HealthyBlue Advantage Platinum 500 Summary of Benefits

Non-Integrated Deductible

Services	In-Network You Pay[1]	Out-of-Network You Pay[1]
	Visit www.carefirst.com/doctor to locate providers and facilities	
24-HOUR NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **www.carefirst.com/needcare** to learn more about your options for care.	When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health questions and treatment options.	
WELLNESS PROGRAM & BLUE REWARDS		
Visit **www.carefirst.com/sharecare** for more information.	You have access to a comprehensive wellness program as part of your medical plan. You also have Blue Rewards, an incentive program where you can get rewarded for completing certain activities.	
ANNUAL MEDICAL DEDUCTIBLE (Benefit Period)[2,3]		
Individual/Family	$500 Individual/$1,000 Family (aggregate)	$1,000 Individual/$2,000 Family (aggregate)
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit Period)[2,4,5]		
Individual/Family	$1,500 Individual/$3,000 Family (aggregate)	$3,000 Individual/$6,000 Family (aggregate)
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	No charge*
Adult Physical Examination (including routine GYN visit)	No charge*	No charge* after deductible
Breast Cancer Screening	No charge*	No charge*
Pap Test	No charge*	No charge* after deductible
Prostate Cancer Screening	No charge*	No charge* after deductible
Colorectal Cancer Screening	No charge*	No charge* after deductible
PCP AND SPECIALIST SERVICES		
FACILITY CHARGE[6]—In addition to the physician copays/coinsurances listed below, if a service is rendered on a hospital campus, ADD facility charge if applicable (also applies to Artificial Insemination and In Vitro Fertilization on page 2)	Deductible, then $50 per visit	Deductible, then $150 per visit
Office Visits for Illness—PCP[6,7]	No charge*	Deductible, then $50 per visit
Office Visits for Illness—Specialist[6,7]	$30 per visit	Deductible, then $50 per visit
Allergy Testing[6]	$30 per visit	Deductible, then $50 per visit
Allergy Shots[6]	$30 per visit	Deductible, then $50 per visit
Physical, Speech, and Occupational Therapy[6] (PT & OT limited to 30 visits each/benefit period when combined; ST limited to 30 visits/benefit period)	$30 per visit	Deductible, then $50 per visit
Chiropractic[6] (limited to 30 visits/benefit period)	$30 per visit	Deductible, then $50 per visit
Acupuncture[6] (limited to 30 visits/benefit period)	$30 per visit	Deductible, then $50 per visit

HealthyBlue Advantage Platinum 500 Summary of Benefits

Services	In-Network You Pay[1]	Out-of-Network You Pay[1]
IMMEDIATE AND EMERGENCY SERVICES		
Convenience Care (retail health clinics such as CVS MinuteClinic or Walgreens Healthcare Clinic)	No charge*	Deductible, then $50 per visit
Urgent Care Center[8] (such as Patient First or ExpressCare)	$50 per visit	$50 per visit
Hospital Emergency Room Services[8]		
■ Facility	$200 per visit (waived if admitted)	$200 per visit (waived if admitted)
■ Physician	$30 per visit	$30 per visit
Ambulance (if medically necessary)[8]	$30 per service	$30 per service
DIAGNOSTIC SERVICES		
Labs[9]		
■ Non-Hospital/Freestanding Facility	No charge*	Deductible, then $50 per visit
■ Hospital	Deductible, then $15 per visit	Deductible, then $80 per visit
X-ray[9]		
■ Non-Hospital/Freestanding Facility	No charge*	Deductible, then $50 per visit
■ Hospital	Deductible, then $30 per visit	Deductible, then $80 per visit
Imaging[9]		
■ Non-Hospital/Freestanding Facility	$100 per visit	Deductible, then $150 per visit
■ Hospital	Deductible, then $200 per visit	Deductible, then $250 per visit
SURGERY AND HOSPITALIZATION—(Members are responsible for both physician and facility fees)		
Outpatient Surgery (Non-Hospital)		
■ Facility	$100 per visit	Deductible, then $200 per visit
■ Physician	$30 per visit	Deductible, then $50 per visit
Outpatient Surgery (Hospital)		
■ Facility	Deductible, then $200 per visit	Deductible, then $300 per visit
■ Physician	Deductible, then $30 per visit	Deductible, then $50 per visit
Inpatient Surgery and Hospital Services		
■ Facility	Deductible, then $500 per admission	Deductible, then $600 per admission
■ Physician	Deductible, then $30 per visit	Deductible, then $50 per visit
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 100 days/benefit period)	No charge*	Deductible, then $50 per visit
Hospice (limited to 180 day hospice eligibility period)	No charge*	Deductible, then $50 per visit
Skilled Nursing Facility (limited to 100 days/admission)	Deductible, then $30 per admission	Deductible, then $50 per admission
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then $50 per visit
Delivery and Facility Services	Deductible, then $500 per admission	Deductible, then $600 per admission
Artificial and Intrauterine Insemination[6,10]	Not covered	Not covered
In Vitro Fertilization Procedures[6,10]	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for both physician and facility fees)		
Office Visits	No charge*	Deductible, then $50 per visit
Outpatient Services		
■ Facility	$30 per visit	Deductible, then $50 per visit
■ Physician	$30 per visit	Deductible, then $50 per visit
Inpatient Services		
■ Facility	Deductible, then $500 per admission	Deductible, then $600 per admission
■ Physician	Deductible, then $30 per visit	Deductible, then $50 per visit

