

BlueChoice HMO Summary of Benefits

Arlington Public Schools

Services	In-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.
ANNUAL DEDUCTIBLE (Benefit period)²	
Individual	None
Family	None
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)³	
Medical ⁴	\$2,250 Individual/\$4,500 Family
Prescription Drug ⁴	Combined with medical out-of-pocket maximum
LIFETIME MAXIMUM BENEFIT	
Lifetime Maximum	None
PREVENTIVE SERVICES	
Well-Child Care (including exams & immunizations)	No charge*
Adult Physical Examination (including routine GYN visit)	No charge*
Breast Cancer Screening	No charge*
Pap Test	No charge*
Prostate Cancer Screening	No charge*
Colorectal Cancer Screening	No charge*
OFFICE VISITS, LABS AND TESTING	
Office Visits for Illness ^{5,6}	Virtual Connect through CloseKnit- No charge* (closeknithealth.com) All other providers - \$15 PCP/\$20 Specialist per visit
Imaging (MRA/MRS, MRI, PET & CAT scans) ⁷	\$50 per visit
Lab ⁷	No charge*
X-ray ⁷	No charge*
Allergy Testing	\$15 PCP/\$20 Specialist per visit
Allergy Shots	\$15 PCP/\$20 Specialist per visit
Physical, Speech and Occupational Therapy ⁸ (limited to 30 visits/injury/benefit period)	\$20 per visit
Chiropractic	Not covered
Acupuncture	Not covered (except when approved or authorized by Plan when used for anesthesia)
EMERGENCY SERVICES	
Urgent Care Center	\$20 per visit
Emergency Room—Facility Services	\$50 per visit (waived if admitted)
Emergency Room—Physician Services	No charge*
Ambulance (if medically necessary)	No charge*

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Services	In-Network You Pay ¹
HOSPITALIZATION—(Members are responsible for both physician and facility fees)	
Outpatient Facility Services	\$20 per visit
Outpatient Physician Services	No charge*
Inpatient Facility Services	No charge*
Inpatient Physician Services	No charge*
HOSPITAL ALTERNATIVES	
Home Health Care	No charge*
Hospice	No charge*
Skilled Nursing Facility	No charge*
MATERNITY	
Preventive Prenatal and Postnatal Office Visits	No charge*
Delivery and Facility Services	No charge*
Nursery Care of Newborn	No charge*
Artificial and Intrauterine Insemination ⁹ (limited to 6 attempts per live birth)	50% of Allowed Benefit
In Vitro Fertilization Procedures ⁹	50% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for applicable physician and facility fees)	
Inpatient Facility Services	No charge*
Inpatient Physician Services	No charge*
Outpatient Facility Services	No charge*
Outpatient Physician Services	No charge*
Office Visits ^{5,6}	Virtual Connect through CloseKnit- No charge* (closeknithealth.com) All other providers - \$15 per visit
Medication Management	\$15 per visit
MEDICAL DEVICES AND SUPPLIES	
Durable Medical Equipment	No charge*
Hearing Aids for ages 0-18 (limited to 1 hearing aid per hearing-impaired ear every 36 months)	No charge*
VISION	
Routine Exam (limited to 1 visit/benefit period)	\$10 per visit
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers

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Note: Allowed Benefit is the fee that participating providers in the network have agreed to accept for a particular service. The participating 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 For family coverage only: When one family member meets the individual deductible, they can start receiving benefits. Each family member cannot contribute more than the individual deductible amount. The family deductible must be met before the remaining family members can start receiving benefits.
- 3 For Family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit.
- 4 Plan has integrated medical and prescription drug out-of-pocket maximum.
- 5 "Telemedicine services" refers to the use of interactive audio, including audio-only telephone conversation between a health care provider and the Member when required by law, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Use of e-mail, online questionnaires or Fax is not considered a telemedicine service. Providers will use their professional judgment to determine if a telemedicine visit is appropriate or if an in-person visit is required.
- 6 CloseKnit is a registered Trademark owned by, and is the trade name of, Atlas Health, LLC. Atlas Health, LLC d/b/a CloseKnit does not provide Blue Cross Blue Shield products or services and is providing telehealth services to CareFirst members.
- 7 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.
- 8 Visit Limitation does not apply to children ages 2-10 when Physical, Speech and Occupational Therapy is for treatment of Autism Spectrum Disorder.
- 9 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.

