI) means a practical marker used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

2.9 Diabetic Supplies and Services.

A. Coverage will be provided for Medically Necessary diabetes equipment; diabetes supplies; and diabetes outpatient self-management training and educational services, including medical nutritional counseling at a CareFirst approved facility.

B. The services must be Medically Necessary as determined by CareFirst for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.

C. In-person, outpatient self-management training and educational services, including medical nutritional therapy, shall be provided through an in-person program provided by an appropriately licensed, registered, or certified CareFirst -approved facility or Health Care Provider whose scope of practice includes diabetes education or management.

2.10 Dental Services.

A. Accidental Injury. Benefits include Medically Necessary, as determined by CareFirst BlueChoice, dental services needed as a result of an accidental bodily injury (except for accidents caused by chewing) when the Member requests treatment within 60 days of the accident.

B. General Anesthesia for Dental Care. Benefits for Medically Necessary general anesthesia in conjunction with dental care and associated Hospital or ambulatory facility charges will be provided to a Member when determined by a licensed dentist in consultation with the Member's treating physician to effectively and safely provide dental care:

1. If the Member is:

a. Seven years of age or younger;

b. Developmentally or otherwise severely disabled; and

c. For whom a successful result cannot be expected under local anesthesia because of the physical, intellectual or other medically compromising condition of the Member.

2. Or, if the Member is:

   a. Seventeen years of age or younger;

   b. An extremely uncooperative, fearful, or uncommunicative individual;

   c. An individual with dental needs of such magnitude that treatment should not be delayed or deferred; and

   d. An individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

3. A determination of medical necessity shall include but not be limited to a consideration of whether the age, physical condition or mental condition requires general anesthesia and the admission to a Hospital or outpatient surgery facility in order to safely provide the dental care.

4. Benefits for general anesthesia and associated Hospital or ambulatory facility charges are restricted to dental care that is provided by:

   a. A fully accredited specialist in pediatric dentistry;

   b. A fully accredited specialist in oral and maxillofacial surgery; and

   c. A dentist to whom Hospital privileges have been granted.

5. Benefits for the general anesthesia and associated Hospital or ambulatory facility charges require prior authorization by CareFirst BlueChoice. The Member or provider of service must contact CareFirst BlueChoice prior to the date that services are rendered to obtain approval.

6. Benefits are not provided for general anesthesia and associated Hospital or ambulatory facility charges for dental care rendered for temporomandibular joint disorders.

7. Benefits for the underlying dental care are not covered.

2.11 Oral Surgery. Benefits include:

A. Medically Necessary procedures, as determined by CareFirst BlueChoice, to attain functional capacity, correct a congenital anomaly, reduce a dislocation, repair a fracture, excise tumors, cysts or exostoses, or drain abscesses with cellulitis and are performed on sound natural teeth and supporting structures, lips, tongue, roof and floor of the mouth, accessory sinuses, salivary glands or ducts, and jaws.

B. Medically Necessary procedures, as determined by CareFirst BlueChoice, needed as a result of an accidental injury, when the Member requests oral surgical services or the need for oral surgical services is identified in the patient's medical records within 60 days of the accident. Benefits for such oral surgical services shall be provided up to three (3) years from the date of injury.

C. Surgical treatment for temporomandibular joint syndrome (TMJ) if there is clearly demonstrable radiographic evidence of joint abnormality due to an illness.

D. All other procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae for Cosmetic purposes or for correction of the malocclusion are excluded.

E. Services as a result of accidental injury and trauma. In the event there are alternative procedures that meet generally accepted standards of professional care for a Member's condition, benefits will be based upon the lowest cost alternative.

2.12 Reconstructive Breast Surgery. Benefits will be provided for reconstructive breast surgery resulting from a Mastectomy performed as a result of breast cancer. Mastectomy means the surgical removal of all or part of a breast as a result of breast cancer.

A. Reconstructive Breast Surgery includes:

1. Augmentation mammoplasty;

2. Reduction mammoplasty; and

3. Mastopexy.

B. Benefits are provided for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery on the diseased breast is performed.

C. Benefits are provided regardless of whether the Mastectomy was performed while the Member was covered under the Contract.

D. Coverage will be provided for prostheses for a Member who has undergone a Mastectomy as well as services resulting from physical complications at all stages of Mastectomy including lymphedema.

2.13 Reconstructive Surgery. Benefits for reconstructive surgery are limited to surgical procedures that are Medically Necessary, as determined by CareFirst BlueChoice and operative procedures performed on structures of the body to improve or restore bodily function or to correct a deformity resulting from disease, trauma or previous therapeutic intervention.

2.14 Habilitative Services. Occupational Therapy, Physical Therapy and Speech Therapy for the treatment of a Dependent child under the age of 19 years with a congenital or genetic birth defect that enhance the Dependent child's ability to function. This includes a defect existing at or from birth, including a hereditary defect. Congenital or genetic birth defects include, but are not limited to: autism or an autism spectrum disorder and cerebral palsy.

Benefits are not available for Habilitative Services delivered through early intervention and school services. Prior authorization is required.

2.15 Chlamydia Screening.

A. Definitions

Chlamydia Screening Test means any laboratory test that specifically detects for infection by one or more agents of *Chlamydia trachomatis* and is approved for this purpose by the FDA.

Multiple Risk Factors means having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives, or cervical ectopy.

B. Covered Services

1. An annual routine Chlamydia Screening Test for:

a. Female Members who are under the age of 20 years if they are sexually active; and at least 20 years old if they have Multiple Risk Factors.

b. Male Members who have Multiple Risk Factors.

2.16 Osteoporosis Prevention and Treatment Services.

A. Benefits are available for Bone Mass Measurement for the prevention, diagnosis, and treatment of Osteoporosis when the Bone Mass Measurement is requested by a Health Care Provider for the Qualified Individual.

B. Bone Mass Measurement means a radiologic or radioisotopic procedure or other scientifically proven technology performed on a Qualified Individual for the purpose of identifying bone mass or detecting bone loss.

C. Qualified Individual means:

1. An estrogen deficient individual at clinical risk for osteoporosis;

2. An individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;

3. An individual receiving long-term glucocorticoid steroid therapy;

4. An individual with primary hyperparathyroidism; or

5. An individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

2.17 Treatment for Cleft Lip or Cleft Palate or Both. Benefits will be provided for inpatient or outpatient expenses arising from orthodontics, oral surgery, otologic, audiological and speech/language for cleft lip or cleft palate or both.

2.18 Cardiac Rehabilitation. Cardiac Rehabilitation benefits are provided to Members who have been diagnosed with significant cardiac disease, as defined by CareFirst BlueChoice, or, who have suffered a myocardial infarction or have undergone invasive cardiac treatment immediately preceding referral for Cardiac Rehabilitation, as defined by CareFirst BlueChoice. Coverage is provided for all Medically Necessary services, as determined by CareFirst BlueChoice. Services must be provided at a CareFirst BlueChoice approved place of service equipped and approved to provide Cardiac Rehabilitation.

1. Benefits will not be provided for maintenance programs.

2. Covered Cardiac Rehabilitation services are not subject to referral or utilization management requirements, if treatment is received from a Contracting Provider.

SECTION 3
INPATIENT HOSPITAL SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
In a Contracting Provider Hospital when admitted under the care of a PCP or by another Contracting Physician if referred by a PCP.	Coverage for the services listed below. The coverage is subject to the limitations, if any, stated in the Schedule of Benefits.	Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

HOSPITAL ADMISSIONS MUST BE AUTHORIZED OR APPROVED BY CAREFIRST BLUECHOICE

3.1 **Covered Inpatient Hospital Services**. A Member will receive benefits for services listed below when admitted to a Contracting Provider Hospital under the care of a PCP or other Contracting Physician to whom the Member was referred. Coverage of inpatient Hospital services is subject to certification by Utilization Management for Medical Necessity. Benefits are provided for:

A. Room and Board. Room and board in a semiprivate room (or in a private room when Medically Necessary as determined by CareFirst BlueChoice).