HealthyBlue Advantage Platinum 500 Summary of Benefits

Services	In-Network You Pay[1]	Out-of-Network You Pay[1]
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 25% of Allowed Benefit	Deductible, then 45% of Allowed Benefit
Hearing Aids	Not covered	Not covered
PRESCRIPTION DRUGS[11,12]		
Formulary List	Visit **www.carefirst.com/acarx** to locate Formulary List	
Annual Prescription Drug Deductible	$0	
Preventive Drugs	No charge*	
Diabetic Supplies, Oral Chemo Drugs and Medication Assisted Treatment Drugs	No charge*	
Generic Drugs	30-day & 90-day (maintenance drugs only) supplies - No charge*	
Preferred Brand Drugs[13] (Preferred Insulin $0)	30-day supply $45; 90-day supply $90 (maintenance drugs only)	
Non-preferred Brand Drugs[14] (Non-preferred Insulin capped at $50 for 30 days/$100 for 90 days)	30-day supply $65; 90-day supply $130 (maintenance drugs only)	
Preferred Specialty Drugs (available when purchased through mail order)	30-day supply 50% up to $100 maximum; 90-day supply 50% up to $200 maximum (maintenance drugs only)	
Non-Preferred Specialty Drugs (available when purchased through mail order)	30-day supply 50% up to $150 maximum; 90-day supply 50% up to $300 maximum (maintenance drugs only)	
PEDIATRIC VISION—(Through the end of the calendar year in which the dependent turns 19)		
Routine Exam (limited to 1 visit/benefit period)	No charge*	Total charge minus $40 reimbursement
Frames and Contact Lenses—Pediatric Collection Only	No charge*	Reimbursements apply
Spectacle Lenses	No charge*	Reimbursements apply
PEDIATRIC DENTAL—(Through the end of the calendar year in which the dependent turns 19)		
Annual Dental Deductible	$25	$50
Class I Preventative & Diagnostic Services—Exams (2 per year). Cleanings (2 per year), fluoride treatments (2 per year), sealants, bitewing X-rays (2 per year), full mouth X-ray (one every 3 years)	No charge*	20% of Allowed Benefit
Class II Basic Services—Fillings (amalgam or composite), simple extractions, non-surgical periodontics	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Class III Major Services—Surgical periodontics, endodontics, oral surgery	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Class IV Major Services—Restorative Crowns, dentures, inlays and onlays	Deductible, then 50% of Allowed Benefit	Deductible, then 65% of Allowed Benefit
Class V Medically Necessary Orthodontic Services	50% of Allowed Benefit	65% of Allowed Benefit

Note: Allowed Benefit is the fee that providers in the network have agreed to accept for a particular service. The provider cannot charge the member more than this amount for any covered service. Example: Dr. Carson charges $100 to see a sick patient. To be part of CareFirst's network, he has agreed to accept $50 for the visit. The member will pay their copay/coinsurance and deductible (if applicable) and CareFirst will pay the remaining amount up to $50.

