CareFirst

Your Prescription Drug & Dental Benefit Options

July 1, 2024–June 30, 2025

ACPS Alexandria City Public Schools

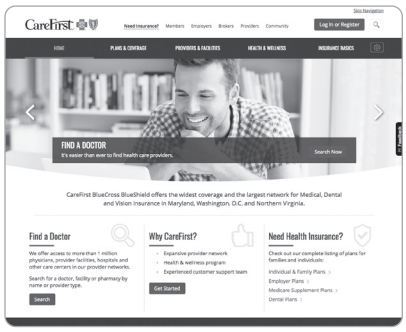
ALEXANDRIA CITY PUBLIC SCHOOLS

Contents

Welcome

Welcome to your plan for healthy living

From preventive services to maintaining your health, to our extensive network of providers and resources, CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) are there when you need care. We will work together to help you get well, stay well and achieve any wellness goals you have in mind.



Visit **carefirst.com/acps** *for up-to-date information on your plan.*

We know that health insurance is one of the most important decisions you make for you and your family—and we thank you for choosing CareFirst. This guide will help you understand your plan benefits and all the services available to you as a CareFirst member.

Please keep and refer to this guide while you are enrolled in this plan.

How your plan works

Find out how your health plan works and how you can access the highest level of coverage.

What's covered

See how your benefits are paid, including any deductibles, copayments or coinsurance amounts that may apply to your plan.

Getting the most out of your plan

Take advantage of the added features you have as a CareFirst member:

- Wellness discount program offering discounts on fitness gear, gym memberships, healthy eating options and more.
- Online access to quickly find a doctor or search for benefits and claims.
- Health information on our website includes health calculators, tracking tools and podcast videos on specific health topics.
- *Vitality* magazine with healthy recipes, preventive health care tips and a variety of articles.

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Prescription Drug Program

A total prescription for health

Prescription drugs are an integral part of high-quality health care. The prescription benefits your employer is offering give you an affordable and convenient way to make the best decisions when it comes to your prescriptions.

Your prescription benefits

As a CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc. (CareFirst) member, you'll have access to:

- A nationwide network of 66,000 participating pharmacies[1]
- Access to thousands of covered prescription drugs
- Mail Service Pharmacy, a convenient and fast option to refill your prescriptions through home delivery
- Coordinated medical and pharmacy programs to help improve your overall health and reduce costs

Keeping you informed

Together with our pharmacy benefit manager, CVS Caremark®[2], we keep you informed about your prescription drug coverage and provide you with periodic updates about your plan through targeted mailings and phone calls. Take the call and/or review your mailed notices to learn about lower-cost drug alternatives, possible safety concerns, drug tier changes and more.

Online tools and resources

To get the most from your prescription drug plan, you need to stay informed. Our easy-to-use, interactive tools and resources are available 24/7. Visit **carefirst.com/rxgroup** to see if a drug is covered, find a pharmacy, learn how drugs interact with each other and get more information about medications. You can access even more tools and resources once you're a member through My Account **(carefirst.com/myaccount)** by selecting *Drug and Pharmacy Resources* under *Coverage.*

[1] If your employer has selected the RxChoice network, you will have access to 57,000 retail pharmacies.

[2] CVS Caremark is an independent company that provides pharmacy benefit management services to CareFirst members.

Understanding your formulary

A formulary is a list of covered prescription drugs. Our drug list is reviewed and approved by an independent national committee comprised of physicians, pharmacists and other health care professionals who make sure the drugs on the formulary are safe and clinically effective. The prescription drugs found on the CareFirst Formulary (drug list) are divided into tiers. These tiers include zero-dollar cost share, generics, preferred brand and non-preferred brand drugs. Your cost share is determined by the tier the drug falls into.

Drug tier	Description
Tier 0: $0 Drugs	■ Preventive drugs (e.g. statins, aspirin, folic acid, fluoride, iron supplements, smoking cessation products and FDA-approved contraceptives for women) are available at a zero-dollar cost share if prescribed under certain medical criteria by your doctor. ■ Oral chemotherapy drugs and diabetic supplies (e.g. insulin syringes, pen needles, lancets, test strips, and alcohol swabs) are also available at a zero dollar cost share.
Tier 1: Generic Drugs $	■ Generic drugs are the same as brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. ■ Generic drugs generally cost less than brand-name drugs.
Tier 2: Preferred Brand Drugs $$	■ Preferred brand drugs are brand-name drugs that may not be available in generic form, but are chosen for their cost effectiveness compared to alternatives. Your cost-share will be more than generics but less than non-preferred brand drugs. If a generic drug becomes available, the preferred brand drug may be moved to the non-preferred brand category.
Tier 3: Non-Preferred Brand Drugs $$$	■ Non-preferred brand drugs often have a generic or preferred brand drug option where your cost share will be lower.

Note: If the cost of your drug is less than your copay or coinsurance, you only pay the cost of the drug. Once you meet your deductible (if applicable to your plan), you may pay a different copay or coinsurance for drugs depending on the drug tier. Some drugs may not be covered based on your plan. There is an exception process if you need an excluded drug to be covered for medical necessity reasons. Check your benefit summary or enrollment materials for specific plan information. Once you are a member, you can view specific cost-share information in My Account.

Preferred Drug List

CareFirst's Preferred Drug List includes generic and preferred brand drugs selected for their quality, effectiveness and safety by the CVS Caremark national Pharmacy and Therapeutics (P&T) committee. By using the Preferred Drug List, you can work with your doctor or pharmacist to make safe and cost-effective decisions to better manage your health care and out-of-pocket costs.

Non-preferred drugs aren't included on the Preferred Drug List; they are still covered but at the highest cost share. Also, some drugs on the Preferred Drug List may not be covered based on your plan. To see your formulary and Preferred Drug List, go to **carefirst.com/rxgroup**.

Prescription guidelines

Some medications are only intended to be used in limited quantities; others require that your doctor obtain prior authorization through CareFirst before they can be filled. These drug guidelines are indicated on the formulary found at **carefirst.com/rxgroup**.

- **Quantity limits** are placed on selected drugs for safety, quality or utilization reasons. Limits may be placed on the amount of the drug covered per prescription or for a defined period of time. If your doctor decides that a different quantity of medication is right for you, your doctor can request prior authorization for coverage.
- **Prior authorization** is required before you fill prescriptions for certain drugs. Your doctor must obtain prior authorization before they can be filled. Without prior authorization approval, your drugs may not be covered.
- **Step therapy** ensures you receive a lower-cost drug option as the first step in treating certain health conditions. When similar drugs are available, step therapy guides your doctor to prescribe the lower-cost option first. You may then move up the cost levels until you find the drug that works best for you. Higher step drugs may require prior authorization by your doctor before they can be covered.

Two ways to fill

Retail pharmacies

With access to 66,000 pharmacies[1] across the country, you can visit **carefirst.com/rxgroup** and use our *Find a Pharmacy* tool to locate a convenient participating pharmacy. Be sure to take your prescription and member ID card with you when filling prescriptions.

Mail Service Pharmacy

Mail order is a convenient way to fill your prescriptions, especially for refilling drugs taken frequently. You can register three ways—online through My Account, by phone or by mail. Once you register, you'll be able to:

- Refill prescriptions online, by phone or by email
- Choose your delivery location
- Consult with pharmacists by phone 24/7
- Schedule automatic refills
- Receive email notification of order status
- Choose from multiple payment options

Ways to save

Here are some ways to help you save on your prescription drug costs.

- **Use generic drugs**—generic drugs can cost up to 80% less than their brand-name counterparts. Made with the same active ingredients as their brand-name counterparts, generics are also equivalent in dosage, safety, strength, quality, performance and intended use.
- **Use drugs on the Preferred Drug List**—the Preferred Drug List identifies generic and preferred brand drugs that may save you money.
- **Use the Drug Pricing Tool**—this tool allows you to compare the cost of a drug purchased at a pharmacy versus purchasing the same drug through mail order, as well as view generic drugs available at a lower cost.
- **Use mail order**—by using our Mail Service Pharmacy you get the added convenience of having your prescriptions delivered right to your home. Plus, if you pay a coinsurance for your maintenance drugs, the overall cost of the drug may be less expensive through mail order, reducing your out-of-pocket costs.

[1] If your employer has selected the RxChoice network, you will have access to 57,000 retail pharmacies.

Care management programs

We offer care management programs and tools designed to improve your health while lowering your overall health care costs.

Specialty Pharmacy Coordination Program

This program addresses the unique clinical needs of members taking high-cost specialty drugs for certain complex health conditions like multiple sclerosis, rheumatoid arthritis and hemophilia. Members receive enhanced one-on-one support with a registered nurse and dedicated clinical team who will coordinate care with your doctor.

The program provides:

- 24-hour pharmacist assistance
- Injection training coordination
- Educational materials for your specific condition
- Drug interaction monitoring and review
- A one-month supply of your specialty drugs mailed to your home or office, or available for pick up at any CVS retail pharmacy

Comprehensive Medication Review

When you are taking multiple drugs to treat a medical condition, it can be overwhelming. The Comprehensive Medication Review program can connect you with a CVS Caremark pharmacist who will review your drugs and talk to your doctor about dosages, duration and any other pertinent issues. The pharmacist will work with your doctor to evaluate opportunities to:

- Identify possible drug interactions
- Improve drug adherence
- Reduce gaps in care
- Eliminate duplications in drug therapy

The program works with your doctor to ensure that you are not only taking the best drugs to manage your conditions, but you are also able to take your drugs as prescribed.

Medication Therapy Management Program

Taking medications as prescribed not only helps improve your health but can also reduce your health care costs. CareFirst's Medication Therapy Management program is designed to help you get the best results from your drug therapy.

We review pharmacy claims for opportunities to:

- Save you money
- Support compliance with medications
- Improve your care
- Ensure safe use of high-risk medications

When opportunities are identified, "Drug Advisories" will be communicated to either you and/or your doctor regarding your drug therapy. Through our Pharmacy Advisor program, you may also have the opportunity to speak one-to-one with a pharmacist, who can answer questions and help you manage your prescription drugs.

Should you have any questions about your prescription benefits, please contact CareFirst Pharmacy Services at 800-241-3371.

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Pharmacy Program Summary of Benefits for Point of Service (POS) Plan

Formulary 2 ■ 3-Tier ■ $0 Deductible ■ $10/30/50

Plan Feature	Amount You Pay	Description
Individual Deductible	None	Your benefit does not have a deductible.
Family Deductible	None	Your benefit does not have a family deductible.
Drug Out-of-Pocket Maximum	Individual $1,000 Individual + 1 $2,000 Family $3,000	All deductibles, copays, coinsurance and other eligible out-of-pocket costs count toward your out-of-pocket maximum, except balance billed amounts.
Preventive Drugs (up to a 34-day supply)	$0	A preventive drug is a prescribed medication or item on CareFirst's Preventive Drug List.*
Oral Chemotherapy Drugs and Diabetic Supplies (up to a 34-day supply)	$0	Diabetic supplies include needles, lancets, test strips and alcohol swabs.
Generic Drugs (Tier 1) (up to a 34-day supply)	$10	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (up to a 34-day supply)	$30	All preferred brand drugs are covered at this copay level.
Non-preferred Brand Drugs (Tier 3) (up to a 34-day supply)	$50	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Discuss using alternatives with your physician or pharmacist.
Maintenance Drugs (up to a 90-day supply)	Generic: $20 Preferred Brand: $60 Non-preferred Brand: $100	Maintenance drugs of up to a 90-day supply are available for twice the copay through Mail Service Pharmacy or a CVS Retail Pharmacy.