B. Physician and Medical Services. Inpatient physician and medical services provided by or under the direction of the attending Contracting Physician, including:

1. Inpatient Contracting Physician visits;
2. Consultations by Contracting Physician Specialists;
3. Intensive care services;
4. Rehabilitation Services;
5. Respiratory therapy, radiation therapy and chemotherapy services;
6. Anesthesia services and supplies;
7. Diagnostic procedures, laboratory tests and x-ray services;
8. Medically Necessary Ancillary Services rendered to the Member.

C. Services and Supplies. Related inpatient services and supplies that are not Experimental or Investigational, as determined by CareFirst BlueChoice, and ordinarily furnished by the Hospital to its patients, including:

1. The use of:

a. Operating rooms;

b. Treatment rooms; and

c. Special equipment in the Hospital.

2. Drugs, medications, solutions, biological preparations, and services associated with the administration of the same.

3. Medical and surgical supplies.

4. Blood, blood plasma and blood products, and related donor processing fees that are not replaced by or on behalf of the Member. Administrations of infusions are covered.

5. Surgically implanted Prosthetic devices that replace an internal part of the body. This includes hip joints, skull plates, cochlear implants and pacemakers. Available benefits under this provision do not include items such as artificial limbs or eyes, Hearing Aids, or other external prosthetics, which may be provided under other provisions of the contract. See Section 9, Medical Devices and Supplies and Section 2.12, Reconstructive Breast Surgery.

6. Medical social services.

3.2 Number of Hospital Days Covered. Provided the conditions, including the requirements in Section 3.3 below are met and continue to be met, as determined by CareFirst BlueChoice, benefits for Inpatient Hospital Services will be provided as follows:

A. Hospitalization for Rehabilitation. Benefits are provided for an admission or transfer to CareFirst BlueChoice approved facility for rehabilitation. Benefits provided during any confinement will not exceed the benefit limitation, if any, stated in the Schedule of Benefits. As used in this paragraph, a confinement means a continuous period of hospitalization or two or more admissions separated by 30 days. This limit on hospitalization applies to any portion of an admission that:

1. Is required primarily for Physical Therapy or other rehabilitative care; and

2. Would not be Medically Necessary based solely on the Member's need for inpatient acute care services other than for rehabilitation.

B. Inpatient Coverage Following a Mastectomy. Coverage will be provided for a minimum Hospital stay of not less than:

1. Forty-eight (48) hours following a radical or modified radical Mastectomy; and

2. Twenty-four (24) hours following a partial Mastectomy with lymph node dissection for the treatment of breast cancer.

C. Hysterectomies. Coverage will be provided for vaginal hysterectomies and abdominal hysterectomies. Coverage includes a minimum stay in the Hospital of:

1. Not less than twenty-three (23) hours for a laparoscopy-assisted vaginal hysterectomy; and

2. Not less than forty-eight (48) hours for a vaginal hysterectomy.

In consultation with the Contracting Provider, the Member may elect to stay less than the minimum prescribed above when appropriate.

D. Childbirth. Coverage will be provided for a minimum Hospital stay of not less than:

1. Forty-eight (48) hours for both the mother and newborn following a routine vaginal delivery;

2. Ninety-six (96) hours for both the mother and newborn following a routine cesarean section.

Prior authorization is not required for the minimum Hospital stays listed above.

Whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the Hospital, coverage includes additional hospitalization for the newborn for up to four (4) days.

If the delivery occurs in the Hospital the length of stay begins at the time of the delivery. If the delivery occurs outside of the Hospital the length of stay begins upon admission to the Hospital. The Member and provider may agree to an early discharge.

E. Other Hospitalization. Hospitalization for Covered Services other than those described above, will also be provided subject to the provisions of Section 3.3, below.

3.3 Inpatient Hospital Pre-Admission Review. Coverage of inpatient Hospital services is subject to the requirements for pre-admission review, concurrent review and discharge planning for all covered hospitalizations. Such review and approval shall determine:

A. The need for hospitalization;

B. The appropriateness of the approved Hospital or facility requested;

C. The approved length of confinement in accordance with CareFirst BlueChoice-established criteria; and

D. Additional aspects such as second surgical opinion and/or pre-admission testing requirements;

E. Failure or refusal to comply with notice requirements and other CareFirst BlueChoice authorization and approval procedures may result in reduction of the Member's benefits or exclusion of services from coverage.

Payment for Ancillary Services may not be denied solely based on the fact that the denial of the hospitalization day was appropriate. Instead a denial of inpatient Ancillary Services must be based on the Medical Necessity of the specific Ancillary Service. In determining the Medical Necessity of an Ancillary Service performed on a denied hospitalization day, consideration must be given to the necessity of providing the Ancillary Service in the acute setting for each day in question.

SECTION 4
SKILLED NURSING FACILITY SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
In a Contracting Provider Skilled Nursing Facility when admitted under the care of a PCP or by another Contracting Physician when referred by a PCP.	Coverage for the services listed below. The coverage is subject to the limitations, if any, stated in the Schedule of Benefits.	Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

SKILLED NURSING FACILITY SERVICES MUST BE AUTHORIZED OR APPROVED BY CAREFIRST BLUECHOICE

4.1 **Covered Skilled Nursing Facility Services**. When the Member meets the conditions for coverage listed below in Section 4.2, the services listed below are available to Members in a Skilled Nursing Facility:

A. Room and board in a semiprivate room;

B. Inpatient physician and medical services provided by or under the direction of the attending Contracting Physician.

C. Services and supplies that are not Experimental or Investigational as determined by CareFirst BlueChoice and ordinarily furnished by the facility to inpatients for diagnosis or treatment, including:

1. Use of special equipment in the facility;

2. Drugs, medications, solutions, biological preparations, and Medical Supplies used while the Member is an inpatient in the facility.

4.2 **Conditions for Coverage**. Skilled Nursing Facility care must be authorized or approved by CareFirst BlueChoice as meeting the following conditions for coverage:

A. **Skilled Nursing Facility** means a licensed institution (or a distinct part of a Hospital) that provides continuous Skilled Nursing Care and related services for Members who require medical care, Skilled Nursing Care or Rehabilitation Services.

B. The Member must be under the care of his or her PCP or other physician to whom the Member was referred.

C. The admission to the Skilled Nursing Facility must be a substitute for a Hospital admission. Skilled Nursing Facility benefits will not be provided in a facility that is used primarily as a rest home or a home for the aged, or in a facility for the care of drug addiction or alcoholism.

D. The Member requires Skilled Nursing Care or skilled rehabilitation services that are required on a daily basis and can only be provided on an inpatient basis. Skilled Nursing Care means non-Custodial Care that requires medical training as a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for performance.

4.3 **Custodial Care Is Not Provided**. Benefits will not be provided for any day in a Skilled Nursing Facility that CareFirst BlueChoice determines is primarily for Custodial Care.

A. Custodial Care means care that is:

1. Not directed to the cure of an illness or recovery from an accident; and
2. Mainly for meeting the activities of daily living, e.g. bathing, eating; and
3. Not routinely provided by a trained medical professional; and
4. May be provided by person without professional medical skills or professional medical training.

B. Services may be deemed Custodial Care even if:

1. A Member cannot self-administer the care;
2. No one in the Member's household can perform the services;
3. Ordered by a physician;
4. Necessary to maintain the Member's present condition; or
5. Covered by Medicare.

4.4 **Number of Days of Care**. Benefits will be provided up to the maximum day limit, if any stated in the Schedule of Benefits.