* No copayment or coinsurance.

1 When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.
2 In- and out-of-network deductible and out-of-pocket maximums do not contribute to each other.
3 Aggregate - For family coverage only: The family deductible must be met before any member starts receiving benefits. The deductible may be met by one member or any combination of members.
4 Aggregate - For family coverage only: The family out-of-pocket maximum must be met before any member's services will be covered at 100% up to the Allowed Benefit. The out-of-pocket maximum may be met by one member or any combination of members.
5 All drug costs are subject to the in-network out-of-pocket maximum.
6 If a service is rendered on a hospital campus you could receive two bills, one from the physician and one from the facility.
7 "Telemedicine services" refers to the use of a combination of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Use of audio-only telephone, electronic mail message (e-mail), or facsimile transmission (FAX) is not considered a telemedicine service.
8 If the out-of-network benefit is listed as contributing toward the in-network deductible, then it also contributes toward the in-network out-of-pocket maximum.
9 Members accessing laboratory services inside the CareFirst Service area (Maryland, D.C., Northern Virginia) must use LabCorp as their Lab Test facility and a non-hospital/freestanding facility for X-rays and specialty Imaging for In-Network benefits. Services performed by any other provider, while inside the CareFirst Service area will be considered Out-of-Network. Members accessing laboratory, X-rays, and specialty Imaging services outside of Maryland, D.C. or Northern Virginia, may use any participating BlueCard PPO facility and receive in-network benefits.
10 Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. Preauthorization required.
11 Except for emergency services or out-of-area urgent care, if a member goes to a non-participating pharmacy, the member is responsible for the copay/coinsurance for the drug plus the difference between the allowed charge and the actual charge for that drug (called balance billed amount). The balance billed amount does not contribute to the out-of-pocket maximum.
12 Benefits for Specialty Drugs are only available when Specialty Drugs are purchased from and dispensed by a specialty Pharmacy in the Exclusive Specialty Pharmacy Network.
13 If a Generic drug becomes available for a Preferred Brand drug, the Preferred Brand drug moves to the Non-preferred Brand drug tier.
14 If a provider prescribes a Non-preferred Brand drug, and the Member selects the Non-preferred Brand drug when a Generic drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the Non-preferred Brand drug and the Generic drug up to the cost of the drug. This amount will not contribute to the Out-of-Pocket Maximum.

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

The benefits described are issued under form numbers: VA/CFBC-CF/HB ADV (1/17); VA/CFBC-CF/HB ADV 500/SOB (R. 1/21); VA/CFBC-CF/SG/2021 AMEND (1/21); VA/CFBC-CF/SG/AUTH AMEND/ADV (1/20); VA/CFBC/SG/INCENT (1/21);
VA/CFBC/SG/RX AMEND (1/21); VA/CFBC/DOL APPEAL (R. 1/20); VA/CFBC/SG/SMART SHOP (1/21); VA/GRPAPP/HCR (R. 1/19); VA/CFBC-CF/GC (R. 1/19); SUM5063-1P

CareFirst
Family of health care plans

Exclusions

14.1 General Exclusions Coverage is not provided for:

A. Any services, tests, procedures, or supplies which CareFirst determines are not necessary for the prevention, diagnosis, or treatment of the Member's illness, injury, or condition. Although a service or supply 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 CareFirst's judgment, 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:
   1. Are furnished without charge; or
   2. Are normally furnished without charge to persons without health insurance coverage; or
   3. Would have been furnished without charge if a Member were not covered under the Evidence of Coverage or under any health insurance. This exclusion does not apply to:
      a) Medicaid;
      b) Care received in a Veteran's hospital unless the care is rendered for a condition that is a result of a Member's military service.

D. Any service, supply, drug or procedure that is not specifically listed in the Member's Evidence of Coverage as a covered benefit or that do not meet all other conditions and criteria for coverage as determined by CareFirst, except as required to be covered under state or federal laws and regulations. Provision of services by a health care 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. Routine, palliative, or Cosmetic foot care (except for conditions determined by CareFirst to be Medically Necessary such as care rendered for diabetes or vascular disease), 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.

F. Routine eye examinations and vision services. This exclusion does not apply to evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for infants, children, and adolescents and as listed in Section 3 and Section 1.21.