Visit **carefirst.com/acps** *for the most up-to-date drug lists, including the prescription guidelines. Prescription guidelines indicate drugs that require your doctor to obtain prior authorization from CareFirst before they can be filled and drugs that can be filled in limited quantities.*

This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Policy Form Numbers: VA/CFBC/RX3 (R. 8/12) • VA/CF/RX3 (R. 8/12)

Infertility medication covered up to a maximum of $30,000 per lifetime.

Benefit designs are subject to and may be impacted by certain state regulations.

Non-Contracting Pharmacy: If the Member purchases a Prescription Drug Covered Service or Diabetic Supply from a Non-Contracting Pharmacy, the Member is responsible for paying the total charge and Submitting a claim to CareFirst or its designee for reimbursement. Members will be entitled to reimbursement from CareFirst or its designee up to the amount of the Allowed Benefit, minus any applicable Member payment amounts, as stated in the Schedule of Benefits. Members may be responsible for balances above the Allowed Benefit.

Non-Contracting Pharmacy means a Pharmacist or Pharmacy that does not contract with CareFirst or its designee.

Below are limitations and exclusions contained in your CareFirst BlueChoice or CareFirst medical policy to which the prescription rider is attached.

Medical Limitations and Exclusions—CareFirst BlueChoice

10.1 Coverage is Not Provided For:

A. Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst BlueChoice.
B. Services that are Experimental/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.
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 the Member was not covered under the Evidence of Coverage or under any health insurance.
D. Services that are not described as covered in the Evidence of Coverage or that do not meet all other conditions and criteria for coverage, as determined by CareFirst BlueChoice. Referral by a Primary Care Physician and/or the provision of services by a Contracting Provider does not, by itself, entitle a Member to benefits if the services are not covered or do not otherwise meet the conditions and criteria for coverage.
E. Except for Emergency Services, Urgent Care and follow-up care after emergency surgery, benefits will not be provided for any service(s) provided to a Member by Non-Contracting Physicians or Non-Contracting Providers, unless written prior 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 above, dental care including extractions; treatment of cavities; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia, except for the treatment of a cleft lip or cleft palate; false teeth; or any other dental services or supplies. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
H. Benefits will not be provided for cosmetic surgery (except as specifically provided for reconstructive breast surgery and reconstructive surgery as listed above) or other services primarily intended to correct, change or improve appearances.
I. Treatment rendered by a health care provider who is a member of the Member's family (parents, spouse, brothers, sisters, children).
J. Any prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage. 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 a rider purchased by the Group and attached to the Evidence of Coverage.
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. 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.
L. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
M. Services to reverse voluntary, surgically induced infertility, such as a reversal of a sterilization.
N. All assisted reproductive technologies (except artificial insemination and intrauterine insemination), including in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same unless covered under a rider purchased by the Group and attached to the Evidence of Coverage.
O. Fees or charges relating to fitness programs, weight loss or weight control programs; physical conditioning; pulmonary rehabilitation programs; exercise programs; and use of passive or patient-activated exercise equipment.
P. Treatment for obesity except for the surgical treatment of Morbid Obesity.
Q. 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.
R. Services furnished as a result of a referral prohibited by law.
S. 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.
T. Health education classes and self-help programs, other than birthing classes or for the treatment of diabetes.
U. Acupuncture services except when approved or authorized by CareFirst BlueChoice when used for anesthesia.
V. Any service related to recreational activities. This includes, but is not limited to sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst BlueChoice even though they may have therapeutic value or be provided by a health care provider.
W. Coverage under this Description of Covered Services does not include the cost of services or payment for services for any illness, injury or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:
   1. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or
   2. From any federal, state, county or municipal facility or other government agency, including, in the case of service-connected disabilities, the Veterans Administration, to the extent that Benefits are payable by the federal, state, county or municipal facility or other government agency and provided at no charge to the Member, but excluding Medicare benefits and Medicaid benefits.

   Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for benefits.
X. Private duty nursing.
Y. Non-medical, health care provider services, including, but not limited to:
   1. Telephone consultations, failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the health care practitioner or the healthcare practitioner's staff.
   2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Description of Covered Services are available for Covered Services rendered to the Member by a health care provider.
Z. Educational therapies intended to improve academic performance.
AA. Vocational rehabilitation and employment counseling.
BB. Routine eye examinations, frames and lenses or contact lenses. Benefits for routine eye examinations, frames and lenses or contact lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.
CC. Custodial, personal, or domiciliary care that is provided to meet the activities of daily living, e.g., bathing, toileting and eating (care which may be provided by persons without professional medical skills or training).

DD. 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.
EE. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.
FF. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst BlueChoice, and CareFirst BlueChoice approved services listed in the Transplants section of this Description of Covered Services).
GG. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
HH. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

10.2 Infertility Services.
Coverage for Artificial Insemination (and intrauterine insemination) does not include the following:
A. Any costs associated with freezing, storage or thawing of sperm for future attempts or other use.
B. Any charges associated with donor sperm.
C. Infertility services that include the use of any surrogate or gestational carrier service.
D. Infertility services when the infertility is a result of elective male or female surgical sterilization procedures, with or without reversal.
E. Infertility services for domestic partners or common law spouses, except in those states that recognize those unions.
F. All self-administered fertility drugs.

10.3 Organ and Tissue Transplants.
Benefits will not be provided for the following:
A. Non-human organs and their implantation.
B. Any Hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.
C. Any charges related to transportation, lodging, and meals unless authorized or approved by 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 this Description of Covered Services.

10.4 Inpatient Hospital Services.
Coverage is not provided for the following:
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, phone rentals, guest trays and laundry charges.
C. Except for covered Emergency Services and Childbirth, 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.

10.5 Home Health 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.

10.6 Hospice Benefits.
Coverage is not provided for:
A. Services, visits, medical equipment or supplies that are not included in the 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.

10.7 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. Mental retardation, after diagnosis.
D. Psychoanalysis.

10.8 Inpatient Mental Health and Substance.
The following services are excluded:
A. Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.
B. Custodial Care.
C. Observation or isolation.

10.9 Emergency Services and Urgent Care.
Benefits will not be provided for:
A. Emergency care if the Member could have foreseen the need for the care before it became urgent (for example, periodic chemotherapy or dialysis treatment).
B. Medical services rendered outside of the Service Area which could have been foreseen by the Member prior to departing the Service Area.
C. Charges for emergency and Urgent Care services received from a Non-Contracting Provider after the Member could reasonably be expected to travel to the nearest Contracting Provider.
D. Charges for services when the claims filing and notice procedures stated in Section 7 of this Description of Covered Services have not been followed by the Member.
E. 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.
F. Except for covered ambulance services, travel, including travel required to return to the Service Area, whether or not recommended by a Contracting Provider.
G. Treatment received in an emergency department to treat a health care problem that does not meet the definition of Emergency Services as defined in Section 7 of this Description of Covered Services.

10.10 Medical Devices and Supplies.
Coverage is not provided for:
A. 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.
B. Furniture items. Movable articles or accessories which serve as a place upon which to rest (people or things) or in which things are placed or stored, e.g. chair or dresser.
C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body, e.g. exercycle or other physical fitness equipment.
D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home, e.g. parallel bars.
E. Environmental control equipment. Any device such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.

F. Eyeglasses, contact lenses, dental prostheses or appliances, or hearing aids. Benefits for eyeglasses and contact lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.
G. Corrective shoes, unless they are an integral part of the lower body brace, shoe lifts or special shoe accessories.
H. Medical equipment/supplies of an expendable nature, except those specifically listed as a Covered Medical Supply in this Description of Covered Services. Non-covered supplies include incontinence pads or ace bandages.

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given in the benefit plan.

Prescription Drug Exclusions

Benefits will not be provided under this rider for:

1. Any devices, appliances, supplies, and equipment except as otherwise provided in the Evidence of Coverage.
2. Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities.
3. Prescription Drugs for cosmetic use.
4. Prescription Drugs administered by a physician or dispensed in a physician's office.
5. Drugs, drug therapies or devices that are considered Experimental/Investigational by CareFirst BlueChoice.
6. Except for items included on the Preventive Drug List, Over-the-Counter medications or supplies lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a Prescription Drug.
7. Vitamins, except CareFirst BlueChoice will provide a benefit for Prescription Drug:
   a. Prenatal vitamins.
   b. Fluoride and fluoride containing vitamins.
   c. Single entity vitamins, such as Rocaltrol and DHT.
   d. Vitamins included on the Preventive Drug List.
8. Infertility drugs and agents for use in connection with infertility services or treatments that are excluded from coverage under the Evidence of Coverage to which this rider is attached.
9. Any portion of a Prescription Drug that exceeds:
   a. a thirty-four (34) day supply for Prescription Drugs; or,
   b. a ninety (90) day supply for Maintenance Drugs unless authorized by CareFirst BlueChoice.
10. Prescription Drugs that are administered or dispensed by a health care facility for a Member who is a patient in the health care facility. This exclusion does not apply to Prescription Drugs that are dispensed by a Pharmacy on the health care facility's premises for a Member who is not a patient in the health care facility.
11. Prescription Drugs for weight loss.
12. Biologicals and allergy extracts.
13. Blood and blood products. (May be covered under the medical benefits in the Evidence of Coverage to which this rider is attached.)