SECTION 5
HOME HEALTH SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
In a Member's home by a Contracting Provider Home Health Agency when authorized or approved by CareFirst BlueChoice.	Coverage for the services listed below. The coverage is subject to the limitations, if any, stated in the Schedule of Benefits.	Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

HOME HEALTH SERVICES MUST BE AUTHORIZED OR APPROVED BY CAREFIRST BLUECHOICE

5.1 **Covered Home Health Services**. Services must be provided within the Service Area when requested by a PCP or other physician when duly referred. Benefits are provided for:

A. Part-time or intermittent home nursing care by or under the supervision of a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.);

B. Rehabilitation Services;

C. Part-time or intermittent home health aid services;

D. Drugs and medications directly administered to the patient during a covered home health visit and incidental Medical Supplies directly expended in the course of a covered home health visit. Drugs, medications and medical supplies for home use (other than as described above) and purchase or rental of durable medical equipment are not covered under this Section. (See Section 9, Medical Devices and Supplies. Benefits for self-administered prescription drugs may be available through an Attachment to the Contract.);

E. Diagnostic Tests and Laboratory Services ordered by the PCP or other physician to whom the Member was referred;

F. Services of a medical social worker.

5.2 **Conditions for Coverage**. Benefits are provided when a Member:

A. Is under the care of the PCP or other physician to whom the Member was referred;

B. Resides within the Service Area;

C. Is confined to home due to a medical condition;

D. Would otherwise be eligible for a Hospital, or Skilled Nursing Facility admission;

E. Requires Skilled Nursing Care or Rehabilitation Services in order to qualify for home health aide services or other types of home health care. Skilled Nursing Care means non-Custodial Care that requires medical training as a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for performance.

F. The Medical Necessity of home health services must be certified by CareFirst BlueChoice as meeting the criteria for coverage;

G. The need for home health services must not be custodial in nature.

H. Services of a home health aide, medical social worker or registered dietician may also be provided but must be under the supervision of a licensed professional (RN or LPN) nurse.

5.3 Number of Home Health Visits.

A. Home Health Visits Following Mastectomy or Surgical Removal of a Testicle. For a Member who receives less than 48 hours of inpatient hospitalization following a Mastectomy or the surgical removal of a testicle, or who undergoes a Mastectomy or the surgical removal of a testicle on an outpatient basis, benefits will be provided for::

1. One home visit scheduled to occur within twenty-four (24) hours after discharge from the Hospital or outpatient health care facility; and

2. An additional home visit if prescribed by the Member's attending physician.

B. All other Home Health Visits will be provided up to the maximum visit limit, if any, stated in the Schedule of Benefits.

SECTION 6
HOSPICE CARE SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
As an inpatient or outpatient of a Qualified Hospice Care Program, when authorized or approved by CareFirst BlueChoice.	Coverage for the services listed below. The coverage is subject to the limitations, if any, listed below or stated in the Schedule of Benefits.	Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

HOSPICE CARE SERVICES MUST BE AUTHORIZED OR APPROVED BY CAREFIRST BLUECHOICE

6.1 **Covered Hospice Care Services**. Services are covered when provided by a Qualified Hospice Care Program. CareFirst BlueChoice will monitor the care for ongoing appropriateness. Benefits are provided for inpatient and outpatient care and include the following:

A. Intermittent nursing care by or under the direction of a registered nurse;

B. Medical social services for the terminally ill patient and his or her Immediate Family. Immediate Family means the patient's spouse, parents, siblings, grandparents, and children;

C. Counseling, including dietary counseling, for the terminally ill Member;

D. Non-Custodial home health visits;

E. Services, visits, medical/surgical equipment or supplies; including equipment and medication required to maintain the comfort and manage the pain of the terminally ill Member;

F. Laboratory Tests and X-Ray Services;

G. Ambulance services, when Medically Necessary as determined by CareFirst BlueChoice;

H. “Respite Care” means temporary care provided to the terminally ill Member to relieve the Family Caregiver from the daily care of the Member;

I. Home visits within the Service Area;

J. Family Counseling will be provided for the Immediate Family and Family Caregiver before the death of the terminally ill Member when authorized or approved by CareFirst BlueChoice. Family Counseling means counseling given to the Immediate Family or Family Caregiver of the terminally ill Member for the purpose of learning to care for the Member and to adjust to the death of the Member. Family Caregiver means a relative by blood, marriage, or adoption who lives with or is the primary caregiver of the terminally ill Member;

K. Bereavement Services will be provided for the Immediate Family or Family Caregiver of the Member. Bereavement Counseling means counseling provided to the Immediate Family or Family Caregiver of the Member after the Member's death to help the Immediate Family or Family Caregiver cope with the Member's death;

6.2 Conditions for Coverage. Hospice Care Services must meet the following conditions:

A. The Member must have a life expectancy of six (6) months or less;

B. The Member's attending PCP or other referring physician must submit a written Hospice Care Services plan of treatment to CareFirst BlueChoice;

C. The Member must meet the criteria of the Qualified Hospice Care Program. A Qualified Hospice Care Program means a coordinated, interdisciplinary program of hospice care services for meeting the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement to:

1. Individuals who have no reasonable prospect of cure as estimated by a physician; and

2. The immediate families or family caregivers of those individuals.

D. The Medical Necessity and continued appropriateness of Hospice Care Services must be authorized or approved by CareFirst BlueChoice as meeting the criteria for coverage.

6.3 Hospice Eligibility Period. Is the period of time that begins on the first date hospice services are rendered and will terminate one hundred eighty (180) days later or on the death of the terminally ill Member, whichever first occurs. Any extension of the Hospice Eligibility Period must be authorized or approved by CareFirst BlueChoice. If CareFirst BlueChoice determines, based on grounds of Medical Necessity, that the benefit eligibility period should be extended, eligibility will be continued for up to thirty (30) additional days of outpatient services or fourteen (14) additional days of inpatient care.

SECTION 7
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
In Contracting Physician's offices or other CareFirst BlueChoice approved facilities, or	Coverage for the services listed below.	Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.
In a CareFirst BlueChoice approved Hospital or Qualified Substance Abuse Treatment Facility when admitted under the care of a Contracting Physician.	Coverage for the services listed below.	Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

HOSPITALIZATION MUST BE AUTHORIZED OR APPROVED BY THE MENTAL HEALTH AND SUBSTANCE ABUSE MANAGEMENT PROGRAM

7.1 Definitions.

A. The **Mental Health Management and Substance Abuse Program** refers to utilization management, benefits administration and provider network activities administered by or on behalf of CareFirst BlueChoice to ensure that mental health and substance abuse services are Medically Necessary and provided in a cost-effective manner.

B. **Qualified Substance Abuse Treatment Facility** means a non-residential facility or distinct part of a facility which is licensed in the jurisdiction(s) in which it operates and/or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a substance abuse and alcohol treatment facility that operates a program for the treatment and rehabilitation of alcohol and substance abuse.

C. **Partial Hospitalization** means the provision of medically directed intensive or intermediate short-term treatment for mental illness, emotional disorders, drug abuse or alcohol abuse for a period of less than 24 hours but more than 4 hours in a day for a Member or Subscriber in a licensed or certified facility or program.

D. **Substance Abuse** means a disease that is characterized by a pattern of pathological use of alcohol and or a drug and repeated attempts to control its use, and which has caused significant harmful effects in at least one of the following aspects of the Member's daily life: medical, legal, financial or psycho-social.

7.2 Outpatient Mental Health and Substance Abuse Services. Outpatient services must be obtained from Contracting Providers.

A. Coverage of mental illness, emotional disorders, and alcohol abuse and drug abuse services includes evaluation, diagnosis and treatment of acute and non-acute conditions.

B. Medication management visits in connection with mental illness, emotional disorders, alcohol abuse or drug abuse will be covered in the same manner as medication management visits for physical illnesses.

C. Coverage of substance abuse and related mental health conditions include detoxification and rehabilitative services in a CareFirst BlueChoice designated program.

D. Other covered medical and medical Ancillary Services will be covered for conditions related to mental illness, emotional disorders, alcohol abuse and drug abuse on the same basis as other covered medical conditions.

E. Coverage for psychological and neuropsychological testing is provided for outpatient services to treat mental illnesses, emotional disorders, drug abuse, or alcohol abuse including psychological and neuropsychological testing for psychological diagnostic purposes. Services include evaluation, diagnosis and treatment of acute and non-acute conditions.