G. Any type of dental care (except treatment of accidental bodily injuries, oral surgery, cleft lip or cleft palate or both, or ectodermal dysplasia and pediatric dental services listed in the sections noted below), including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess and periodontal disease, removal of teeth, orthodontics, replacement of teeth, or any other dental services or supplies. Benefits for accidental bodily injury are described in Section 1.22.A. Benefits for oral surgery are described in Section 1.23. Benefits for treatment of cleft lip, cleft palate or both or ectodermal dysplasia are described in Section 1.5.E and Section 1.24. Benefits for pediatric dental services are described in Section 2. All other procedures involving the teeth or areas and structures surrounding and/or supporting the teeth, including surgically altering the mandible or maxillae (orthognathic surgery) for Cosmetic purposes or for correction of malocclusion unrelated to a documented 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. This exclusion includes treatment of varicose veins or telangiectatic dermal veins (spider veins) for cosmetic purposes.

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. All non-Prescription Drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained without a prescription and self-administered by the Member, except as listed as a Covered Service above, including but not limited to: cosmetics or health and beauty aids, 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, except for Over-the-Counter medication or supplies dispensed under a written prescription by a health care provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B".

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

L. All assisted reproductive technologies including artificial insemination and intrauterine insemination, 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.

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

N. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.

O. Abortion, except when performed under the following circumstances:
   1. the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself; or
   2. the pregnancy is the result of an alleged act of rape or incest. This exclusion does not apply to plans purchased off of the Exchange.

P. Expenses related to a surrogate pregnancy when the surrogate is not a Member.

Q. Paternity testing.

R. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence and medical therapy.

S. Fees and charges relating to fitness programs, weight loss, or weight control programs, physical 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 self-management training and educational services received as outpatient diabetes care or as part of a covered preventive services visit. This exclusion includes charges for health club memberships, health spa services, exercise classes, and personal trainer services. Cardiac rehabilitation programs are covered as described in Section 1.

T. Medical or surgical treatment for obesity, weight reduction, dietary control, commercial weight loss programs, or medical nutritional therapy for treatment of obesity. This exclusion does not apply to:
   1. Surgical procedures for the treatment of Morbid Obesity;
   2. Well child care visits for obesity evaluation and management;
   3. Evidence-based items or services for preventive care and screening for obesity that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);
   4. For infants, children, and adolescents, evidence-informed preventive care and screening for obesity provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
   5. Office visits for the treatment of childhood obesity.

U. Nutritional counseling and related services, except when provided as part of diabetes education, hospice care, or when received as part of a preventive services screening.

V. Nutritional and/or dietary supplements, except as provided in Section 9 or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased Over the Counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

W. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof.

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

Y. Services that are solely based on court order or as a condition of parole or probation, unless approved by CareFirst.

Z. Health education classes and self-help programs, other than programs for the treatment of diabetes or provided as part of a covered preventive services visit.

AA. Acupuncture services.

BB. 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 provider.

CC. 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.

DD. Non-medical services, including, but is not limited to:
   1. Telephone consultations, failure to keep a scheduled visit, completion of forms (except for forms that may be required by CareFirst), copying charges or other administrative services provided by the health care provider or the health care provider's staff. This exclusion does not apply to telemedicine as described in Section 1.30.
   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 the Evidence of Coverage are available for Covered Services rendered to the Member by a health care provider.

EE. Group Speech Therapy

FF. Non-medical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.

GG. Services, drugs, or supplies the Member receives without charge while in active military service.

HH. Custodial Care.

II. Services or supplies received before the Effective Date of the Member's coverage under the Evidence of Coverage.

JJ. Durable Medical Equipment or Medical 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 program designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

MM. Chiropractic services or spinal manipulation treatment other than spinal manipulation treatment for musculoskeletal conditions of the spine.
NN. Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.
OO. Biofeedback therapy, neurofeedback, and related testing.
PP. Applied behavioral analysis.
QQ. Birthing Centers

14.2 Pediatric Dental Services

A. Limitations
   1. Covered Dental Services must be performed by or under the supervision of a Dentist with an active and unrestricted license, within the scope of practice for which licensure or certification has been obtained.
   2. Benefits will be limited to standard procedures and will not be provided for personalized restorations or specialized techniques in the construction of dentures including precision attachments, custom denture teeth and implant supported fixed or removable prostheses.
   3. 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.
   4. CareFirst will reimburse only after all dental procedures for the condition being treated have been completed (this provision does not apply to orthodontic services).
   5. 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 procedure.