Reminder: To enroll in HMO, HMO Referral and Plus plans, members must live or work within the CareFirst service area of Maryland, Washington, D.C. or Northern Virginia.

Note: Upon enrollment in CareFirst BlueChoice, you will need to select a Primary Care Provider (PCP). To select a PCP, go to www.carefirst.com/findadoc for the most current listing of PCPs from our online provider directory. You may also call the Member Services number on the back of your CareFirst ID card for assistance in selecting a PCP or obtaining a printed copy of the CareFirst BlueChoice provider directory.

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/GC (R. 1/13); VA/CFBC/EOC (R. 1/09); VA/CFBC/DOCS (R. 1/09); VA/BC-OOP/SOB (R. 1/09); VA/BC-OOP/SOB HDHP (9/06); VA/CFBC/BLCRD (R. 1/17); VA/CFBC/HMO/BLCRD (R. 1/17); VA/BC-OOP/VISION (R. 6/04); VA/CFBC/RX3 (R. 1/18); VA/CFBC/ATTC (R. 1/10 and any amendments).



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CST6437-1P (10/23) ■ VA ■ 51+ Option 3



Exclusions and Limitations

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. Services to reverse voluntary, surgically induced infertility, such as a reversal of a sterilization.
- M. 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.
- N. 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.
- O. Treatment for obesity except for the surgical treatment of Morbid Obesity.
- P. 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.
- Q. Services furnished as a result of a referral prohibited by law.
- R. 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.
- S. Health education classes and self-help programs, other than birthing classes or for the treatment of diabetes.

- T. Acupuncture services except when approved or authorized by CareFirst BlueChoice 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 BlueChoice even though they may have therapeutic value or be provided by a health care provider.
- V. 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.

- W. Private duty nursing.
- X. 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.
- Y. Educational therapies intended to improve academic performance.
- Z. Vocational rehabilitation and employment counseling.
- AA. 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.
- BB. 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).
- CC. 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.
- DD. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.
- EE. 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).
- FF. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
- GG. Services required solely for administrative purposes, for example: 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. 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, hoist/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.

Pharmacy Program Summary of Benefits

Arlington Public Schools HMO RX Plan

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.
Out-of-Pocket Maximum	See medical summary of benefits for annual out-of-pocket amount	If you reach your out-of-pocket maximum, CareFirst or CareFirst BlueChoice will pay 100% of the applicable allowed benefit for most covered services for the remainder of the year. 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 30-day supply)	\$0	A preventive drug is a prescribed medication or item on CareFirst's Preventive Drug List at carefirst.com/rx .
Oral Chemotherapy Drugs (up to a 30-day supply)	\$0	Oral chemotherapy drugs are covered at this copay level.
Diabetic Supplies (up to a 30-day supply)	\$0	Diabetic supplies include needles, syringes, lancets, test strips and alcohol swabs.
Insulin (up to a 30-day supply)	Preferred Brand: \$0 Non-preferred Brand: \$50	Preferred insulin is covered at \$0 copay and non-preferred insulin is covered at \$50 copay for a one-month supply.
Generic Drugs (Tier 1) (up to a 30-day supply)	\$20	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (up to a 30-day supply)	\$30	All preferred brand drugs are covered at this copay level.
Non-preferred Brand Drugs (Tier 3) (up to a 30-day supply)	\$45	All non-preferred brand drugs on this copay level are not on the Preferred Drug List at carefirst.com/rx . Discuss using alternatives with your doctor or pharmacist.
Maintenance Drugs (up to a 90-day supply)	Generic: \$40 Preferred Brand: \$60 Non-preferred Brand: \$90	Maintenance generic, preferred brand and non-preferred brand drugs up to a 90-day supply are available for the cost of two one-month supply copays through Mail Service Pharmacy or a retail pharmacy.
Restricted Generic Substitution	If your doctor prescribes a non-preferred brand drug when a generic is available, you will pay the non-preferred brand copay or coinsurance 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 or coinsurance. 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 copay or coinsurance.	
 Visit carefirst.com/rx 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. 1/18) • VA/CF/RX3 (R. 1/18)



CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield Medicare Advantage is the shared business name of CareFirst Advantage, Inc., CareFirst Advantage PPO, Inc. and CareFirst Advantage DSNP, Inc. CareFirst BlueCross BlueShield Community Health Plan Maryland is the business name of CareFirst Community Partners, Inc. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst Advantage, Inc., CareFirst Advantage PPO, Inc., CareFirst Advantage DSNP, Inc., CareFirst Community Partners, Inc., CareFirst BlueCross BlueShield Community Health Plan District of Columbia, CareFirst BlueChoice, Inc., First Care, Inc., and The Dental Network, Inc. are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can see the Glossary at www.carefirst.com/sbcg or call 1-855-258-6518 to request a copy. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.carefirst.com.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-Network: \$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes, all In-Network services are provided without a deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Medical and Prescription Drug combined: In-Network: \$2,250 individual/\$4,500 family.	The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family member(s) on the plan , each family member may need to meet their own out-of-pocket limits , OR all family members may combine to meet the overall family out-of-pocket limit , depending upon plan coverage. Please refer to your contract for further details.
What is not included in the out-of-pocket limit ?	Premiums, balance-billing charges, health care this plan doesn't cover, copayments for certain services, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.carefirst.com or call 855-258-6518 for a list of Network providers.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Provider: \$15 copay per visit Hospital Facility: \$20 copay per visit	Provider & Hospital Facility: Not Covered	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	<u>Specialist</u> visit	Provider & Hospital Facility: \$20 copay per visit	Provider & Hospital Facility: Not Covered	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Retail health clinic	\$20 copay per visit	Not Covered	None
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	Some services may have limitations or exclusions based on your contract
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab Tests: Non-Hospital: \$15 PCP/\$20 Specialist copay per visit Hospital: No Charge X-Ray: Non-Hospital: \$15 PCP/\$20 Specialist copay per visit Hospital: No Charge	Lab Tests: Non-Hospital & Hospital: Not Covered X-Ray: Non-Hospital & Hospital: Not Covered	In-Network Lab Test benefits apply only to tests performed at LabCorp.
	Imaging (CT/PET scans, MRIs)	Non-Hospital: \$15 PCP/\$20 Specialist copay per visit Hospital: \$50 copay per visit	Non-Hospital & Hospital: Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.carefirst.com/rxgroup	Generic drugs	\$20 copay	Paid As In-Network	For all prescription drugs: Prior authorization may be required for certain drugs; No Charge for preventive drugs or contraceptives; Copay applies to up to 30-day supply; Up to 90-day supply of maintenance drugs is 2 copays; Specialty Drugs: Participating Providers: covered when purchased through the Exclusive Specialty Pharmacy Network Non-Participating Providers: Not Covered
	Preferred brand drugs	\$30 copay	Paid As In-Network	
	Non-preferred brand drugs	\$45 copay	Paid As In-Network	
	Preferred Specialty drugs	\$20/\$30/\$45 copay	Not Covered	
	Non-preferred Specialty drugs	\$20/\$30/\$45 copay	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-Hospital & Hospital: \$20 copay per visit	Non-Hospital & Hospital: Not Covered	None
	Physician/surgeon fees	Non-Hospital & Hospital: No Charge	Non-Hospital & Hospital: Not Covered	None
If you need immediate medical attention	Emergency room care	\$50 copay per visit	Paid As In-Network	Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply; Copay waived if admitted
	Emergency medical transportation	\$50 copay per visit	Not Covered	None
	Urgent care	\$20 copay per visit	Not Covered	Limited to unexpected, urgently required services; Copay waived if admitted
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Prior authorization is required
	Physician/surgeon fees	No Charge	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$15 copay per visit Hospital Facility: No Charge	Office Visit & Hospital Facility: Not Covered	For treatment at an Outpatient Hospital Facility, additional charges may apply
	Inpatient services	No Charge	Not Covered	Prior authorization is required; Additional professional charges may apply
If you are pregnant	Office visits	No Charge	Not Covered	For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
	Childbirth/delivery professional services	No Charge	Not Covered	None
	Childbirth/delivery facility services	No Charge	Not Covered	Additional professional charges may apply
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Prior authorization is required
	Rehabilitation services	Provider & Hospital Facility: \$20 copay per visit	Provider & Hospital Facility: Not Covered	If a service is rendered at a Hospital Facility, the additional Facility charge may apply Benefits for Speech, Physical and Occupational Therapies are limited to 30 visits per injury/incident/condition per benefit period
	Habilitation services	Provider & Hospital Facility: \$20 copay per visit	Provider & Hospital Facility: Not Covered	Prior authorization is required If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Skilled nursing care	No Charge	Not Covered	Prior authorization is required
	Durable medical equipment	No Charge	Not Covered	None
	Hospice services	Inpatient and Outpatient Facility: No Charge	Inpatient and Outpatient Facility: Not Covered	Prior authorization is required
If your child needs dental or eye care	Children's eye exam	\$10 copay per visit	Not Covered	Benefits are limited to 1 visit per benefit period
	Children's glasses	Discount programs available to all Members	Not Covered	Benefits are limited to 1 set of glasses/lenses per benefit period
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
• Chiropractic care • Cosmetic surgery	• Coverage provided outside the US. See www.carefirst.com • Dental care (Adult) • Long-term care	• Non-emergency care when travelling outside the US • Routine foot care • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion • Acupuncture • Bariatric surgery	• Hearing aids • Infertility treatment	• Private-duty nursing • Routine eye care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565.