7.3 Inpatient Mental Health and Substance Abuse Services. Covered Services include the following:

A. Services for care and treatment of mental illness, emotional disorders, alcohol abuse or drug abuse, which, in the judgment of CareFirst BlueChoice, are Medically Necessary and treatable through inpatient hospitalization. Inpatient care is not covered if, in CareFirst BlueChoice's judgment, the condition and/or the treatment to be provided does not meet the criteria established by CareFirst BlueChoice for admission to a Hospital. Hospitalization in a specialized facility that is not a CareFirst BlueChoice approved facility is not covered;

B. Diagnosis and treatment for the abuse of or addiction to alcohol and drugs, including inpatient detoxification and rehabilitative services in an acute care Hospital or Qualified Substance Abuse Treatment Facility. A Member must meet the applicable criteria for acceptance into, and continued participation in, treatment facilities/programs, as determined by CareFirst BlueChoice;

C. Visits to the patient in the Hospital or facility by Contracting Physicians and Contracting Providers.

D. Other covered medical and medical Ancillary Services will be covered for conditions related to mental illness, emotional disorders, alcohol abuse and drug abuse on the same basis as other covered medical conditions.

7.4 Residential Crisis Services

A. Residential Crisis Services are intensive mental health and support services that are:

1. Provided to a Dependent child or an adult Member with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the ability of the Member to function in the community; and

2. Designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, shorten the length of inpatient stay, or reduce the pressure on general hospital emergency departments; and

3. Provided by entities that are licensed by the State of Maryland Department of Health and Mental Hygiene or the applicable licensing laws of any State or the District of Columbia to provide Residential Crisis Services; or

4. Located in subacute beds in an inpatient psychiatric facility, for an adult Member.

SECTION 8
EMERGENCY SERVICES AND URGENT CARE

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
At Contracting Provider Urgent Care Facilities and at Hospital emergency rooms and Urgent Care Facilities in or out of the Service Area.	Coverage for the services listed below. The coverage is subject to the limitations, if any, stated in the Schedule of Benefits.	Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

8.1 Definitions.

A. **Urgent Care** means treatment for a condition that is not a threat to life or limb but does require prompt medical attention. Also, the severity of an urgent condition does not necessitate a trip to the Hospital emergency room. An Urgent Care facility is a free-standing facility that is not a physician's office and which provides Urgent Care.

B. **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:

1. Serious jeopardy to the mental or physical health of the individual; or

2. Danger of serious impairment of the individual's bodily functions; or

3. Serious dysfunction of any of the individual's bodily organs; or

4. 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 BlueChoice determines.

8.2 Emergency Services and Urgent Care.

A. Benefits are available to a Member for Emergency Services and Urgent Care twenty-four (24) hours per day. Benefits for Emergency Services, Urgent Care and follow-up care after emergency surgery are provided regardless of whether the services are rendered inside or outside of the Service Area.

If a Member requires care while traveling or temporarily residing outside the Service Area, the Member must follow the emergency procedures established by CareFirst BlueChoice. In the case of travel or temporary residence outside the Service Area, benefits will be paid or provided for expenses incurred for treatment of an illness or injury only if:

1. The need for care could not reasonably have been foreseen before departing the Service Area or sufficiently in advance so as to permit the Member to return to the Service Area for the care before it became urgent;

2. The care was urgently required to alleviate acute pain or prevent further significant deterioration of the Member's condition;

3. The Member could not, without medically harmful results, return to the Service Area to receive treatment;

4. CareFirst BlueChoice determines that the travel was for some purpose other than the receipt of medical treatment; and,

5. CareFirst BlueChoice determines that the services were Medically Necessary.

B. In the case of a Hospital that has an emergency department, benefits include:

1. Appropriate medical screening;

2. Assessment and stabilization services; and

3. Ancillary Services routinely available to the emergency department, to determine whether or not an Emergency condition exists.

C. A provider is not required to obtain prior authorization or approval from CareFirst BlueChoice in order to obtain reimbursement for Emergency Services, Urgent Care or follow-up care after emergency surgery.

D. A Hospital, or other provider, or CareFirst BlueChoice, when CareFirst BlueChoice has reimbursed the provider, may attempt to collect payment from a Member for health care services that do not meet the criteria for Emergency Services.

E. Except as provided below, benefits are not provided for routine follow-up treatment within the Service Area provided by non- Contracting Providers. Follow-up treatment outside of the Service Area is covered if required in connection with a covered out-of-area Emergency or Urgent Care and CareFirst BlueChoice determines that the Member could not reasonably be expected to return to the Service Area for such care.

8.3 Notice to CareFirst BlueChoice in the event of an Emergency.

A. If the Member is admitted to a Hospital as a result of an Emergency, CareFirst BlueChoice must be notified the earlier of:

1. The end of the first business day after first receiving the care; or

2. Within 48 hours after first receiving the care.

B. If it was not reasonably possible to give notice, this requirement will be met if notice was given as soon as reasonably possible. The Member must provide information about the Emergency and the care received. If the Member does not return to the Service Area and transfer care to a Contracting Physician or Contracting Provider as soon as, in the judgment of CareFirst BlueChoice, the Member was able to do so without medically harmful results, no further benefits will be provided for services received on or after such date.

8.4 Ambulance Services.

A. Benefits are available for Medically Necessary air transportation and ground ambulance services as authorized and approved by CareFirst BlueChoice.

B. If a Member is outside of the United States and requires treatment for Emergency Services, benefits are provided for Medically Necessary air and ground transportation to the nearest facility where appropriate medical care is available.

8.5 **Follow-up Care after Emergency Surgery**. If CareFirst BlueChoice authorizes, directs, refers, or otherwise allows a Member to access a Hospital emergency facility or other urgent care facility for a medical condition that meets the criteria for Medical Emergency, as defined in the Contract, and requires emergency surgery:

A. Coverage shall be provided for services provided by the physician, surgeon, oral surgeon, periodontist, or podiatrist who performed the surgical procedure, for follow-up care that is Medically Necessary, directly related to the condition for which the surgical procedure was performed and provided in consultation with the Member's PCP; and

B. The Member will be responsible for the same copayment for each follow-up visit as would be required for a visit to a Contracting Physician for specialty care.

SECTION 9
MEDICAL DEVICES AND SUPPLIES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
Medical Devices and Supplies obtained through designated Contracting Providers when authorized or approved by CareFirst BlueChoice.	Coverage for the services listed below. The coverage is subject to the limitations, if any, stated in the Schedule of Benefits.	Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

9.1 Covered Benefits. Benefits will be provided for Medical Devices and Supplies when:

A. Obtained from a designated Contracting Provider; and

B. The Member has coverage under the Contract at the time that the Durable Medical Equipment, Prosthetic, Orthotic Device, or Medical Supply is prescribed and received. The Member must continue to be eligible for coverage for the duration of time for which Durable Medical Equipment is rented.

9.2 Authorization or Approval of Medical Devices and Supplies by CareFirst BlueChoice. Benefits are limited to the least expensive Medically Necessary Durable Medical Equipment, Medical Supply, Orthotic Device or Prosthetic adequate to meet the patient's medical needs.

To qualify for coverage for Medical Devices, the Member or the provider must contact CareFirst BlueChoice prior to the purchase or rental of any Medical Device to obtain prior authorization-of such purchase or rental. CareFirst BlueChoice will determine the Medical Necessity for the covered Medical Device and the appropriateness of the type of appliance, device, equipment or supply requested. CareFirst BlueChoice will then recommend the Contracting Provider from whom the Member is authorized to obtain the Medical Device in order to receive benefits. Failure to contact CareFirst BlueChoice in advance of the purchase or rental and/or failure and refusal to comply with the authorization given by CareFirst BlueChoice will result in exclusion of the Medical Device from coverage.

9.3 Responsibility of CareFirst BlueChoice. CareFirst BlueChoice will not be liable for any claim, injury, demand or judgment based on tort or other grounds (including express or implied warranty of equipment) arising out of or in connection with the rental, sale, use, maintenance or repair of a Medical Device.

9.4 Definitions.

A. **Durable Medical Equipment** means equipment that:

1. Is primarily and customarily used to serve a medical purpose;
2. Is not useful to a person in the absence of illness or injury;
3. Is ordered or prescribed by a physician or other qualified practitioner;
4. Is consistent with the diagnosis;
5. Is appropriate for use in the home;
6. Is reusable; and can withstand repeated use.

B. **Hearing Aid** means a device that is of a design and circuitry to optimize audibility and listening skills in the environment experienced by children and is non-disposable.