B. Exclusions

   Benefits will not be provided for:
   1. Replacement of a denture or crown as a result of loss or theft.
   2. Replacement of an existing denture or crown that is determined by CareFirst to be satisfactory or repairable.
   3. Replacement of dentures, metal and/or porcelain crowns, inlays, onlays and crown build-ups 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 and are judged by CareFirst to be adequate and functional.
   4. Gold foil fillings.
   5. Periodontal appliances.
   6. Bacteriologic studies, histopathologic exams, accession of tissue, caries susceptibility tests, diagnostic radiographs, and other pathology procedures, unless specifically listed as a Covered Dental Service.
   7. Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service.
   8. 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.
   9. Transseptal fiberotomy.
   10. Orthognathic Surgery.
   11. The repair or replacement of any orthodontic appliance, unless specifically listed as a Covered Dental Service.
   12. Any orthodontic services after the last day of the month in which Covered Dental Services ended except as specifically described in Section 2.
   13. 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.
   14. Transitional orthodontic appliance, including a lower lingual holding arch placed where there is not premature loss of the primary molar.
   15. Limited or complete occlusal adjustments in connection with periodontal surgical treatment when received in conjunction with restorative service on the same date of service.
   16. Orthodontic or any other services for Cosmetic purposes.
   17. Oral orthotic appliances, unless specifically listed as a Covered Dental Service.
   18. Bridges and recementation of bridges.

14.3 Pediatric Vision Services

Benefits will not be provided for the following:

A. Any pediatric vision service stated in Section 3 for Members over age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive covered pediatric vision services through the rest of that Calendar Year.
B. Diagnostic services, except as listed in Section 3.
C. Services or supplies not specifically approved by the Vision Care Designee where required in this Description of Covered Services.
D. Orthoptics, vision training, and low vision aids.
E. Non-prescription (Plano) lenses and/or glasses, sunglasses or contact lenses.
F. Except as otherwise provided, Vision Care services that are strictly Cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
   1. Services and materials not meeting accepted standards of optometric practice.
G. Services and materials resulting from the Member's failure to comply with professionally prescribed treatment.
H. Office infection control charges.
I. State or territorial taxes on vision services performed.
J. Special lens designs or coatings other than those described herein.
K. Replacement of lost and/or stolen eyewear.
L. Two pairs of eyeglasses in lieu of bifocals.
M. Insurance of contact lenses.

14.4 Organ and Tissue 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 that are covered.
B. Any hospital or professional charges related to any accidental injury or medical condition of 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. Donor search services, including compatibility testing of potential donors who are not immediate, blood related family members.
F. Any service, supply, or device related to a transplant that is not listed as a benefit.

14.5 Inpatient Hospital Services

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

A. Private room, unless Medically Necessary and/or 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 health care facility admission or any portion of a health care facility 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.
E. Care provided by interns, residents, or other hospital employees that are billed separately from the hospital.

14.6 Home Health Care Services

Coverage is not provided for:

A. Custodial Care, domestic, or housekeeping services.
B. Meals on Wheels or other similar food service arrangements.

14.7 Hospice Care 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 Care 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. Meals on Wheels or other similar food service arrangements.
G. Rental or purchase of renal dialysis equipment and supplies. Benefits for dialysis equipment and supplies are available in Section 9, Medical Devices and Supplies.

14.8 Mental Health and Substance Use Disorder Services

Coverage is not provided for:

A. Services solely on court order or as a condition of parole or probation unless approved or authorized by the CareFirst Medical Director.
B. Cognitive rehabilitation therapy or coma stimulation therapy.
C. Treatment of social maladjustment without symptoms of a psychiatric disorder.
D. Custodial Care.
E. Remedial or special education services.
F. Inpatient admissions for environmental changes.