Does this plan provide Minimum Essential Coverage? Yes
[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-258-6518.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-258-6518.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$0
■ Specialist Copayment	\$20
■ Hospital (facility) Copayment	\$0
■ Other Copayment	\$15

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$90
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$10
The total Peg would pay is	\$100

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$0
■ Specialist Copayment	\$20
■ Hospital (facility) Copayment	\$0
■ Other Copayment	\$0

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$610
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$610

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist Copayment	\$20
■ Hospital (facility) Copayment	\$50
■ Other Copayment	\$15

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$260
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$260

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

BluePreferred High Option Plan 90/70 Summary of Benefits

Arlington Public Schools

Services	In-Network You Pay ^{1,2}	Out-of-Network You Pay ^{1,3}
	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.	
WELLBEING PROGRAM		
Visit www.carefirst.com/myaccount for more information.	You have access to a comprehensive wellness program as part of your medical plan.	
ANNUAL DEDUCTIBLE (Benefit period) ⁴		
Individual	\$300	\$750
Family	\$600	\$1,500
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period) ⁵		
Medical ⁶	\$3,000 Individual/\$6,000 Family	\$3,750 Individual/\$7,500 Family
Prescription Drug ⁶	All drug costs are subject to in-network out-of-pocket maximum	All drug costs are subject to in-network out-of-pocket maximum
LIFETIME MAXIMUM BENEFIT		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	Deductible, then 30% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	No charge*	Deductible, then 30% of Allowed Benefit
Breast Cancer Screening	No charge*	Plan pays 100% of Allowed Benefit
Pap Test	No charge*	Deductible, then 30% of Allowed Benefit
Prostate Cancer Screening	No charge*	Deductible, then 30% of Allowed Benefit
Colorectal Cancer Screening	No charge*	Deductible, then 30% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness ^{7,8}	Virtual Connect through CloseKnit- No charge* (closeknithealth.com) All other providers - \$20 PCP/\$40 Specialist copay	Deductible, then 30% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans)	\$100 copay, deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Lab	No charge*	Deductible, then 30% of Allowed Benefit
X-ray	No charge*	Deductible, then 30% of Allowed Benefit
Allergy Testing	\$20 PCP per visit/\$40 Specialist per visit	Deductible, then 30% of Allowed Benefit
Allergy Shots	\$20 PCP per visit/\$40 Specialist per visit	Deductible, then 30% of Allowed Benefit
Physical, Speech and Occupational Therapy (Speech therapy and occupational therapy-unlimited visits; Physical Therapy and Pulmonary Rehabilitation therapy limited to 75 visits per benefit period)	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Chiropractic	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Acupuncture (limited to pain relief, nausea due to chemotherapy/radiation, and hypermesis of pregnancy)	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit

PROPOSED LOW HMO PLAN

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In-Network: \$400 individual/\$800 family	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes, all In-Network preventive care services, as well as the following (non-hospital facilities only, when applicable): Primary care, Specialist, Retail health, Diagnostic testing, Prescription drugs, Emergency room, Urgent care, Mental health outpatient services and Home health care	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	There are no other specific deductibles.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Medical and Prescription Drug combined: In-Network: \$3,000 individual/\$6,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a <u>plan</u> year for covered services. If you have other family member(s) on the <u>plan</u> , each family member may need to meet their own <u>out-of-pocket limits</u> , OR all family members may combine to meet the overall family <u>out-of-pocket limit</u> , depending upon <u>plan</u> coverage. Please refer to your contract for further details.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billing charges, health care this plan doesn't cover, copayments for certain services, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. For a list of Network providers, www.carefirst.com/arlingtonnpublicschool or call 833-630-1157	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Provider: \$30 copay per visit Hospital Facility: Deductible, then \$100 copay per visit, then 20% of Allowed Benefit	Provider & Hospital Facility: Not Covered	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Specialist visit	Provider: \$60 copay per visit Hospital Facility: Deductible, then \$100 copay per visit, then 20% of Allowed Benefit	Provider & Hospital Facility: Not Covered	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Retail health clinic	\$30 copay per visit	Not Covered	None
	Preventive care/screening/immunization	No Charge	Not Covered	Some services may have limitations or exclusions based on your contract
If you have a test	Diagnostic test (x-ray, blood work)	Lab Tests: Non-Hospital: \$30 PCP/\$60 Specialist copay per visit Hospital: Deductible, then 20% of Allowed Benefit X-Ray: Non-Hospital: \$30 PCP/\$60 Specialist copay per visit Hospital: Deductible, then 20% of Allowed Benefit	Lab Tests: Non-Hospital & Hospital: Not Covered X-Ray: Non-Hospital & Hospital: Not Covered	In-Network Lab Test benefits apply only to tests performed at LabCorp.
	Imaging (CT/PET scans, MRIs)	Non-Hospital: \$100 copay per visit	Non-Hospital & Hospital: Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Hospital: Deductible, then \$100 copay per visit, then 20% of Allowed Benefit		
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.carefirst.com/arlingtonpublicschool	Generic drugs	\$4 copay	Paid As In-Network	For all prescription drugs: Prior authorization may be required for certain drugs; No Charge for preventive drugs or contraceptives; Copay applies to up to 30-day supply; Up to 90-day supply of maintenance drugs is 2 copays; Specialty Drugs: Participating Providers: covered when purchased through the Exclusive Specialty Pharmacy Network Non-Participating Providers: Not Covered
	Preferred brand drugs	35% of Allowed Benefit up to a minimum of \$35 and maximum of \$50	Paid As In-Network	
	Non-preferred brand drugs	50% of Allowed Benefit up to a minimum of \$50 and maximum of \$100	Paid As In-Network	
	Preferred Specialty drugs	\$4/35% of Allowed Benefit up to a minimum of \$35 and maximum of \$50/ 50% of Allowed Benefit up to a minimum of \$50 and maximum of \$100	Not Covered	
	Non-preferred Specialty drugs	\$4/35% of Allowed Benefit up to a minimum of \$35 and maximum of \$50/ 50% of Allowed Benefit up to a minimum of \$50 and maximum of \$100	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-Hospital & Hospital: Deductible, then \$100 copay per visit, then 20% of Allowed Benefit	Non-Hospital & Hospital: Not Covered	None
	Physician/surgeon fees	Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	Non-Hospital & Hospital: Not Covered	None
	Emergency room care	\$250 copay per visit	Paid As In-Network	Limited to Emergency Services or unexpected, urgently required services; Additional

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention				professional charges may apply; Copay waived if admitted
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Not Covered	None
	Urgent care	\$50 copay per visit	Not Covered	Limited to unexpected, urgently required services; Copay waived if admitted
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then \$250 copay per admission, then 20% of Allowed Benefit	Not Covered	Prior authorization is required
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$30 copay per visit Hospital Facility: 20% of Allowed Benefit	Office Visit & Hospital Facility: Not Covered	For treatment at an Outpatient Hospital Facility, additional charges may apply
	Inpatient services	Deductible, then \$250 copay per admission, then 20% of Allowed Benefit	Not Covered	Prior authorization is required; Additional professional charges may apply
If you are pregnant	Office visits	No Charge	Not Covered	For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
	Childbirth/delivery professional services	Deductible, then 20% of Allowed Benefit	Not Covered	None
	Childbirth/delivery facility services	Deductible, then \$250 copay per admission, then 20% of Allowed Benefit	Not Covered	Additional professional charges may apply
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Prior authorization is required
	Rehabilitation services	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	Provider & Hospital Facility: Not Covered	If a service is rendered at a Hospital Facility, the additional Facility charge may apply Benefits for Speech, Physical and Occupational Therapies are limited to 30 visits per injury, incident, condition per benefit period

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	Provider & Hospital Facility: Not Covered	Prior authorization is required If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Not Covered	Prior authorization is required
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Not Covered	None
	Hospice services	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	Inpatient and Outpatient Facility: Not Covered	Prior authorization is required
If your child needs dental or eye care	Children's eye exam	\$10 copay per visit	Not Covered	Benefits are limited to 1 visit per benefit period
	Children's glasses	Discount programs available to all Members	Not Covered	Benefits are limited to 1 set of glasses/lenses per benefit period
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- Chiropractic care
- Cosmetic surgery
- Coverage provided outside the US. See www.carefirst.com
- Dental care (Adult)
- Long-term care
- Non-emergency care when travelling outside the US
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Abortion
- Acupuncture
- Bariatric surgery
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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

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provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565.