C. **Inherited Metabolic Disease** means a disease caused by an inherited abnormality of body chemistry, including a disease for which the State screens newborn babies.

D. **Low Protein Modified Food Product** means a food product that is:

1. Specially formulated to have less than 1 gram of protein per serving; and

2. Intended to be used under the direction of a physician for the dietary treatment of an Inherited Metabolic Disease.

Low Protein Modified Food Product does not include a natural food that is naturally low in protein.

E. **Medical Device**, as used in the Contract, means Durable Medical Equipment, Hearing Aids, Medical Supplies, Prosthetic and Orthotic Device.

F. **Medical Food** means a food that is:

1. Intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and

2. Formulated to be consumed or administered under the direction of a physician.

G. **Medical Supply** means items that:

1. Are primarily and customarily used to serve a medical purpose;

2. Are not useful to a person in the absence of illness or injury;

3. Are ordered or prescribed by a physician or other qualified practitioner;

4. Are consistent with the diagnosis;

5. Are appropriate for use in the home;

6. Cannot withstand repeated use;

7. Are usually disposable in nature.

H. **Orthotic Device** means items that:

1. Are primarily and customarily used to serve a therapeutic medical purpose;

2. Are prescribed by a Health Care Provider;

3. Are corrective appliances that are applied externally to the body, to limit or encourage its activity, to aid in correcting or preventing deformity, or to provide mechanical support;

4. May be purely passive support or may make use of spring devices; and

5. Include devices necessary for post-operative healing.

I. **Prosthetic Device** means a device which:

1. Is primarily intended to replace all or part of an organ or body part that has been lost due to disease or injury; or

2. Is primarily intended to replace all or part of an organ or body part that was absent from birth; or

3. Is intended to anatomically replace all or part of a bodily function which is permanently inoperative or malfunctioning; and

4. Is prescribed by a Health Care Provider; and

5. Is removable and attached externally to the body.

9.5 Covered Services.

A. **Durable Medical Equipment**

Rental, or, (at CareFirst BlueChoice's option), purchase and replacements or repairs of Medically Necessary Durable Medical Equipment prescribed by a Health Care Provider for therapeutic use for a Member's medical condition.

Durable Medical Equipment or supplies associated or used in conjunction with Medically Necessary Medical Foods and nutritional substances.

CareFirst BlueChoice's payment for rental will not exceed the total cost of purchase. CareFirst BlueChoice's payment is limited to the least expensive Medically Necessary Durable Medical Equipment, adequate to meet the Member's medical needs. CareFirst BlueChoice's payment for Durable Medical Equipment includes related charges for handling, delivery, mailing and shipping, and taxes.

B. **Hair Prosthesis**. Subject to limitations, if any, stated in the Schedule of Benefits, benefits are available for a hair prosthesis when prescribed by a treating oncologist and the hair loss is a result of chemotherapy or radiation treatment for cancer.

C. **Medical Foods and Low Protein Modified Food Products**
Medical Foods and Low Protein Modified Food Products for the treatment of Inherited Metabolic Diseases if the Medical Foods or Low Protein Modified Food Products are:

1. Prescribed as Medically Necessary for the therapeutic treatment of Inherited Metabolic Diseases; and;

2. Administered under the direction of a physician.

Coverage for Medical Foods and Nutritional Substances. Medically Necessary medical foods and nutritional therapy for the treatment of disorders when ordered and supervised by a Health Care Provider qualified to provide the diagnosis and treatment in the field of the disorder/disease, as determined by CareFirst BlueChoice.

D. **Medical Supplies**

E. **Orthotic Devices, Prosthetic Devices.** Benefits include:

1. Supplies and accessories necessary for effective functioning of Covered Service;

2. Repairs or adjustments to Medically Necessary devices that are required due to bone growth or change in medical condition, reasonable weight loss or reasonable weight gain, and normal wear and tear during normal usage of the device; and

3. Replacement of Medically Necessary devices when repairs or adjustments fail and/or are not possible.

F. **Hearing Aids.** Covered Services for a minor Dependent child:

1. One Hearing Aid, prescribed, fitted and dispensed by a licensed audiologist for each hearing-impaired ear;

2. Non-routine services related to the dispensing of a covered Hearing Aid, such as assessment, fitting, orientation, conformity and evaluation.

9.6 **Repairs**. Benefits for the repair, maintenance or replacement of a Medical Device require authorization or approval by CareFirst BlueChoice. Benefits are limited to:

A. Coverage of maintenance costs is limited to routine servicing such as testing, cleaning, regulating and checking of equipment.

B. Coverage of repair costs is limited to adjustment required by normal wear or by a change in the Member's condition and repairs necessary to make the equipment/appliance serviceable. Repair will not be authorized if the repair costs exceed the market value of the Medical Device.

C. Replacement coverage is limited to once every two benefit years due to irreparable damage and/or normal wear or a significant change in medical condition. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the Member or of a family member are not covered.

9.7 **Exclusions.** Specific exclusions related to Medical Devices and Supplies are listed with the Exclusions and Limitations at the end of this Description of Covered Services.

SECTION 10
VISION CARE SERVICES

This Section contains certain terms that have a specific meaning as to Vision Care benefits. These terms are capitalized and are defined in 10.2 below, or in the Program Description.

This Section contains specific exclusions and limitations applicable to Vision Care benefits that are in addition to the exclusions and limitations contained in the Program Description.

10.1 General Provisions.

A. CareFirst has contracted with Davis Vision, Inc., a national provider of Vision Care services, to administer Vision Care benefits. Davis Vision, Inc. has special agreements with optometrists and ophthalmologists to provide Vision Care benefits to Members. These optometrists and ophthalmologists are Contracting Providers.

Davis Vision, Inc. is an independent company and administers the Vision Care Services on behalf of CareFirst BlueChoice.

B. Benefits for routine Vision Care are limited to the services listed in this Section.

C. To receive benefits under this Section, the Member is required to receive Vision Care from a Contracting Provider.

D. The Member's responsibility for covered Vision Care is stated in Section 10.5, Schedule of Benefits. In addition, the Member will be responsible for services, supplies or care which are not covered. Services, supplies or care that are not listed as Vision Care benefits or are listed as an exclusion are not Covered Services under this Section.

10.2 Definitions. In addition to the definitions contained in the Program Description, the underlined terms, below, when capitalized, have the following meanings:

Allowed Benefit in this Section only means:

For a Contracting Provider, the Allowed Benefit for a Covered Service is the lesser of:

a. The actual charge; or

b. The amount allowed for the service in effect on the date that the service is rendered.

The benefit payment is made directly to a Contracting Provider. When a Member receives a vision examination from a Contracting Provider, the benefit payment is accepted as payment in full, except for any applicable copayment. The Contracting Provider may collect any applicable copayment.

Benefit Period means the period of time during which covered Vision Care benefits are eligible for payment. The Benefit Period is on a contract year basis.

Contracting Provider means any optometrist or ophthalmologist licensed as such by the duly constituted authority in the jurisdiction in which Vision Care is rendered when acting within the scope of such license; and, that has contracted with Davis Vision, Inc. to provide Vision Care in accordance with the terms of this Section.

Non-Contracting Provider means any optometrist or ophthalmologist licensed as such by the duly constituted authority in the jurisdiction in which Vision Care is rendered when acting within the scope of such license; and, who does not have an agreement with Davis Vision, Inc. for the rendering of Vision Care. A Non-Contracting Provider under this Section may or may not have contracted with CareFirst. The Member should contact Davis Vision, Inc. for the current list of Contracting Providers.

Vision Care means those services for which benefits are provided under this Section.

10.3 What is Covered. Vision Examination. One vision examination per Benefit Period. A vision examination may include, but is not limited to:

A. Case history;
B. External examination of the eye and adnexa;
C. Ophthalmoscopic examination;
D. Determination of refractive status;
E. Binocular balancing test;
F. Tonometry test for glaucoma;
G. Gross visual field testing;
H. Color vision testing;
I. Summary finding; and,
J. Recommendation, including prescription of corrective lenses.

10.4 How It Is Covered. When the Member receives a vision examination from a Contracting Provider, the benefit payment is accepted as payment in full, except for any applicable copayment.