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Medical Limitations and Exclusions—CareFirst BlueCross BlueShield

10.1 General Exclusions

Coverage is not provided for the following:

A. Any service, test, procedure, supply, or item which CareFirst determines not necessary for the prevention, diagnosis or treatment of the Member's illness, injury, or condition. Although a service may be listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in the Member's particular case.
B. Any treatment, procedure, facility, equipment, drug, drug usage, device, or supply which, in the judgment of CareFirst, is Experimental/Investigational, or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment, except for covered benefits for Clinical Trials.
C. The cost of services that are furnished without charge or are normally furnished without charge if a Member was not covered under the Evidence of Coverage or under any health insurance, or any charge or any portion of a charge which by law the provider is not permitted to bill or collect from the Member directly.
D. Any service, supply, or procedure that is not specifically listed in the Member's Evidence of Coverage as a covered benefit or that does not meet all other conditions and criteria for coverage as determined by CareFirst.
E. Services that are beyond the scope of the license of the provider performing the service.
F. Routine foot care, including services related to hygiene or any services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet, or partial removal of a nail without the removal of its matrix. However, benefits will be provided for these services if CareFirst determines that medical attention was needed because of a medical condition affecting the feet, such as diabetes and, that all other conditions for coverage have been met.
G. Any type of dental care (except treatment of accidental injuries, oral surgery, and cleft lip, cleft palate, or ectodermal dysplasia, as described in this Description of Covered Services) including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess, removal of impacted teeth, orthodontia, false teeth, or any other dental services or supplies, unless provided in a separate rider or amendment to this Evidence of Coverage. Benefits for oral surgery are Section 2.21 in the Outpatient and Office Services Section of this Description of Covered Services. All other procedures involving the teeth or areas surrounding the teeth, including shortening of the mandible or maxillae for Cosmetic purposes or for correction of malocclusion unrelated to a functional impairment are excluded.
H. Cosmetic surgery (except benefits for Reconstructive Breast Surgery or reconstructive surgery) or other services primarily intended to correct, change, or improve appearances. Cosmetic means a service or supply which is provided with the primary intent of improving appearances and not for the purpose of restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention as determined by CareFirst.
I. Treatment rendered by a Health Care Provider who is the Member's Spouse, parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or resides in the Member's home.
J. Any prescription drugs, unless administered to the Member in the course of covered outpatient or inpatient treatment or unless the prescription drug is specifically identified as covered. Take-home prescriptions or medications, including self-administered injections which can be administered by the patient or by an average individual who does not have medical training, or medications which do not medically require administration by or under the direction of a physician are not covered, even though they may be dispensed or administered in a physician or provider office or facility, unless the take-home prescription or medication is specifically identified as covered. Benefits for prescription drugs may be available through a rider or amendment purchased by the Group and attached to the Evidence of Coverage.
K. All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies routinely obtained and self-administered by the Member, except for the CareFirst benefits described in this Evidence of Coverage and diabetic supplies.
L. Food and formula consumed as a sole source or supplemental nutrition, except as listed as a Covered Service in this Description of Covered Services.
M. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
N. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.
O. Fees and charges relating to fitness programs, weight loss or weight control programs, physical, pulmonary conditioning programs or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education, except for diabetes outpatient self-management training and educational services. Cardiac rehabilitation programs are covered as described in this Evidence of Coverage.

P. Medical and surgical treatment for obesity and weight reduction, except in the instance of Morbid Obesity.
Q. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof. Benefits for vision may be available through a rider or amendment purchased by the Group and attached to the Evidence of Coverage.
R. Services solely based on a court order or as a condition of parole or probation, unless approved by CareFirst.
S. Health education classes and self-help programs, other than birthing classes or those for the treatment of diabetes.
T Acupuncture services, except when approved or authorized by CareFirst when used for anesthesia.
U. Any service related to recreational activities. This includes, but is not limited to, sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst even though they may have therapeutic value or be provided by a Health Care Practitioner.
V. Any service received at no charge to the Member in any federal hospital or facility, or through any federal, state, or local governmental agency or department, not including Medicaid. (This exclusion does not apply to care received in a Veteran's hospital or facility unless that care is rendered for a condition that is a result of the Member's military service.)
W. Private Duty Nursing.
X. Non-medical, provider services, including but not limited to:
    1. Telephone consultations, failure to keep a scheduled visit, completion of forms, copying charges, or other administrative services provided by the Health Care Practitioner or the Health Care Practitioner's staff.
    2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Evidence of Coverage are available for Covered Services rendered to the Member by a Health Care Provider.
Y. Speech Therapy, Occupational Therapy, or Physical Therapy, unless CareFirst determines that the condition is subject to improvement. Coverage does not include non-medical Ancillary Services such as vocational rehabilitation, employment counseling, or educational therapy.
Z. Services or supplies for injuries or diseases related to a covered person's job to the extent the covered person is required to be covered by a workers' compensation law.
AA. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst, and services listed under the Section 2.14 Transplants Section of this Description of Covered Services), whether or not recommended by an Eligible Provider.
BB. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.
CC. Contraceptive drugs or devices, unless specifically identified as covered in this Evidence of Coverage, or in a rider or amendment to this Evidence of Coverage.
DD. Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.
EE. Services, drugs, or supplies the Member receives without charge while in active military service.
FF. Habilitative Services delivered through early intervention and school services.
GG. Custodial Care.
HH. Coverage does not include non-medical Ancillary Services, such as vocational rehabilitation, employment counseling, or educational therapy.
II. Services or supplies received before the effective date of the Member's coverage under this Evidence of Coverage.
JJ. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
KK. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.
LL. Work Hardening Programs. Work Hardening Program means a highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

10.2 Infertility Services .
Benefits will not be provided for any assisted reproductive technologies including artificial insemination, as well as in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same.

10.3 Transplants
Benefits will not be provided for the following:
A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary non-Experimental/ Investigational skin grafts.
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.
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 Description of Covered Services.

10.4 Inpatient Hospital Services
Coverage is not provided (or benefits are reduced, if applicable) for the following:
A. Private room, unless Medically Necessary and authorized or approved by CareFirst. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.
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 (other than Medically Necessary Ancillary Services) that had not been approved by CareFirst, whether or not services are Medically Necessary and/or meet all other conditions for coverage.
D. Private Duty Nursing.

10.5 Home Health Services
Coverage is not provided for:
A. Private Duty Nursing.
B. Custodial Care.

10.6 Hospice Services
Benefits will not be provided for the following:
A. Services, visits, medical equipment, or supplies not authorized by CareFirst.
B. Financial and legal counseling.
C. Any services for which a Qualified Hospice Program does not customarily charge the patient or his or her family.
D. Reimbursement for volunteer services.
E. Chemotherapy or radiation therapy, unless used for symptom control.
F. Services, visits, medical equipment, or supplies that are not required to maintain the comfort and manage the pain of the terminally ill Member.
G. Custodial Care, domestic, or housekeeping services.

10.7 Medical Devices and Supplies
Benefits will not be provided for purchase, rental, or repair of the following:
A. Convenience items. Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for a Member (e.g., an exercycle or other physical fitness equipment, elevators, hoyer lifts, shower/bath bench).
B. Furniture items, movable objects or accessories that serve as a place upon which to rest (people or things) or in which things are placed or stored (e.g., chair or dresser).
C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body, (e.g., exercycle or other physical fitness equipment).
D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home (e.g., parallel bars).

E. Environmental control equipment. Equipment that can be used for non-medical purposes, such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.
F. Eyeglasses or contact lenses (except when used as a prosthetic lens replacement for aphakic patients as in this Evidence of Coverage), dental prostheses or appliances (except for Medically Necessary treatment of Temporomandibular Joint Syndrome (TMJ)).
G. Corrective shoes (unless required to be attached to a leg brace), shoe lifts, or special shoe accessories.
H. Medical equipment/supplies of an expendable nature, except as specifically listed as a Covered Medical Supply in this Evidence of Coverage. Non-covered supplies include incontinence pads or ace bandages.

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given in the benefit plan.

Prescription Drug Exclusions

Benefits will not be provided under this rider for:

1. Any devices, appliances, supplies, and equipment except as otherwise provided in Evidence of Coverage.
2. Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities.
3. Prescription Drugs for cosmetic use.
4. Prescription Drugs administered by a physician or dispensed in a physician's office.
5. Drugs, drug therapies or devices that are considered Experimental/Investigational by CareFirst.
6. Except for items included on the Preventive Drug List, Over-the-Counter medications or supplies lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a Prescription Drug.
7. Vitamins, except CareFirst will provide a benefit for Prescription Drug:
   a. Prenatal vitamins.
   b. Fluoride and fluoride containing vitamins.
   c. Single entity vitamins, such as Rocaltrol and DHT.
   d. Vitamins included on the Preventive Drug List.
8. Infertility drugs and agents for use in connection with infertility services or treatments that are excluded from coverage under the Evidence of Coverage to which this rider is attached.
9. Any portion of a Prescription Drug that exceeds:
   a. a thirty-four (34) day supply for Prescription Drugs; or,
   b. a ninety (90) day supply for Maintenance Drugs unless authorized by CareFirst.
10. Prescription Drugs that are administered or dispensed by a health care facility for a Member who is a patient in the health care facility. This exclusion does not apply to Prescription Drugs that are dispensed by a Pharmacy on the health care facility's premises for a Member who is not a patient in the health care facility.
11. Prescription Drugs for weight loss.
12. Biologicals and allergy extracts.
13. Blood and blood products. (May be covered under the medical benefits in the Evidence of Coverage to which this rider is attached.)

Not all services and procedures are covered by your benefits contract. This list is a summary and is not intended to itemize every procedure not covered by CareFirst BlueCross BlueShield. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Pharmacy Program Summary of Benefits for Qualified Health Plan (QHP) with HSA

Formulary 2 ■ 3-Tier ■ Integrated Deductible ■ 10%/20%/30%

Plan Feature	Amount You Pay	Description
Individual Deductible	$1,600	Integrated with medical
Family Deductible	$3,200	Integrated with medical
Out-of-Pocket Maximum	$6,500 Individual and $13,000 Family	Integrated with medical. All deductibles, copays, coinsurance and other eligible out-of-pocket costs count toward your out-of-pocket maximum, except balance billed amounts.
Preventive Drugs (up to a 34-day supply)	$0	A preventive drug is a prescribed medication or item on CareFirst's Preventive Drug List.*
Oral Chemotherapy Drugs and Diabetic Supplies (up to a 34-day supply)	$0	Diabetic supplies include needles, lancets, test strips and alcohol swabs.
Generic Drugs (Tier 1) (up to a 34-day supply)	10% coinsurance	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (up to a 34-day supply)	20% coinsurance	All preferred brand drugs are covered at this copay level.
Non-preferred Brand Drugs (Tier 3) (up to a 34-day supply)	30% coinsurance	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Discuss using alternatives with your physician or pharmacist.
Restricted Generic Substitution If a provider prescribes a non-preferred brand drug when a generic is available, you will pay the non-preferred brand copay PLUS the cost difference between the generic and brand drug up to the cost of the prescription. If a generic version is not available, you will only pay the copay. Also, if your prescription is written for a brand-name drug and DAW (dispense as written) is noted by your doctor, you will only pay the non-preferred brand copay and not the cost difference between the generic and brand drug.		
Maintenance Drugs (up to a 90-day supply)	Generic: 10% Preferred Brand: 20% Non-preferred Brand: 30%	Maintenance drugs up to a 90-day supply are available through Mail Service or a CVS Retail Pharmacy
Visit **carefirst.com/acps** *for the most up-to-date drug lists, including the prescription guidelines. Prescription guidelines indicate drugs that require your doctor to obtain prior authorization from CareFirst before they can be filled and drugs that can be filled in limited quantities.*		

This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Policy Form Numbers: VA/CFBC/RX3 (R. 8/12) • VA/CF/RX3 (R. 8/12)

Infertility medication covered up to a maximum of $30,000 per lifetime.

Benefit designs are subject to and may be impacted by certain state regulations.