14.9 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, and 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 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, dental prostheses, appliances, or hearing aids (including the examinations to prescribe or fit hearing aids), except as otherwise provided herein for cleft lip or cleft palate or both, or ectodermal dysplasia or as stated in Section 1.21, Section 1.22.A.1, Section 2, and Section 3.
G. Corrective shoes (unless required to be attached to a leg brace), shoe lifts, or special shoe accessories or inserts.
H. Tinnitus maskers

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** 0**ን 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 òǵbufọ̀ 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.

हन्दी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य ततथयों का उल्लेख हो और आपके ललए ककसी तनयत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधति सयिता अपनी भाषा में तनःशुल्क पाने का अथकिार है। सदस्यों को अपने पचिान पत्र के पीछे हदए गए फोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के ललए 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 हदया जाएगा।

Ɓǎsɔ́ɔ̀-wùɖù (Bassa) Tò Ɖùǔ Cáo! Bɔ̃ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fù à-fű́á-tìǐn nyɛɛ jè dyí. Bɔ̃ nìà kɛ ɓéɖé wé jɛ́ɛ́ ɓě ɓɛ́ m̀ ké ɖɛ wa mó m̀ ké nyuɛɛ nyu hwɛ̀ 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-wùɖù mú ɓɛ́ m̀ ké se wíɖí ɖò pɛ́è. Kpooɔ̀ nyɔ ɓě mɛ ɖá fű́ùn-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 cɛ ɓɛ́ m̀ ké nɔ̀ɓà mɔ̀à 0 kɛɛ dyi pàɖàìn hwɛ̀. Ɔ jǔ ké nyɔ ɖò dyi m̀ gɔ̃ jǔǐn, po wuɖu m̀ mɔ́ poɛ dyiɛ, ké nyɔ ɖò mu ɓó nììn ɓɛ́ ɔ ké nì wuɖuɔ̀ mú zà.

বাাংলা (Bengali) লক্ষ্য করুন: এই ননাটশি আপনার ববমা কভাশরজ সম্পশক তথ্য রশশে। এর মশযয গুরুত্বপূর্ তাবরখ থাকশত পাশর এবাং বনবদয়ে্ট তাবরশখর মশযয আপনাশক পদশক্ষপ বনশত হশত পাশর। ববনা খরশ বনশজর ভাষা এই তথ্য পাওোর এবাং সহাতো পাওোর অবযকার আপনার আশ। সদসযশদরশক তাশদর পবরপেশরে বপশেন থাকা নম্বশর কল করশত হশব। অশনযরা 855-258-6518 নম্বশর কল কশর 0 টপিশত না বলা পর্ন্ত অশপক্ষা করশত পাশরন। র্খন নকাশনা এশজন্ট উত্তর নদশবন তখন আপনার বনশজর ভাষার নাম বলুন এবাং আপনাশক নদাভাষীর সশ সাংরুক্ত করা হশব।

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 855-258-6518 پر 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 شناسایی شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518 تماس 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。

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 855-258-6518번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Dine Bizaad *(Navajo)* Ge': Dif bee it hane'igif bii' dahǫ́áQ bee eedahǫ́zin beeso ach' h naanil nik'ist'i'fgii ba. Bii' dahǫ́áQQ doo fiyisif yoolkaaligif dǫ́ǫ́ t'aadoo le'e adadoolyłiligii da yǫ́keedgo t'aa doo bee e'e'aahi ajiil'łih. Bee na ahǫ́ǫ́t'i' dii bee it hane' dǫ́ǫ́ nika'adoowot t'aa nfnizaad bee t'aa jiik'e. Atah danilinigif beesh bee hane'e bee wǫ́tta'igif nitt'izgo bee nee hǫ́dolzinfgif bikeed , bikaa' bich'l' hodoonihjĮ́'. Aadǫ́ǫ́ naanata' ef kojl' dahǫ́doolnih įǫ́ǫ́ǫ̨ǫ́ǫ̨ǫ́ǫ́ǫ́ą́į dǫ́ǫ́ yii diitts'llt yattł'łgif t'aa nflefjĮ́ aadǫ́ǫ́ ef bikee'dǫ́ǫ́ naasbc;ác;ás bit adidiilchit. Aka'anidaalwǫ́'fgif neidiit go, saad bee yanitt'i'fgif yii diikit dǫ́ǫ́ ata' halne'e la nfka'adoolwot.