10.5 Schedule of Benefits.

SERVICE	MEMBER PAYS
Vision Examination	$10 when Member receives Covered Services from a Contracting Provider.

10.6 Exclusions. The following services are excluded from coverage:

A. Diagnostic services, except as listed in What is Covered.

B. Medical care or surgery. Covered Services related to medical conditions of the eye may be covered under the medical benefits Section of the Program Description.

C. Prescription drugs except as may be necessary for a vision exam.

D. Orthoptics, vision training and low vision aids.

E. Vision Care services for cosmetic use.

F. Frames, lenses, sunglasses or contact lenses.

G. Services obtained from Non-Contracting Providers.

SECTION 11
REFERRALS

11.1 Referral Requirements.

A. Benefits for services rendered by Contracting Physicians other than the PCP are only provided when prior written referral by a PCP is obtained for the specified Covered Service.

B. The exceptions to the PCP referral requirement are listed below in Section 11.2.

11.2 Exceptions to Requirement for PCP Referral. A Member may self-refer to Contracting Providers for:

A. Routine eye exams provided by a Contracting Provider optometrist or vision center. However, services provided by an ophthalmologist require a referral.

B. Except for infertility services, covered gynecological and obstetric services from a Contracting Provider certified nurse midwife or Contracting Provider Obstetrician/Gynecologist.

C. Covered Services rendered at Contracting Provider radiologist offices whether ordered by a Contracting Provider or non- Contracting Provider.

D. Covered Services rendered by Contracting Provider laboratory whether ordered by a Contracting Provider or a non-Contracting Provider.

E. Emergency and Urgent Care services as described in Section 8.

F. Covered Services that are directly related to a diagnosis of cancer, including, but not limited to, office visits and care by an Oncologist, chemotherapy, and radiation therapy by Contracting Providers without a referral by the Member's Primary Care Provider. Benefits are subject to review and approval under utilization management requirements established by CareFirst BlueChoice. Contracting Providers will handle utilization management procedures on behalf of the Member.

G. Covered Services rendered by a Contracting Provider ophthalmologist.

Note: CareFirst BlueChoice reserves the right to make changes to the categories of providers or services that do not require a Primary Care Provider referral. Notice of such changes will be provided to the Member.

11.3 Standing or Condition Management Referral to a Specialist.

A. Definitions.

1. A **Condition Management Referral** is a referral that allows a Contracting Specialist to act as a PCP:

   a. Solely for the condition for which the Member was referred; and

   b. Only for the authorized treatment period.

   The Contracting Physician Specialist shall be permitted to provide and coordinate the primary and specialty care for the Member's condition and includes authorizing such referrals, procedures, tests, and other medical services as the Member's PCP would otherwise be permitted to provide or authorize.

2. A **Standing Referral** is a referral to a Contracting Physician Specialist that does not have a specified treatment period. The referral is subject to periodic review by the PCP and CareFirst BlueChoice to determine whether the Standing Referral continues to be Medically Necessary.

3. **Specialist** as used in this Section means a physician who is:

   a. Certified or eligible for certification by the appropriate specialty board; and

   b. Trained in practice in a specified field of medicine.

B. Condition Management Referral or Standing Referral to a Specialist.

1. A Member may request a Condition Management Referral or a Standing Referral from the PCP to a Contracting Physician Specialist for a condition that:

   a. Is life threatening, degenerative, chronic or disabling; or

   b. Requires a Specialist over a prolonged period of time.

2. Upon request for a referral, the PCP will contact CareFirst BlueChoice to obtain authorization.

C. Standing Referral for Cancer Patients.

1. A Member who has been diagnosed with cancer may request a Standing Referral from their PCP to a:

   a. Contracting Physician who is a board-certified physician in pain management; or

   b. Contracting Physician who is an oncologist.

2. A Standing Referral does not authorize the Contracting Physician to assume the responsibilities for care other than cancer care and pain management. The referral is subject to periodic review by the PCP and CareFirst BlueChoice.

D. Standing Referral for Pregnancy.

1. A Member who is pregnant may obtain a standing referral to an obstetrician.

2. After the Member who is pregnant receives a standing referral to an obstetrician, the obstetrician is responsible for the primary management of the Member's pregnancy, including the issuance of referrals in accordance with CareFirst BlueChoice's policies and procedures, through the postpartum period.

11.4 Conditions for a Referral to a Non-Contracting Specialist or Non-Contracting Nonphysician Specialist.

A Specialist is a physician who is certified or trained in a specified field of medicine.

A Nonphysician Specialist means a Health Care Provider who:

1. is not a physician;

2. is licensed or certified under the Health Occupations Article of the Annotated Code of Maryland or the applicable licensing laws of any State or the District of Columbia; and

3. is certified or trained to treat or provide Covered Services for a specified condition or disease in a manner that is within the scope of the license or certification of the Health Care Provider.

A Member may request a referral to a Specialist or Nonphysician Specialist who is not a Contracting Physician or Contracting Provider if:

1. The Member is diagnosed with a condition or disease that requires specialized medical care; and

   a. CareFirst BlueChoice does not contract with a Specialist or Nonphysician Specialist with the professional training and expertise to treat or provide Covered Services for the condition or disease; or

   b. CareFirst BlueChoice cannot provide reasonable access to a Specialist or Nonphysician Specialist with the professional training and expertise to treat or provide Covered Services for the condition or disease without unreasonable delay or travel.

2. The non-contracting Specialist or Nonphysician Specialist will be reimbursement the same as would be provided to a specialist who is a Contracting Physician or Contracting Provider. The Member may be subject to balance billing.

A decision by CareFirst BlueChoice not to provide access to or coverage of treatment by a Specialist in accordance with this section constitutes an Adverse Benefit Determination as defined in the Program Description, if the decision is based on a finding that the proposed service is not Medically Necessary, appropriate, or efficient.

11.5 Continuing Care with Terminated Providers.

A. When a Contracting Provider terminates their agreement with CareFirst BlueChoice, for any reason except for cause, benefits will be provided for continuing care rendered by the terminated provider as described in this Section. CareFirst BlueChoice will send a notice to the Member that the Contracting Provider is no longer available.

B. The Member may, upon request, continue to receive Covered Services from his/her PCP for up to 90 days after the date of the notice of the PCP's termination from CareFirst BlueChoice's provider panel, if termination was for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status. In addition, a Member may continue treatment with a terminated provider if:

1. A Member was in an active course of treatment with the terminated Contracting Provider prior to the date the Member was notified. The Member needs to request, from CareFirst BlueChoice, to continue receiving care from the terminated Contracting Provider. Benefits will be provided for a period of 90 days from the date the Member is notified by CareFirst BlueChoice that the terminated Contracting Provider is no longer available.

2. A Member who has entered her second trimester of pregnancy may continue to receive Covered Services from the terminated Contracting Provider through postpartum care directly related to the delivery.

3. A Member that was terminally ill (as defined by § 1861(dd)(3)(A) of the Social Security Act) at the time the Contracting Provider's agreement terminated may continue to receive Covered Services directly related to the treatment of the terminal illness until the Member dies.

11.6 CareFirst BlueChoice Personnel Availability for Prior Authorization.

CareFirst BlueChoice requires prior authorization for certain medical treatment as stated in the Contract. Check the specific description of the Covered Services for a notice regarding prior authorization. CareFirst BlueChoice shall have personnel available to provide prior authorization at all times when such prior authorization is required.

SECTION 12
EXCLUSIONS AND LIMITATIONS

12.1 Coverage Is Not Provided For:

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

B. Services that are Experimental or Investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time the service in question is rendered, as determined by CareFirst BlueChoice.

This exclusion will not be used, however, to deny Patient Cost when a clinical trial meets the criteria stated in Section 2.

C. The cost of services that:

1. Are furnished without charge; or

2. Are normally furnished without charge to persons without health insurance coverage; or

3. Would have been furnished without charge if a Member was not covered under the Contract or under any health insurance.

D. Services that are not described as covered in the Contract or that do not meet all other conditions and criteria for coverage, as determined by CareFirst BlueChoice. Referral by a PCP and/or the provision of services by a Contracting Provider does not, by itself, entitle a Member to benefits if the services are non-covered or do not otherwise meet the conditions and criteria for coverage.