Non-Contracting Pharmacy: If the Member purchases a Prescription Drug Covered Service or Diabetic Supply from a Non-Contracting Pharmacy, the Member is responsible for paying the total charge and Submitting a claim to CareFirst or its designee for reimbursement. Members will be entitled to reimbursement from CareFirst or its designee up to the amount of the Allowed Benefit, minus any applicable Member payment amounts, as stated in the Schedule of Benefits. Members may be responsible for balances above the Allowed Benefit.

Non-Contracting Pharmacy means a Pharmacist or Pharmacy that does not contract with CareFirst or its designee.

Below are limitations and exclusions contained in your CareFirst BlueChoice or CareFirst medical policy to which the prescription rider is attached.

Medical Limitations and Exclusions—CareFirst BlueChoice

10.1 Coverage is Not Provided For:

A. Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst BlueChoice.
B. Services that are Experimental/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.
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 the Member was not covered under the Evidence of Coverage or under any health insurance.
D. Services that are not described as covered in the Evidence of Coverage or that do not meet all other conditions and criteria for coverage, as determined by CareFirst BlueChoice. Referral by a Primary Care Physician and/or the provision of services by a Contracting Provider does not, by itself, entitle a Member to benefits if the services are not covered or do not otherwise meet the conditions and criteria for coverage.
E. Except for Emergency Services, Urgent Care and follow-up care after emergency surgery, benefits will not be provided for any service(s) provided to a Member by Non-Contracting Physicians or Non-Contracting Providers, unless written prior 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 above, dental care including extractions; treatment of cavities; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia, except for the treatment of a cleft lip or cleft palate; false teeth; or any other dental services or supplies. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
H. Benefits will not be provided for cosmetic surgery (except as specifically provided for reconstructive breast surgery and reconstructive surgery as listed above) or other services primarily intended to correct, change or improve appearances.
I. Treatment rendered by a health care provider who is a member of the Member's family (parents, spouse, brothers, sisters, children).
J. Any prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage. 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 a rider purchased by the Group and attached to the Evidence of Coverage.
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. 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.
L. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
M. Services to reverse voluntary, surgically induced infertility, such as a reversal of a sterilization.
N. All assisted reproductive technologies (except artificial insemination and intrauterine insemination), including in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same unless covered under a rider purchased by the Group and attached to the Evidence of Coverage.
O. Fees or charges relating to fitness programs, weight loss or weight control programs; physical conditioning; pulmonary rehabilitation programs; exercise programs; and use of passive or patient-activated exercise equipment.
P. Treatment for obesity except for the surgical treatment of Morbid Obesity.
Q. 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.
R. Services furnished as a result of a referral prohibited by law.
S. 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.
T. Health education classes and self-help programs, other than birthing classes or for the treatment of diabetes.
U. Acupuncture services except when approved or authorized by CareFirst BlueChoice when used for anesthesia.
V. Any service related to recreational activities. This includes, but is not limited to sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst BlueChoice even though they may have therapeutic value or be provided by a health care provider.
W. Coverage under this Description of Covered Services does not include the cost of services or payment for services for any illness, injury or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:
   1. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or
   2. From any federal, state, county or municipal facility or other government agency, including, in the case of service-connected disabilities, the Veterans Administration, to the extent that Benefits are payable by the federal, state, county or municipal facility or other government agency and provided at no charge to the Member, but excluding Medicare benefits and Medicaid benefits.

   Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for benefits.
X. Private duty nursing.
Y. Non-medical, health care provider services, including, but not limited to:
   1. Telephone consultations, failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the health care practitioner or the healthcare practitioner's staff.
   2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Description of Covered Services are available for Covered Services rendered to the Member by a health care provider.
Z. Educational therapies intended to improve academic performance.
AA. Vocational rehabilitation and employment counseling.
BB. Routine eye examinations, frames and lenses or contact lenses. Benefits for routine eye examinations, frames and lenses or contact lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.
CC. Custodial, personal, or domiciliary care that is provided to meet the activities of daily living, e.g., bathing, toileting and eating (care which may be provided by persons without professional medical skills or training).

DD. 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.
EE. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.
FF. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst BlueChoice, and CareFirst BlueChoice approved services listed in the Transplants section of this Description of Covered Services).
GG. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
HH. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

10.2 Infertility Services.
Coverage for Artificial Insemination (and intrauterine insemination) does not include the following:
A. Any costs associated with freezing, storage or thawing of sperm for future attempts or other use.
B. Any charges associated with donor sperm.
C. Infertility services that include the use of any surrogate or gestational carrier service.
D. Infertility services when the infertility is a result of elective male or female surgical sterilization procedures, with or without reversal.
E. Infertility services for domestic partners or common law spouses, except in those states that recognize those unions.
F. All self-administered fertility drugs.

10.3 Organ and Tissue Transplants.
Benefits will not be provided for the following:
A. Non-human organs and their implantation.
B. Any Hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.
C. Any charges related to transportation, lodging, and meals unless authorized or approved by 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 this Description of Covered Services.

10.4 Inpatient Hospital Services.
Coverage is not provided for the following:
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, phone rentals, guest trays and laundry charges.
C. Except for covered Emergency Services and Childbirth, 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.

10.5 Home Health 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.

10.6 Hospice Benefits.
Coverage is not provided for:
A. Services, visits, medical equipment or supplies that are not included in the 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.

10.7 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. Mental retardation, after diagnosis.
D. Psychoanalysis.

10.8 Inpatient Mental Health and Substance.
The following services are excluded:
A. Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.
B. Custodial Care.
C. Observation or isolation.

10.9 Emergency Services and Urgent Care.
Benefits will not be provided for:
A. Emergency care if the Member could have foreseen the need for the care before it became urgent (for example, periodic chemotherapy or dialysis treatment).
B. Medical services rendered outside of the Service Area which could have been foreseen by the Member prior to departing the Service Area.
C. Charges for emergency and Urgent Care services received from a Non-Contracting Provider after the Member could reasonably be expected to travel to the nearest Contracting Provider.
D. Charges for services when the claims filing and notice procedures stated in Section 7 of this Description of Covered Services have not been followed by the Member.
E. 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.
F. Except for covered ambulance services, travel, including travel required to return to the Service Area, whether or not recommended by a Contracting Provider.
G. Treatment received in an emergency department to treat a health care problem that does not meet the definition of Emergency Services as defined in Section 7 of this Description of Covered Services.

10.10 Medical Devices and Supplies.
Coverage is not provided for:
A. 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.
B. Furniture items. Movable articles or accessories which serve as a place upon which to rest (people or things) or in which things are placed or stored, e.g. chair or dresser.
C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body, e.g. exercycle or other physical fitness equipment.
D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home, e.g. parallel bars.
E. Environmental control equipment. Any device such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.

F. Eyeglasses, contact lenses, dental prostheses or appliances, or hearing aids. Benefits for eyeglasses and contact lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.
G. Corrective shoes, unless they are an integral part of the lower body brace, shoe lifts or special shoe accessories.
H. Medical equipment/supplies of an expendable nature, except those specifically listed as a Covered Medical Supply in this Description of Covered Services. Non-covered supplies include incontinence pads or ace bandages.

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given in the benefit plan.

Prescription Drug Exclusions

Benefits will not be provided under this rider for:

1. Any devices, appliances, supplies, and equipment except as otherwise provided in the Evidence of Coverage.
2. Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities.
3. Prescription Drugs for cosmetic use.
4. Prescription Drugs administered by a physician or dispensed in a physician's office.
5. Drugs, drug therapies or devices that are considered Experimental/Investigational by CareFirst BlueChoice.
6. Except for items included on the Preventive Drug List, Over-the-Counter medications or supplies lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a Prescription Drug.
7. Vitamins, except CareFirst BlueChoice will provide a benefit for Prescription Drug:
   a. Prenatal vitamins.
   b. Fluoride and fluoride containing vitamins.
   c. Single entity vitamins, such as Rocaltrol and DHT.
   d. Vitamins included on the Preventive Drug List.
8. Infertility drugs and agents for use in connection with infertility services or treatments that are excluded from coverage under the Evidence of Coverage to which this rider is attached.
9. Any portion of a Prescription Drug that exceeds:
   a. a thirty-four (34) day supply for Prescription Drugs; or,
   b. a ninety (90) day supply for Maintenance Drugs unless authorized by CareFirst BlueChoice.
10. Prescription Drugs that are administered or dispensed by a health care facility for a Member who is a patient in the health care facility. This exclusion does not apply to Prescription Drugs that are dispensed by a Pharmacy on the health care facility's premises for a Member who is not a patient in the health care facility.
11. Prescription Drugs for weight loss.
12. Biologicals and allergy extracts.
13. Blood and blood products. (May be covered under the medical benefits in the Evidence of Coverage to which this rider is attached.)

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Medical Limitations and Exclusions—CareFirst BlueCross BlueShield

10.1 General Exclusions

Coverage is not provided for the following:

A. Any service, test, procedure, supply, or item which CareFirst determines not necessary for the prevention, diagnosis or treatment of the Member's illness, injury, or condition. Although a service may be listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in the Member's particular case.
B. Any treatment, procedure, facility, equipment, drug, drug usage, device, or supply which, in the judgment of CareFirst, is Experimental/Investigational, or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment, except for covered benefits for Clinical Trials.
C. The cost of services that are furnished without charge or are normally furnished without charge if a Member was not covered under the Evidence of Coverage or under any health insurance, or any charge or any portion of a charge which by law the provider is not permitted to bill or collect from the Member directly.
D. Any service, supply, or procedure that is not specifically listed in the Member's Evidence of Coverage as a covered benefit or that does not meet all other conditions and criteria for coverage as determined by CareFirst.
E. Services that are beyond the scope of the license of the provider performing the service.
F. Routine foot care, including services related to hygiene or any services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet, or partial removal of a nail without the removal of its matrix. However, benefits will be provided for these services if CareFirst determines that medical attention was needed because of a medical condition affecting the feet, such as diabetes and, that all other conditions for coverage have been met.
G. Any type of dental care (except treatment of accidental injuries, oral surgery, and cleft lip, cleft palate, or ectodermal dysplasia, as described in this Description of Covered Services) including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess, removal of impacted teeth, orthodontia, false teeth, or any other dental services or supplies, unless provided in a separate rider or amendment to this Evidence of Coverage. Benefits for oral surgery are Section 2.21 in the Outpatient and Office Services Section of this Description of Covered Services. All other procedures involving the teeth or areas surrounding the teeth, including shortening of the mandible or maxillae for Cosmetic purposes or for correction of malocclusion unrelated to a functional impairment are excluded.
H. Cosmetic surgery (except benefits for Reconstructive Breast Surgery or reconstructive surgery) or other services primarily intended to correct, change, or improve appearances. Cosmetic means a service or supply which is provided with the primary intent of improving appearances and not for the purpose of restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention as determined by CareFirst.
I. Treatment rendered by a Health Care Provider who is the Member's Spouse, parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or resides in the Member's home.
J. Any prescription drugs, unless administered to the Member in the course of covered outpatient or inpatient treatment or unless the prescription drug is specifically identified as covered. Take-home prescriptions or medications, including self-administered injections which can be administered by the patient or by an average individual who does not have medical training, or medications which do not medically require administration by or under the direction of a physician are not covered, even though they may be dispensed or administered in a physician or provider office or facility, unless the take-home prescription or medication is specifically identified as covered. Benefits for prescription drugs may be available through a rider or amendment purchased by the Group and attached to the Evidence of Coverage.
K. All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies routinely obtained and self-administered by the Member, except for the CareFirst benefits described in this Evidence of Coverage and diabetic supplies.
L. Food and formula consumed as a sole source or supplemental nutrition, except as listed as a Covered Service in this Description of Covered Services.
M. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
N. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.
O. Fees and charges relating to fitness programs, weight loss or weight control programs, physical, pulmonary conditioning programs or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education, except for diabetes outpatient self-management training and educational services. Cardiac rehabilitation programs are covered as described in this Evidence of Coverage.

P. Medical and surgical treatment for obesity and weight reduction, except in the instance of Morbid Obesity.
Q. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof. Benefits for vision may be available through a rider or amendment purchased by the Group and attached to the Evidence of Coverage.
R. Services solely based on a court order or as a condition of parole or probation, unless approved by CareFirst.
S. Health education classes and self-help programs, other than birthing classes or those for the treatment of diabetes.
T Acupuncture services, except when approved or authorized by CareFirst when used for anesthesia.
U. Any service related to recreational activities. This includes, but is not limited to, sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst even though they may have therapeutic value or be provided by a Health Care Practitioner.
V. Any service received at no charge to the Member in any federal hospital or facility, or through any federal, state, or local governmental agency or department, not including Medicaid. (This exclusion does not apply to care received in a Veteran's hospital or facility unless that care is rendered for a condition that is a result of the Member's military service.)
W. Private Duty Nursing.
X. Non-medical, provider services, including but not limited to:
   1. Telephone consultations, failure to keep a scheduled visit, completion of forms, copying charges, or other administrative services provided by the Health Care Practitioner or the Health Care Practitioner's staff.
   2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Evidence of Coverage are available for Covered Services rendered to the Member by a Health Care Provider.
Y. Speech Therapy, Occupational Therapy, or Physical Therapy, unless CareFirst determines that the condition is subject to improvement. Coverage does not include non-medical Ancillary Services such as vocational rehabilitation, employment counseling, or educational therapy.
Z. Services or supplies for injuries or diseases related to a covered person's job to the extent the covered person is required to be covered by a workers' compensation law.
AA. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst, and services listed under the Section 2.14 Transplants Section of this Description of Covered Services), whether or not recommended by an Eligible Provider.
BB. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.
CC. Contraceptive drugs or devices, unless specifically identified as covered in this Evidence of Coverage, or in a rider or amendment to this Evidence of Coverage.
DD. Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.
EE. Services, drugs, or supplies the Member receives without charge while in active military service.
FF. Habilitative Services delivered through early intervention and school services.
GG. Custodial Care.
HH. Coverage does not include non-medical Ancillary Services, such as vocational rehabilitation, employment counseling, or educational therapy.
II. Services or supplies received before the effective date of the Member's coverage under this Evidence of Coverage.
JJ. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
KK. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.
LL. Work Hardening Programs. Work Hardening Program means a highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

10.2 Infertility Services .
Benefits will not be provided for any assisted reproductive technologies including artificial insemination, as well as in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same.

10.3 Transplants
Benefits will not be provided for the following:
A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary non-Experimental/ Investigational skin grafts.
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.
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 Description of Covered Services.

10.4 Inpatient Hospital Services
Coverage is not provided (or benefits are reduced, if applicable) for the following:
A. Private room, unless Medically Necessary and authorized or approved by CareFirst. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.
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 (other than Medically Necessary Ancillary Services) that had not been approved by CareFirst, whether or not services are Medically Necessary and/or meet all other conditions for coverage.
D. Private Duty Nursing.

10.5 Home Health Services
Coverage is not provided for:
A. Private Duty Nursing.
B. Custodial Care.

10.6 Hospice Services
Benefits will not be provided for the following:
A. Services, visits, medical equipment, or supplies not authorized by CareFirst.
B. Financial and legal counseling.
C. Any services for which a Qualified Hospice Program does not customarily charge the patient or his or her family.
D. Reimbursement for volunteer services.
E. Chemotherapy or radiation therapy, unless used for symptom control.
F. Services, visits, medical equipment, or supplies that are not required to maintain the comfort and manage the pain of the terminally ill Member.
G. Custodial Care, domestic, or housekeeping services.

10.7 Medical Devices and Supplies
Benefits will not be provided for purchase, rental, or repair of the following:
A. Convenience items. Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for a Member (e.g., an exercycle or other physical fitness equipment, elevators, hoyer lifts, shower/bath bench).
B. Furniture items, movable objects or accessories that serve as a place upon which to rest (people or things) or in which things are placed or stored (e.g., chair or dresser).
C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body, (e.g., exercycle or other physical fitness equipment).
D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home (e.g., parallel bars).

E. Environmental control equipment. Equipment that can be used for non-medical purposes, such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.
F. Eyeglasses or contact lenses (except when used as a prosthetic lens replacement for aphakic patients as in this Evidence of Coverage), dental prostheses or appliances (except for Medically Necessary treatment of Temporomandibular Joint Syndrome (TMJ)).
G. Corrective shoes (unless required to be attached to a leg brace), shoe lifts, or special shoe accessories.
H. Medical equipment/supplies of an expendable nature, except as specifically listed as a Covered Medical Supply in this Evidence of Coverage. Non-covered supplies include incontinence pads or ace bandages.

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given in the benefit plan.

Prescription Drug Exclusions

Benefits will not be provided under this rider for:

1. Any devices, appliances, supplies, and equipment except as otherwise provided in Evidence of Coverage.
2. Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities.
3. Prescription Drugs for cosmetic use.
4. Prescription Drugs administered by a physician or dispensed in a physician's office.
5. Drugs, drug therapies or devices that are considered Experimental/Investigational by CareFirst.
6. Except for items included on the Preventive Drug List, Over-the-Counter medications or supplies lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a Prescription Drug.
7. Vitamins, except CareFirst will provide a benefit for Prescription Drug:
   a. Prenatal vitamins.
   b. Fluoride and fluoride containing vitamins.
   c. Single entity vitamins, such as Rocaltrol and DHT.
   d. Vitamins included on the Preventive Drug List.
8. Infertility drugs and agents for use in connection with infertility services or treatments that are excluded from coverage under the Evidence of Coverage to which this rider is attached.
9. Any portion of a Prescription Drug that exceeds:
   a. a thirty-four (34) day supply for Prescription Drugs; or,
   b. a ninety (90) day supply for Maintenance Drugs unless authorized by CareFirst.
10. Prescription Drugs that are administered or dispensed by a health care facility for a Member who is a patient in the health care facility. This exclusion does not apply to Prescription Drugs that are dispensed by a Pharmacy on the health care facility's premises for a Member who is not a patient in the health care facility.
11. Prescription Drugs for weight loss.
12. Biologicals and allergy extracts.
13. Blood and blood products. (May be covered under the medical benefits in the Evidence of Coverage to which this rider is attached.)

Not all services and procedures are covered by your benefits contract. This list is a summary and is not intended to itemize every procedure not covered by CareFirst BlueCross BlueShield. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Specialty Pharmacy Coordination Program

Helping your employees manage costly, complex health conditions

Specialty drugs are one of the most rapidly growing costs in health care. Members taking these drugs generally require high-touch services and on-going clinical support to help manage their condition.

The program addresses the unique clinical needs for the following conditions: crohn's disease, cystic fibrosis, hemophilia, hereditary angioedema, multiple sclerosis, oncology, rheumatoid arthritis, ulcerative colitis, and selected IVIG conditions.

The CareFirst* Specialty Pharmacy Coordination Program offers the best arrangement for specialty drug management by coordinating member care and needs as part of a comprehensive plan monitored closely by qualified professionals.

Better outcomes, both financially and clinically, are derived from the avoidance of costly breakdowns such as relapses and hospital admissions. Selecting the right pharmacy within a network is an important way to avoid these breakdowns and improve consistency of patient care. CareFirst selected CVS Pharmacy as its Exclusive Specialty Pharmacy Network. Members can get a one-month supply of their specialty medication delivered right to their home or to a CVS Pharmacy retail location for pick up.

To help members achieve the best possible outcomes, the following services are available:

- One-on-one support from a registered nurse specializing in their specific condition
- Comprehensive assessment at program initiation
- Dedicated clinical team that coordinates care with their doctor
- Drug interaction review
- Drug and condition-specific education and counseling on medication adherence, side effects and safety
- Refill reminders
- 24-hour pharmacist assistance

* CareFirst refers to CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. collectively.

SUM2660-1P (8/22)

Ways to Save with Generic Drugs

Take control & save on your drug costs

You can save money on prescription drugs by switching to generics. Generic drugs are proven to be just as safe and effective as their brand-name counterparts. The difference? Name and price.

What are generics?

- Generics work the same as brand-name drugs, but cost much less.
- A generic drug is essentially a copy of a brand-name drug. It contains the same active ingredients and is identical in dosage, safety, strength, how it's taken, quality, performance and intended use.
- Generic drugs are approved by the U.S. Food and Drug Administration (FDA).
- Generic drugs are manufactured in facilities that are required to meet the same FDA standards of good manufacturing practices as brand-name products.[1]

Save by using generic drugs

- Generic drugs are less expensive than brand-name medications.
- A study by the FDA concluded that consumers who are able to replace all their branded prescriptions with generics can save up to 52% on their daily drug costs.[2]

FDA-approved generic drugs account for 90% of the prescriptions dispensed in the U.S. Having more generic drugs available reduces health care costs which increases access to medications and helps prevent shortages.

Here's an example of how much you could save by switching to a generic alternative.

Brand name	Generic name	Average monthly cost* of brand	Average monthly cost* of generic	Monthly savings if using generic
Ambien (10mg)	Zolpidem Tartrate	$474	$1	$473
Coumadin (2mg)	Warfarin Sodium	$169	$8	$161
Singulair (10mg)	Montelukast Sodium	$200	$6	$194

* Costs based on CareFirst BlueCross BlueShield November 2018–April 2019 claims at CVS pharmacies and rounded to the nearest dollar.

[1] FDA, Safety, Efficacy, and Quality Remain Top Priorities as We Continue Our Work to Expand Access to Cost-Saving Generic Drugs for the American Public, https://www.fda.gov/news-events/fda-voices-perspectives-fda-leadership-and-experts/safety-efficacy-and-quality-remain-top-priorities-we-continue-our-work-expand-access-cost-saving, accessed September 16, 2019.

[2] FDA, Savings from Generic Drugs Purchased at Retail Pharmacies, https://www.fda.gov/drugs/resourcesforyou/ucm134205.htm, accessed September 16, 2019.

How do I switch to a generic drug?