E. Except for Emergency Services and Urgent Care, benefits will not be provided for any service(s) provided to a Member by non-Contracting Physicians or non-Contracting Providers, unless prior written authorization is specifically obtained from CareFirst BlueChoice.

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

G. Except for treatment for Accidental Injury or benefits for Oral Surgery as described, dental care including extractions; treatment of cavities; care of the gums or bones supporting the teeth; treatment of periodontal abscess; orthodontia, except for the treatment of a cleft lip or cleft palate; false teeth; or any other dental services or supplies.

H. Cosmetic Services (except for Mastectomy – Related Services and services for cleft lip or cleft palate or both).

I. Treatment rendered by a Health Care Provider who is the Member's parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or resides in the Member's home.

J. Any prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under this Contract. Medications that can be self-administered or 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 office or provider facility. Benefits for prescription drugs may be available through an Attachment to the Contract.

K. All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained and self-administered by the Member, except as stated in the Description of Covered Services.

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

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

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

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

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

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

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

S. Acupuncture services except when approved or authorized by CareFirst BlueChoice when used for anesthesia.

T. Any service related to recreational activities. This includes, but is not limited to, sports, games, equestrian, and athletic training, even though such services may be deemed to have therapeutic value.

U. 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.

V. Private duty nursing.

W. Non-medical, Health Care Provider services, including, but not limited to:

1. Telephone consultations, charges for failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the Health Care Provider or his/her staff.

2. Administrative fees charged by a Health Care Provider to a Member to retain the Health Care Provider services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Contract are limited to Covered Services rendered to a Member by a Health Care Provider.

X. Educational therapies intended to improve academic performance.

Y. Vocational rehabilitation and employment counseling.

Z. Services performed or prescribed by or under the direction of a person who is acting beyond his/her scope of practice.

AA. Services performed or prescribed by or under the direction of a person who is not a Health Care Provider.

BB. Oral surgery, dentistry or dental process unless otherwise stated.

CC. Treatment of temporomandibular joint disorders unless otherwise stated.

DD. Habilitative Services for a Member 19 years and older.

EE. Elective Abortions.

FF. Rehabilitative Services delivered through early intervention and school services.

GG. Services related to human reproduction other than specifically described in this Contract including, but not limited to maternity services for surrogate motherhood or surrogate uterine insemination, unless the surrogate mother is a Member.

HH. Work Hardening Programs. Work Hardening Programs are 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.

12.2 Infertility Services.

Coverage will not be provided when:

A. The Member or spouse has undergone elective sterilization with or without reversal.

B. Any surrogate or gestational carrier is used.

C. The service involves the use of donor egg(s), donor sperm or donor embryo(s).

D. The service involves the participation of a common law spouse, except in states that recognize the legality of those relationships.

Coverage will not be provided for:

E. Cryopreservation, storage, and or thawing of sperm, egg(s), or embryo(s).

F. Any charges related in any way to the acquisition, maintenance, storage, examination, testing, sterilization or preservation of donor eggs and/or donor sperm.

12.3 Organ and Tissue Transplants. **Coverage is not provided for**:

A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary, non-experimental skin grafts that are covered under the Contract.

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

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

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

E. Benefits will not be provided for donor search services.

F. Any service, supply or device related to a transplant that is not listed as a benefit in the Contract.

12.4 Inpatient Hospital Services. **Coverage is not provided for**:

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

B. Non-medical items and Convenience Items, such as television and phone rentals, guest trays and laundry charges.

C. Except for covered Emergency Services and Maternity Care, a Hospital admission or any portion of a Hospital admission that had not been authorized or approved by CareFirst BlueChoice, whether or not services are Medically Necessary and/or meet all other conditions for coverage.

D. Private duty nursing.

12.5 Home Health Care Services. **Coverage is not provided for**:

A. Private duty nursing.

B. Custodial Care.

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

12.6 Hospice Benefits. **Coverage is not provided for**:

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

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

C. Financial and legal counseling.

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

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

F. Services, visits, medical/surgical equipment or supplies; including equipment and medication not required to maintain the comfort and to manage the pain of the terminally ill Member.

G. Reimbursement for volunteer services.

H. Custodial Care, domestic or housekeeping services.

I. Meals on Wheels or similar food service arrangements.

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

K. Private duty nursing.

12.7 Outpatient Mental Health and Substance Abuse. **Coverage is not provided for**:

A. Psychological testing, unless Medically Necessary, as determined by CareFirst BlueChoice, and appropriate within the scope of Covered Services.

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

C. Intellectual disability, after diagnosis.

D. Psychoanalysis.

12.8 Inpatient Mental Health and Substance. **Coverage is not provided for**:

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

B. Custodial Care.

C. Observation or isolation.

12.9 Emergency Services and Urgent Care. **Coverage is not provided for**:

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

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

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

D. Except for Medically Necessary follow-up care after emergency surgery, charges for follow-up care received in the Emergency or Urgent Care facility outside of the Service Area unless CareFirst BlueChoice determines that the Member could not reasonably be expected to return to the Service Area for such care.

E. Except for covered ambulance services, travel, including travel required to return to the Service Area, whether or not recommended by a Contracting Provider.

F. Treatment received in an emergency department to treat a health care problem that does not meet the definition of Emergency as defined in Section 8.

12.10 Medical Devices and Supplies. **Coverage is not provided for**:

A. Durable Medical Equipment or supplies associated or used in conjunction with non-covered items or services.

B. Food formula consumed as sole source or supplemental nutrition except as stated in the Description of Covered Services.

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

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

E. 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.

F. 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.

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

H. Eyeglasses, contact lenses, dental prostheses or appliances, or Hearing Aids (except as otherwise provided herein for minor children). Benefits for eyeglasses and contact lenses may be available through an Attachment to or included as a separate Section within the Contract.

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

J Cranial molding orthoses for positional/deformational/non-synostotic plagiocephaly or brachycephaly.

K. Tinnitus maskers

SECTION 13
SCHEDULE OF BENEFITS

CareFirst BlueChoice pays only for Covered Services. The Member pays for services, supplies or care, which are not covered. The Member pays any applicable Coinsurance or Copayment. Services that are not listed in the Description of Covered Services, or are listed in Exclusions and Limitations, are not Covered Services.

When determining the benefits a Member may receive, CareFirst BlueChoice considers all provisions of the Contract, its medical policies, and its operating procedures. When these policies and procedures are not followed, payments for benefits may be denied. Certain Utilization Management Requirements may apply. When these requirements are not met, payments may be denied or reduced.

SERVICE	LIMIT ON BENEFITS	MEMBER PAYMENT
SECTION 2 – OUTPATIENT AND OFFICE SERVICES		
Outpatient Medical Services		
Office Visits	Office visits to CareFirst BlueChoice Specialist requires written referral from Primary Care Physician (PCP), except as otherwise provided in the Contract	$10 per visit (PCP) $20 per visit (Specialist)
Laboratory Tests and X-rays		No copayment or coinsurance
Other Diagnostic Testing		No copayment or coinsurance
Preventive Services		
Well Child Care		$10 per visit
Immunizations		No copayment or coinsurance
Routine GYN Exam	Benefits are limited to 1 per Benefit Period.	$10 per visit (PCP) $20 per visit (Specialist)
Adult Preventive Care	Benefits are limited to 1 per Benefit Period.	$10 per visit (PCP) $20 per visit (Specialist)
Immunizations		No copayment or coinsurance

SERVICE	LIMIT ON BENEFITS	MEMBER PAYMENT
Cancer Screening Tests		
Prostate Cancer Screening	As described in Section 2.1	
Hospital		No copayments or coinsurance
Outpatient Professional		No copayments or coinsurance
Office		$10 per visit (PCP) $20 per visit (Specialist)
Colorectal Cancer Screening	As described in Section 2.1	Benefits are available to the same extent as benefits provided for diagnostic services and surgery
Pap Smear (including those performed using FDA-approved gynecological cytology screening technologies)	Benefits are limited to 1 per Benefit Period.	No copayment or coinsurance
Breast Cancer Screening	Benefits are limited to 1 per Benefit Period.	
Hospital		No copayments or coinsurance
Outpatient Professional		No copayments or coinsurance
Office		$10 per visit (PCP) $20 per visit (Specialist)
Allergy Treatment	Number of visits not limited	$10 per visit (PCP) $20 per visit (Specialist)