You can ask your doctor or pharmacist if any of the prescription medications you are currently taking can be filled with a generic alternative. To find out if there are lower cost drugs available, including generics, which can be used to treat your condition:

- Visit the Drug Search section on **carefirst.com/rxgroup** and review the Preferred Drug List for your formulary.
- Print the list and take it with you to your doctor.
- Ask your doctor if a generic drug could work for you.

How we help you save

To help you get the most savings, our pharmacy benefit manager, CVS Caremark* notifies members by mail about opportunities to save with generic drugs.

- If you fill a prescription for a non-preferred brand drug you will receive a personalized letter from CVS Caremark with available lower-cost generic alternative options plus steps for changing to a generic alternative.
- Plus, a letter will be enclosed that you can take to your doctor on your next visit.

*CVS Caremark is an independent company that provides pharmacy benefit management services.

Maintenance Choice® Program

Options and savings when filling your maintenance medications

Maintenance medications are used to treat chronic, long-term conditions, such as high blood pressure or diabetes, and are taken on a regular, recurring basis. Our Voluntary Maintenance Choice Program allows you to fill your three-month supply of maintenance medications for only two copays.

There are two ways you can fill your three-month supply of maintenance medications:

With CVS Caremark Mail Service, you can:

- Enjoy convenient home delivery service
- Refill your prescriptions online, by phone or email
- Check account balances and make payments through an automated phone system
- Receive email or text notifications of order status
- Access a pharmacist by phone 24 hours a day

At a CVS Pharmacy retail location, you can:

- Access the entire network of CVS pharmacies
- Pick up your medications at a time convenient to you
- Enjoy same-day prescription availability
- Talk with a pharmacist face-to-face

A three-month supply will only be covered through CVS Caremark Mail Service or a CVS Pharmacy retail location. Whether you choose to fill at either option you will only pay the equivalent of two copays for a three-month supply of maintenance medications.

You may also fill a one-month supply of maintenance mediations at any retail pharmacy; however, you will pay the applicable copay for each fill. Therefore, a three-month supply will cost you three copays rather than two copays.

If you would like...	Then...
To register for CVS Mail Service	Choose the option that works best for you: ■ **Online:** Go to **carefirst.com/myaccount** to login or register for My Account. Under the *Coverage tab*, select *Drug and Pharmacy Resources* and select *Request a New Mail Order Prescription*. ■ **By phone:** Call CareFirst Pharmacy Services at 800-241-3371 and our Customer Care representatives can walk you through the process.
To find a CVS Pharmacy retail location	Go to **carefirst.com/myaccount** to login or register for My Account. Click *Drug and Pharmacy Resources* and select *Find a Pharmacy* to find a location convenient for you.

For more information, call CareFirst Pharmacy Services at 800-241-3371.

Mail Service Pharmacy

Reliable. Fast. Convenient.

Take advantage of CVS Caremark Mail Service Pharmacy, a fast and accurate home delivery service that offers a way for you to save both time and money on your long-term (maintenance) prescriptions.*

As a CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc. (CareFirst) member, once you register for Mail Service Pharmacy you'll be able to:

- Refill prescriptions online, by phone or by email
- Schedule automatic refills
- Choose your delivery location
- Consult a pharmacist by phone 24/7
- Receive email notification of order status
- Choose from multiple payment options

It's easy to register for mail service

Choose one of the following three ways:

Online

Go to **carefirst.com/myaccount** and log in. Under the *Coverage* tab, select *Drug and Pharmacy Resources*, and select *Request a New Mail Order Prescription*. Once you've entered your prescription information, we will contact your doctor to request up to a 90-day supply of your medication.

By phone

Call the toll-free phone number on the back of your member ID card. Our Customer Care representatives can walk you through the process.

By mail

If you already have your prescription, you can send it to us with a completed *Mail Service Pharmacy Order Form*. Log in to My Account and select the *Coverage* tab, then choose *Drug and Pharmacy Resources.* Scroll to the bottom of the page and click on *My Drug Forms.* Mailing instructions are included on the form.

* Maintenance medications are used to treat chronic, long-term conditions, such as high blood pressure or diabetes, and are taken on a regular, recurring basis.

BlueDental Plus

Includes access to a national provider network

CareFirst BlueCross BlueShield (CareFirst) offers BlueDental Plus coverage, which allows you the freedom to see any dentist you choose.

Our plusses

- Most plans cover 100% of preventive and diagnostic services
- No claim forms or paperwork to fill out when a member sees a participating dentist
- We coordinate benefits for members with dental coverage from another carrier
- More than 123,000 participating dentists and specialists across the United States.

Our plans

With BlueDental Plus, you'll save the most money by seeing a participating provider.

What's a participating provider?
It's a dentist or specialist who is in our network and accepts our reduced negotiated fees as payment in full. This means no balance for you to pay, keeping your out-of-pocket costs low.

- **Option 1**—By choosing a dentist in the Preferred Provider Network, you pay the lowest out-of-pocket costs. These dentists accept CareFirst's allowed benefit as payment in full. You're only responsible for deductibles and coinsurance. And for your convenience, your provider is reimbursed directly.
- **Option 2**—By choosing a dentist who participates with CareFirst, but not through the Preferred Provider Network, you'll pay slightly higher out-of-pocket costs. Similar to Option 1, there is no balance to pay. You're still responsible for deductibles and coinsurance, and have the convenience of your provider being reimbursed directly.

Can I see a non-participating provider?
Of course. But your out-of- pocket expenses will be highest with providers outside our network. You may have to pay the difference between the dentist's fee and what your plan allows for those services.

Where can I find a dentist?
Visit **carefirst.com/doctor** and select *BlueDental* to view in-network providers.

When do I get my ID card?
Member ID cards are mailed to your home after enrollment. You can also access your ID card—along with other claims and benefit information—at My Account or on the CareFirst mobile app. Visit **carefirst.com/myaccount** to register.

Who can I call with questions about my dental plan?
Call Dental Customer Service toll free at 866-891-2802 between 8 a.m. and 6 p.m. ET, Monday–Friday.

Common dental insurance terms

Deductible: The amount you are responsible for before CareFirst pays for dental services.

Family deductible: A deductible that is satisfied by the combined expenses of all covered family members. For example, a plan with a $25 deductible may be limited to a maximum of three deductibles ($75 per family) regardless of the number of family members.

Coinsurance: Your share of the dentist's fee after CareFirst has paid its share.

Annual maximum: The yearly reimbursement level for an individual/family set by your CareFirst dental plan.

Summary of Benefits

Services	In-network You Pay	Out-of-network You Pay
DEDUCTIBLE APPLIES TO ALL BASIC AND MAJOR SERVICES*	$50 Individual/ $150 Family	$50 Individual/ $150 Family
ANNUAL MAXIMUM APPLIES TO ALL BASIC AND MAJOR SERVICES*	Plan pays $2,000 combined maximum	
PREVENTIVE AND DIAGNOSTIC SERVICES		
▪ Oral Exams (two per benefit period) ▪ Prophylaxis (two cleanings per benefit period) ▪ Bitewing X-rays ▪ Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray (once per 36 months) ▪ Palliative emergency treatment ▪ Fluoride treatments (two per benefit period per member, until the end of the year the member reaches the age 19) ▪ Sealants on permanent molars (once per tooth per 36 months per member, until the end of the year the member reaches the age 19) ▪ Space maintainers (once per 60 months)	No charge	20% of Allowed Benefit[1]
BASIC SERVICES AND MAJOR SERVICES—SURGICAL		
▪ Direct placement fillings using approved materials (one filling per surface per 12 months) ▪ Endodontics (treatment as required involving the root and pulp of the tooth, such as root canal therapy) ▪ Surgical periodontic services including osseous surgery, mucogingival surgery and occlusal adjustments (once per 60 months) ▪ Periodontal scaling and root planing (once per 24 months, one full mouth treatment) ▪ General anesthesia rendered for a covered dental service ▪ Oral surgery (surgical extractions, treatment for cysts, tumor and abscesses, apicoectomy and hemi-section) ▪ Simple extractions	20% of Allowed Benefit after deductible[1]	40% of Allowed Benefit after deductible[1]
MAJOR SERVICES—RESTORATIVE		
▪ Full and/or partial dentures (once per 60 months) ▪ Fixed bridges, crowns, inlays and onlays (once per 60 months) ▪ Denture adjustments and relining (limits apply for regular and immediate dentures) ▪ Recementation of crowns, inlays and/or bridges (once per 12 months) ▪ Repair of prosthetic appliances as required (once in any 12 month period per specific area of appliance) ▪ Dental implants, subject to medical necessity review (once per 60 months)	20% of Allowed Benefit after deductible[1]	40% of Allowed Benefit after deductible[1]
ORTHODONTIC SERVICES		
▪ Benefits for orthodontic services are available for covered members who meet treatment criteria.	50% of Allowed Benefit[1]	50% of Allowed Benefit[1]
ORTHODONTIC LIFETIME MAXIMUM	Plan pays $1,000 combined maximum	

[1] CareFirst payments are based on the CareFirst Allowed Benefit. Participating and Preferred Dentists accept 100% of the CareFirst Allowed Benefit as payment in full for covered services. Non-participating dentists may bill the member for the difference between the Allowed Benefit and their charges.

* Deductible and Annual Maximum Combined In-network/Out-of-network.

Summary of Exclusions: Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

VA Benefits issued under policy form numbers: Group Hospitalization and Medical Services, Inc.: VA/GHMSI/BLUEDENTAL EOC (1/15); VA/GHMSI/BLUEDENTAL DOCS (1/15); VA/GHMSI/BLUEDENTAL SOB (1/15); VA/CF/GC (R.1/13); VA/CF/ELIG (R.1/12) and any amendments.

For more information visit **carefirst.com/acps**

Section 3—Limitations and Exclusions

(in addition to those found in the Evidence of Coverage)

3.1 Limitations.

A. Covered Dental Services must be performed by or under the supervision of a Dentist, within the scope of practice for which licensure or certification has been obtained.
B. Benefits will be limited to standard procedures and will not be provided for personalized restorations or specialized techniques in the construction of dentures or bridges, including precision attachments and custom denture teeth.
C. If a Member switches from one Dentist to another during a course of treatment, or if more than one Dentist renders services for one dental procedure, CareFirst shall pay as if only one Dentist rendered the service.
D. CareFirst will reimburse only after all dental procedures for the condition being treated have been completed (this provision does not apply to orthodontic services).
E. In the event there are alternative dental procedures that meet generally accepted standards of professional dental care for a Member's condition, benefits will be based upon the lowest cost alternative.

3.2 Exclusions. Benefits will not be provided for:

A. Replacement of a denture, bridge, or crown as a result of loss or theft.
B. Replacement of an existing denture, bridge, or crown that is determined by CareFirst to be satisfactory or repairable.
C. Replacement of dentures, bridges, or crowns within 60 months from the date of placement or replacement for which benefits were paid in whole or in part under the terms of the Evidence of Coverage.
D. Treatment or services for temporomandibular joint disorders including but not limited to radiographs and/or tomographic surveys.
E. Gold foil fillings.
F. Dental services in connection with birth defects or mainly for Cosmetic reasons; with the following exceptions:
    1. Benefits will be provided for dental services received by the Member due to trauma to whole Sound Natural Teeth when the dental services are received after the Effective Date of coverage under the Evidence of Coverage only if the Member's medical benefit plan does not provide benefits for such dental services and written proof of denial of a claim for such benefits is submitted to CareFirst, and
    2. Benefits will be provided for dental services in connection with birth defects, including cleft lip or cleft palate or both, only if the Member's medical benefit plan does not provide benefits for such dental services and written proof of denial of a claim for such benefits is submitted to CareFirst.
G. Periodontal appliances.
H. Prescription drugs, including, but not limited to antibiotics administered by the Member, inhalation of nitrous oxide, injected or applied medications that are not part of the dental service being rendered, and localized delivery of chemotherapeutic agents for the treatment of a medical condition, unless specifically listed as a Covered Dental Service in the Description of Covered Services.
I. Splinting.
J. Nightguards, occlusal guards, or other oral orthotic appliances.
K. Bacteriologic studies, histopathologic exams, accession of tissue, caries susceptibility tests, diagnostic radiographs, and other pathology procedures, unless specifically listed as a Covered Dental Service in the Description of Covered Services.
L. Intentional tooth reimplantation or transplantation.
M. Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service, and tissue conditioning.
N. Additional fees charged for visits by a Dentist to the Member's home, to a hospital, to a nursing home, or for office visits after the Dentist's standard office hours. CareFirst shall provide the benefits for the dental service as if the visit was rendered in the Dentist's office during normal office hours.
O. Transseptal fiberotomy or vestibuloplasty.
P. Orthognathic Surgery or other oral Surgery covered under the Member's medical benefit plan.
Q. The repair or replacement of any orthodontic appliance.
R. Any orthodontic services after the last day of the month in which covered services ended except as specifically described in the Description of Covered Services and the Evidence of Coverage.
S. Services or supplies that are not Medically Necessary.
T. Services not specifically listed in the Description of Covered Services as a Covered Dental Service, even if Medically Necessary.
U. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be covered services).
V. Separate billings for dental care services or supplies furnished by an employee of a Dentist which are normally included in the Dentist's charges and billed for by them.
W. Telephone consultations, failure to keep a scheduled visit, completion of forms, or administrative services.
X. Services or supplies that are Experimental or Investigational in nature.
Y. Services, appliances, or supplies related to orthodontic treatment (optional).
Z. Class III, Class IV and Class V services incurred during a Member's Benefit Waiting Period (optional).

How Orthodontic Benefits are Paid

The standard CareFirst orthodontia benefit, if included in the dental plan, covers orthodontic service until the end of the month in which a member reaches age 19, regardless of any treatment that may be in progress. Some plans do not cover orthodontic treatment at all. Your orthodontist will work with you to determine what treatment works best for you and your family.

CareFirst does NOT reduce the lifetime maximum because of a previous dental carrier's payment to the service.

On the following pages are examples of how orthodontic benefits are paid based on different circumstances. These scenarios assume a **Traditional Dental product** with a lifetime maximum benefit of $1,200 and a $3,000 allowed benefit for orthodontic treatment. If the member is receiving treatment from a participating orthodontist, the member and the plan will each pay 50 percent coinsurance of the allowed benefit, with the plan paying up to the orthodontic lifetime maximum benefit amount of $1,200. The member is responsible for the difference between the lifetime maximum and the allowed benefit.

Scenario 1—New orthodontia treatment

The benefit for orthodontic treatment is provided in quarterly installments, and is determined on the anticipated length of treatment, as specified by the orthodontist. Orthodontists will submit one claim for the entire orthodontic course of treatment. Twenty-five percent of the member's lifetime maximum for orthodontic services will be paid upon the initial placement of the bands.

Payments of the remaining allowance will be divided into equal monthly amounts and paid quarterly. Members seeking treatment from a participating orthodontist are responsible for the coinsurance percentage associated with the treatment; the amount of member liability should not exceed the CareFirst allowed benefit. The allowance for the comprehensive treatment will be determined at the time the appliance (e.g. braces, retainer, headgear, etc.) is placed; any increase in allowances that may occur during the course of treatment will not apply to orthodontic cases in progress.

Example #1—Participating orthodontist		
The orthodontic treatment plan costs $5,000 for 24 months.		
CareFirst's initial payment	$300	25% of the member's orthodontic lifetime maximum, $1,200.
CareFirst is responsible for the remaining payment	$900	7 quarterly increments of $117.39 ($900 ÷ 23 months x 3 = $117.39) plus final payment of $78.27 in the 8th quarter.
CareFirst allowed benefit	$3,000	
The member will be liable for	$1,800	$3,000 allowed benefit – $1,200 = $1,800

Example #2—Non-participating orthodontist		
The orthodontic treatment plan costs $5,000 for 24 months.		
CareFirst's initial payment	$300	25% of the member's orthodontic lifetime maximum, $1,200.
CareFirst is responsible for the remaining payment	$900	7 quarterly increments of $117.39 ($900 ÷ 23 months x 3 = $117.39) plus final payment of $78.27 in the 8th quarter.
The member will be liable for any charges in excess of the CareFirst payment	$3,800	$5,000 – $1,200 = $3,800

Scenario 2—CareFirst coverage becomes effective after the start of an ongoing orthodontic treatment plan

Members enrolled after the placement of the appliance (e.g. braces, retainer, headgear, etc.) are eligible to receive orthodontia benefits for the treatment in progress. CareFirst will consider a benefit based on the cost of the remainder of the treatment plan. CareFirst will prorate an orthodontic claim if the banding date is before the members' effective date. Providers will submit the total charges, banding date and number of treatment months for the treatment to be rendered. The prorated payments will be different dependent upon the length of treatment.

Example #1 — 36 month treatment plan, participating orthodontist		
The orthodontic treatment plan costs $5,000 for 36 months and the member had 20 months in treatment prior to CareFirst coverage effective date.		
Monthly treatment plan cost	$138.89	$5,000 ÷ 36 months = $138.89
Total amount CareFirst will not cover for benefit	$2,777.80	$138.89 x 20 months = $2,777.80
New total charge for benefit and what CareFirst and the member will pay over the next 16 months	$2,222.20	$5,000 – 2,777.80 = $2,222.20 $2,222.20 is less than the allowed benefit of $3,000; therefore, CareFirst and the member share the total cost over the remaining 16 months of covered treatment (36 total months of treatment minus 20 months of coverage already received before CareFirst coverage effective date).
Total member is responsible for	$1,111.10	Member is responsible for 50 percent coinsurance ($2,222.20 x 50% = $1,111.10)
Total amount CareFirst is responsible for	$1,111.10	Since the coinsurance is lower than the orthodontic lifetime maximum of $1,200, CareFirst will pay the remaining balance, after the member pays 50 percent coinsurance. CareFirst will make an initial payment of $69.44 ($1,111.10 ÷ 16 months = $69.44) and then 4 quarterly payments of $208.32, plus a final payment of $208.38.

Example #2 — 24 month treatment plan, participating orthodontist		
The orthodontic treatment plan costs $5,000 for 24 months and the member had 20 months in treatment prior to CareFirst coverage effective date.		
Monthly treatment plan cost	$208.33	$5,000 ÷ 24 months = $208.33
Total amount CareFirst will not cover for benefit	$4,166.60	$208.33 x 20 months = $4,166.60
New total charge for benefit and what CareFirst and the member will pay over the next 16 months	$833.40	$5,000 – 4,166.60 = $833.40 $833.40 is less than the allowed benefit of $3,000; therefore, CareFirst and the member share the total cost over the next 4 months of covered treatment (24 total months of treatment minus 20 months of coverage already received before CareFirst coverage effective date).
Total member is responsible for	$416.70	Member is responsible for 50 percent coinsurance ($833.40 x 50% = $416.70)
Total amount CareFirst is responsible for	$416.70	Since the coinsurance is lower than the orthodontic lifetime maximum of $1,200, CareFirst will pay the remaining balance, after the member pays 50 percent coinsurance. CareFirst will make an initial payment of $104.18 ($416.70 ÷ 4 months = $104.18) and then one quarterly payment of $312.52.

This information applies to most standard insured Traditional Dental plans.
This information does not apply to Affordable Care Act (ACA) plans.

Virginia—Limitations and Exclusions GHMSI Traditional Dental Group Contact

(in addition to those found in the Evidence of Coverage)

1.1 Limitations.

A. Covered Dental Services must be performed by or under the supervision of a Dentist, within the scope of practice for which licensure or certification has been obtained

B. Benefits will be limited to standard procedures and will not be provided for personalized restorations or specialized techniques in the construction of dentures or bridges, including precision attachments and custom denture teeth

C. If a Member switches from one Dentist to another during a course of treatment, or if more than one Dentist renders services for one dental procedure, CareFirst shall pay as if only one Dentist rendered the service

D. CareFirst will reimburse only after all dental procedures for the condition being treated have been completed (this provision does not apply to Orthodontic Services) (optional)

E. In the event there are alternative dental procedures that meet generally accepted standards of professional dental care for a Member's condition, benefits will be based upon the lowest cost alternative

1.2 Exclusions. Benefits will not be provided for:

A. Replacement of a denture, bridge, or crown as a result of loss or theft

B. Replacement of an existing denture, bridge, or crown that is determined by CareFirst to be satisfactory or repairable

C. Replacement of dentures, bridges, or crowns within 60 months from the date of placement or replacement for which benefits were paid in whole or in part under the terms of the Contract

D. Treatment or services for temporomandibular joint disorders including but not limited to radiographs and/or tomographic surveys

E. Gold foil fillings

F. Dental services in connection with birth defects or mainly for Cosmetic reasons; with the following exceptions:

   1. Benefits will be provided for dental services received by the Member due to trauma to whole Sound Natural Teeth only if the Member's medical benefit plan does not provide benefits for such dental services and written proof of denial of a claim for such benefits is submitted to CareFirst, and

   2. Benefits will be provided for dental services in connection with birth defects, including cleft lip or cleft palate or both, only if the Member's medical benefit plan does not provide benefits for such dental services and written proof of denial of a claim for such benefits is submitted to CareFirst

G. Periodontal appliances

H. Prescription drugs, including, but not limited to antibiotics administered by the Member, inhalation of nitrous oxide, injected or applied medications that are not part of the dental service being rendered, and localized delivery of chemotherapeutic agents for the treatment of a medical condition, unless specifically listed as a covered service in the Contract

I. Splinting

J. Nightguards, occlusal guards, or other oral orthotic appliances

K. Bacteriologic studies, histopathologic exams, accession of tissue, caries susceptibility tests, diagnostic radiographs, and other pathology procedures, unless specifically listed as a covered service in the Contract

L. Intentional tooth reimplantation or transplantation

M. Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service, and tissue conditioning

N. Additional fees charged for visits by a Dentist to the Member's home, to a hospital, to a nursing home, or for office visits after the Dentist's standard office hours. CareFirst shall provide the benefits for the dental service as if the visit was rendered in the Dentist's office during normal office hours

O. Transseptal fiberotomy or vestibuloplasty

P. Orthognathic Surgery or other oral Surgery covered under the Member's medical benefit plan

Q. The repair or replacement of any orthodontic appliance

R. Any orthodontic services after the last day of the month in which covered services ended except as specifically described in the Evidence of Coverage

S. Services or supplies that are not Medically Necessary

T. Services not specifically shown in the Contract as a Covered Dental Service, even if Medically Necessary

U. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be covered services)

V. Separate billings for dental care services or supplies furnished by an employee of a Dentist which are normally included in the Dentist's charges and billed for by them

W. Telephone consultations, failure to keep a scheduled visit, completion of forms, or administrative services

X. Services or supplies that are Experimental or Investigational in nature

Benefits issued under policy form numbers:

1) Dental Freestanding/Non-Rider contract policy form numbers—Group Regional Traditional Dental:

Group Hospitalization and Medical Services, Inc. (DC jurisdiction): DC/CF/GC (R. 1/13), DC/CF/EOC/D-V (1/12),·DC/ CF/DO-DOCS (R. 10/11), DC/CF/DO-SOB (R. 1/04), DC/CF/ELIG (9/04) and any amendments.