SERVICE	LIMIT ON BENEFITS	MEMBER PAYMENT
Eye Care Services		
Medical Treatment		$10 per visit (PCP) $20 per visit (Specialist)
Rehabilitative Services (includes Physical Therapy, Occupational Therapy, Speech Therapy, and Spinal Manipulation)	Limited to 100 visits per condition per Benefit Period Benefits for spinal manipulation services are limited to Members who are twelve (12) years of age or older	
Hospital		No copayment or coinsurance
Outpatient Professional		$20 per visit
Office		$20 per visit
Cardiac Rehabilitation		
Hospital		No copayment or coinsurance
Outpatient Professional		$20 per visit
Habilitative Services	Limited to Members under age 19	
Hospital		No copayment or coinsurance
Outpatient Professional		$20 per visit
Office		$20 per visit
Chemotherapy		
Hospital		No copayment or coinsurance
Outpatient Professional		$20 per visit
Office		$20 per visit
Maternity Care	The Member maximum payment per pregnancy by a Primary Care Physician (PCP) or Specialist applies only to maternity care performed by the Member's attending obstetrician(s).	$100 per pregnancy or $10 per PCP office visit up to Member maximum payment of $100 per pregnancy if no live birth $200 per pregnancy or $20 per Specialist office visit up to Member maximum payment of $200 per pregnancy if no live birth

SERVICE	LIMIT ON BENEFITS	MEMBER PAYMENT
Infertility Services		
Artificial Insemination		50% of the Allowed Benefit
In-Vitro Fertilization	Benefits for in vitro fertilization (IVF) are limited to three attempts per live birth; and, a lifetime maximum benefit of $100,000. This maximum in no way creates a right to benefits after termination.	50% of the Allowed Benefit
Outpatient Hospital or ambulatory care facility		No copayment or coinsurance
Outpatient medical and surgical professional services provided at an outpatient Hospital or ambulatory care facility		$10 per visit (PCP) $20 per visit (Specialist)
SECTION 3 – INPATIENT HOSPITAL SERVICES		
Inpatient Facility (medical or surgical condition, including maternity)		No copayment or coinsurance
Inpatient Facility (Rehabilitation Services)	Limited to 90 days per Benefit Period	No copayment or coinsurance
Professional Services (medical or surgical condition, including maternity)		No copayment or coinsurance
SECTION 4 – SKILLED NURSING FACILITY SERVICES		
	Number of covered days not limited	No copayment or coinsurance
SECTION 5 – HOME HEALTH CARE SERVICES		
	Number of visits not limited	No copayment or coinsurance
Postpartum Home Visits		No copayment or coinsurance

SERVICE	LIMIT ON BENEFITS	MEMBER PAYMENT
SECTION 6 – HOSPICE CARE SERVICES		
Hospice Care	Limited to the Hospice Eligibility Period. See Section 6.3.	
Inpatient Care		No copayment or coinsurance
Outpatient Care	Unlimited visits during Hospice Eligibility Period.	No copayment or coinsurance
Respite Care		No copayment or coinsurance
Bereavement Services		No copayment or coinsurance

SERVICE	LIMIT ON BENEFITS	MEMBER PAYMENT
SECTION 7 – MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Outpatient Services		
Office visit to Contracting Provider Office, including psychological testing	Number of visits not limited	No copayment or coinsurance
Other outpatient facility,	Number of visits not limited	No copayment or coinsurance
Office Visits for Medication Management	Number of visits not limited	$10 per visit
Partial Hospitalizatio n Program	Number of visits not limited	No copayment or coinsurance
Methadone Maintenance Treatment	The Member payment will not be greater than 50% of its daily cost	No copayment or coinsurance
Psychological testing and Neuro-psychological testing for diagnostic purposes		No copayment or coinsurance
Inpatient Services		
Hospital or Facility Services	Number of days not limited	No copayment or coinsurance
Professional Services		No copayment or coinsurance
Residential Crisis Services		
Facility Services	Number of days not limited	No copayment or coinsurance
Professional Services		No copayment or coinsurance

SERVICE	LIMIT ON BENEFITS	MEMBER PAYMENT
SECTION 8 – EMERGENCY SERVICES AND URGENT CARE		
Contracting Provider Urgent Care Facility	Limited to Emergency Services or unexpected, urgently required services.	$20 per visit
Hospital Emergency Room or Non-Contracting Urgent Care Facility	Limited to Emergency Services or unexpected, urgently required services.	$50 per visit, waived if admitted as inpatient
Other Emergency Services or urgently required services provided by a non-Contracting Physician	Limited to unexpected, urgently required services	$10 per visit (PCP) $20 per visit (Specialist)
Ambulance Services		No copayment or coinsurance
Repatriation of Remains	Limited to a maximum CareFirst BlueChoice payment of 100% of the Allowed Benefit up to $7,500	No copayment or coinsurance
Travel Expense for Serious Illness or Injury	Limited to a maximum CareFirst BlueChoice payment of 100% of the Allowed Benefit up to $10,000	No copayment or coinsurance
SECTION 9 – MEDICAL DEVICES AND SUPPLIES		
		50% of the Allowed Benefit after the Deductible has been met
Diabetic Supplies and Equipment		No copayment or coinsurance
Hair Prosthesis		
Hair Prosthesis	Limited to a maximum CareFirst BlueChoice payment of $350 for one hair prosthesis per Benefit Period.	No copayment or coinsurance
Hearing Aids for Minor Children		
Hearing Aid	Limited to a maximum CareFirst BlueChoice payment of $1,400 every 36 months for one Hearing Aid for each hearing impaired ear.	No copayment or coinsurance
Related Services		$10 per visit (PCP) $20 per visit (Specialist)
Medical Foods and Nutritional Substances		
		No copayment or coinsurance

MAXIMUM ANNUAL COPAYMENTS AND COINSURANCE

If the Group offering includes **two** Types of Coverage, the Maximum Annual Copayments and Coinsurance are:

Individual
$2,000

Family
$5,500

Except as provided below, total Copayments and Coinsurance paid during a Benefit Period by a Subscriber and, if applicable, his or her Dependents are subject to the Maximum Annual Copayment established for the type of coverage in which the Member is enrolled (e.g. Individual or Family) as stated above. The Maximum Annual Copayment and Coinsurance applies on a Benefit Period basis even though the Member may have been enrolled for less than Benefit Period.

If the Subscriber is enrolled under Family coverage or, if applicable, Two-Party coverage (Individual and Adult or Individual and Child) the Member can meet the Maximum Annual Copayment and Coinsurance if individual Copayments and Coinsurance exceed the Maximum Annual Copayment and Coinsurance established for Individual coverage. In addition, if the total Copayments of all covered family members exceed the Maximum Annual Copayment and Coinsurance for the type of coverage enrolled, all covered family members will be deemed to have met the Maximum Annual Copayment and Coinsurance. However, an individual family member cannot contribute more than the Maximum Annual Copayment and Coinsurance for Individual Coverage.

CareFirst BlueChoice will notify the Member if the Maximum Annual Copayment and Coinsurance is reached, based on billing and claims information in our records. If the Member satisfies the Maximum Annual Copayment and Coinsurance, the Member will be entitled to a refund of any excess Copayments and Coinsurance paid and, for the remainder of that Benefit Period, will not be required to pay additional Copayments and Coinsurance for services that are subject to the Maximum Annual Copayment and Coinsurance.

The Maximum Annual Copayment and Coinsurance limit does not apply to charges or Copayments and Coinsurance in connection with any of the following:

- Charges for services which are not covered under this Contract or which exceed the maximum number of covered visits/days under the Member's coverage.
- Copayments required under any Attachments to this Contract, unless the Attachment specifically states otherwise.
- Coinsurance or Copayments for services covered under Section 10 VISION SERVICES.