CareFirst of Maryland, Inc. (MD Groups in CFMI Service Area): CFMI/51+/GC (R. 1/13) • CFMI/EOC/D-V (R. 10/11) • CFMI/DENTAL DOCS (R. 9/11) • CFMI/DENTAL SOB (7/09) • CFMI/ELIG/D-V (7/09) and any amendments.

Group Hospitalization and Medical Services, Inc. (MD Groups in GHMSI Service Area): MD/CF/GC (R. 1/13) • MD/CF/EOC/D-V (R. 10/11) • MD/CF/DENTAL DOCS (R. 9/11) • MD/CF/DO-SOB (7/03) • MD/CF/ELIG (R. 1/08) and any amendments.

Group Hospitalization and Medical Services, Inc. (Virginia): VA/CF/GC (R. 1/13) • VA/CF/EOC D-V (1/12) • VA/DN-DOCS (R. 10/11) • VA/CF/DO-SOB (R. 1/04) • VA/CF/ELIG (1/12); and any amendments.

2) Dental Rider policy form numbers—Group Regional Traditional Dental:

CareFirst of Maryland, Inc. Dental Rider (MD Groups in CFMI Service Area): CFMI/51+/DENTAL RIDER (4/09);

Group Hospitalization and Medical Services, Inc. Dental Riders: MD/CF/DENTAL RIDER (R. 4/08); DC/CF/DENTAL RIDER (R. 6/09); VA/CF/DN RDR (R. 6/09).

CareFirst BlueChoice, Inc. Dental Riders: MD/BC/DENTAL RIDER (R. 4/08); DC/BC/DENTAL RIDER (R. 6/09); VA/BC/DN RDR (R. 6/09).

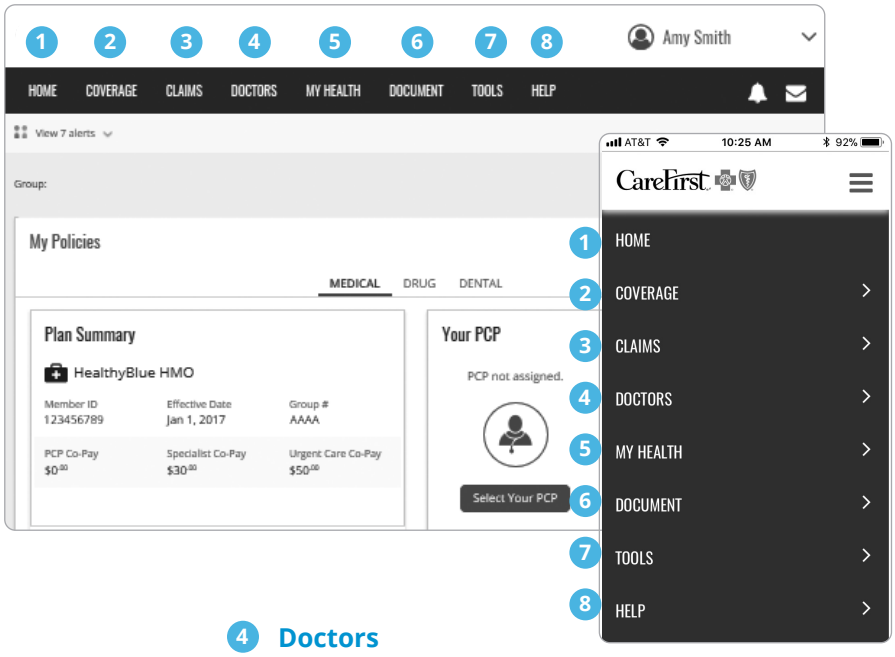
CST4498-1P (3/19)

My Account

It's easy to manage your health care with My Account

As a CareFirst BlueCross BlueShield (CareFirst) member, your personalized benefit information is available 24/7. Register for My Account for secure online access to your coverage details, ID card and more. Plus, you'll also be able to quickly locate in-network providers and facilities nationwide.

Go to **carefirst.com/myaccount** to register.



My Account at a glance

1 Home

- Quickly view plan information including effective date, copays, deductible, out-of-pocket status and recent claims activity
- Manage your personal profile details including password, username and email, or choose to receive materials electronically
- Send a secure message via the *Message Center*
- Check *Alerts* for important notifications

2 Coverage

- Access your plan information—plus, see who is covered
- Update your other health insurance information, if applicable
- View, order or print member ID cards
- Review the status of your health expense account (HSA or FSA)[1]
- Order and refill prescriptions
- View prescription drug claims

3 Claims

- Check your claims activity, status and history
- Review your Explanation of Benefits (EOBs)
- Track your remaining deductible and out-of-pocket total
- Submit out-of-network claims
- Review your year-end claims summary

4 Doctors

- Find in-network providers and facilities nationwide, including specialists, urgent care centers and labs
- Select or change your primary care provider (PCP)
- Locate nearby pharmacies

5 My Health

- Access health and wellness discounts through Blue365
- Learn about your wellness program options[1]
- Track your Blue Rewards progress[1]

6 Documents

- Look up plan forms and documentation[2]
- Download *Vitality*, your annual member resource guide

7 Tools

- Access the Treatment Cost Estimator to calculate costs for services and procedures[3]
- Use the drug pricing tool to determine prescription costs

8 Help

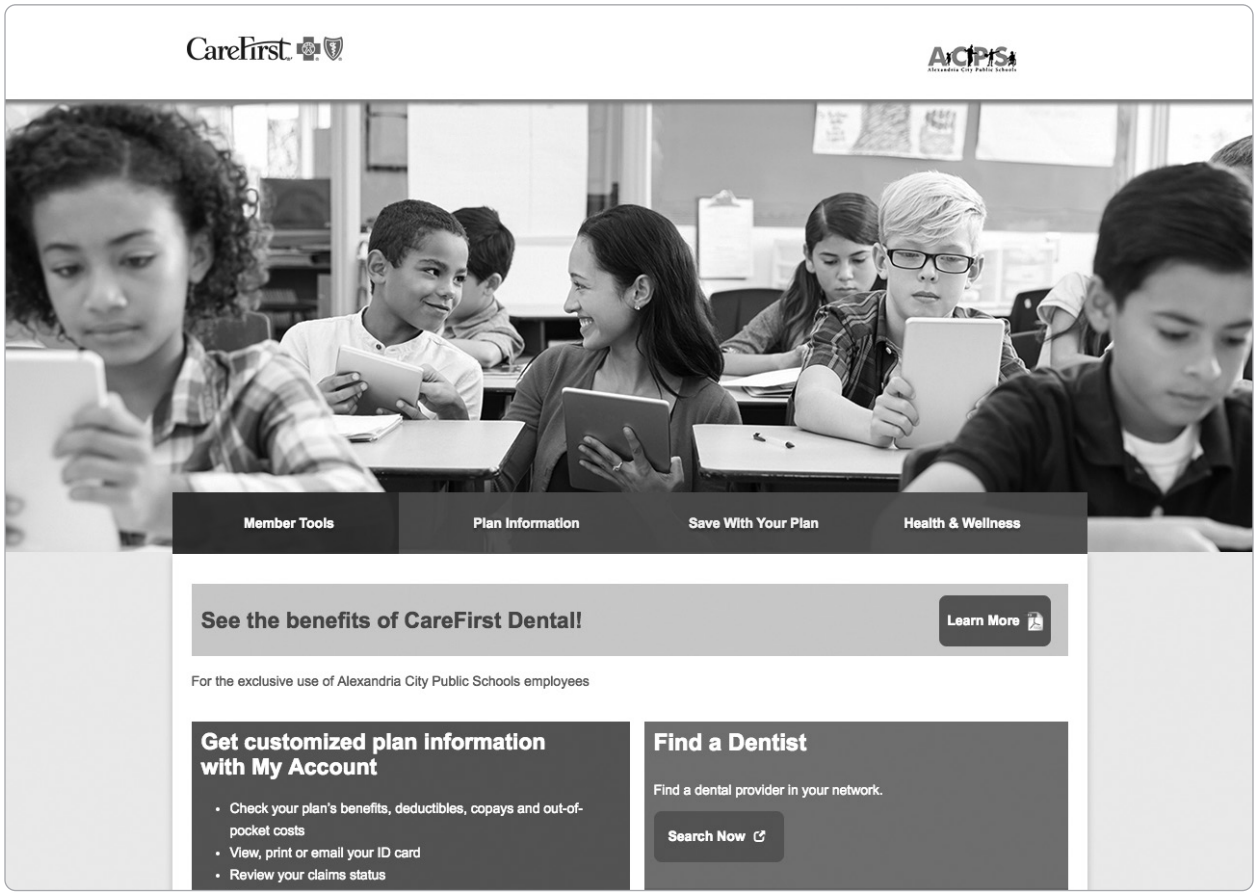
- Find answers to many frequently asked questions
- Send a secure message or locate important phone numbers

[1] Only if offered by your plan.

[2] Only available when using a computer.

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

Your Source For Health Care Information



Benefits include:

- Easy access to My Account—check your plan's benefits, deductibles, copays and out-of-pocket costs
- Find a dentist or locate a pharmacy.
- Look up the details of your plan
- Download or print forms
- Check and compare your prescription costs to help you plan your pharmacy spending.
- Locate essential CareFirst phone numbers
- Learn about health and wellness resources available to you

> **Visit carefirst.com/acps to find information about your health care plan that's personalized for you.**

CST3434-1N (3/19)

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 8/5/19)

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

CareFirst:

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

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

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

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

Civil Rights Coordinator, Corporate Office of Civil Rights

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

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

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

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

Foreign Language Assistance

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

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

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

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

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

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

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

Notice of Nondiscrimination and Availability of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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