Does this plan provide Minimum Essential Coverage? Yes

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Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 833-630-1157 .

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$0
■ Specialist Copayment	\$20
■ Hospital (facility) Copayment	\$0
■ Other Copayment	\$15

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$90
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$10
The total Peg would pay is	\$100

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$0
■ Specialist Copayment	\$20
■ Hospital (facility) Copayment	\$0
■ Other Copayment	\$0

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$610
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$610

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist Copayment	\$20
■ Hospital (facility) Copayment	\$50
■ Other Copayment	\$15

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$260
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$260

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

BluePreferred High Option Plan 90/70 Summary of Benefits

Services	In-Network You Pay ^{1,2}	Out-of-Network You Pay ^{1,3}
EMERGENCY SERVICES		
Urgent Care Center	\$50 per visit	\$50 per visit
Emergency Room—Facility Services	\$200 per visit (waived if admitted)	\$200 per visit (waived if admitted)
Emergency Room—Physician Services	No charge*	No charge*
Ambulance (if medically necessary)	Deductible, then 10% of Allowed Benefit	Deductible, then 10% of Allowed Benefit
HOSPITALIZATION—(Members are responsible for applicable physician and facility fees)		
Outpatient Facility Services	\$100 per visit, deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Outpatient Physician Services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Inpatient Facility Services	\$250 per admission copay, deductible, then 10% of Allowed Benefit	\$250 per admission copay, deductible, then 30% of Allowed Benefit
Inpatient Physician Services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 120 visits per episode of care)	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Hospice	No charge*	No charge*
Skilled Nursing Facility (limited to 120 days/benefit period)	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then 30% of Allowed Benefit
Delivery and Facility Services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Nursery Care of Newborn	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Artificial and Intrauterine Insemination ⁹	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
In Vitro Fertilization Procedures ⁹	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	\$250 per admission copay, deductible, then 10% of Allowed Benefit	\$250 per admission copay, deductible, then 30% of Allowed Benefit
Inpatient Physician Services	No charge*	Deductible, then 30% of Allowed Benefit
Outpatient Facility Services	No charge*	Deductible, then 30% of Allowed Benefit
Outpatient Physician Services	\$20 copay	Deductible, then 30% of Allowed Benefit
Office Visits ^{7,8}	Virtual Connect through CloseKnit- No charge* (closeknithealth.com) All other providers - \$20 copay	Deductible, then 30% of Allowed Benefit
Medication Management	\$20 copay	Deductible, then 30% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	No charge*	Deductible, then 30% of Allowed Benefit
Hearing Aids for ages 0-18 (limited to 1 hearing aid per hearing impaired ear every 36 months)	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
VISION		
Routine Exam (limited to 1 visit/benefit period)	\$10 per visit at participating vision provider	Total charge minus \$33
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers	Not covered

BluePreferred High Option Plan 90/70 Summary of Benefits

Note: Allowed Benefit is the fee that participating providers in the network have agreed to accept for a particular service. The participating 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-network: When covered services are rendered by a provider in the Preferred Provider network, care is reimbursed at the in-network level. In-network coinsurances are based on a percentage of the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that Preferred Providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueCross BlueShield (CareFirst), however, in certain circumstances, the Allowed Benefit for a Preferred Provider may be established by law.
- 3 Out-of-network: When covered services are rendered by a provider not in the Preferred Provider network, care is reimbursed as out-of-network. Out-of-network coinsurances are based on a percentage of the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that Preferred Providers have agreed to accept as payment of covered services. These payments are established by CareFirst, however, in certain circumstances, the Allowed Benefit for an out-of-network provider may be established by law. When services are rendered by Non-Preferred Providers, charges in excess of the Allowed Benefit are the member's responsibility.
- 4 For family coverage only: When one family member meets the individual deductible, they can start receiving benefits. Each family member cannot contribute more than the individual deductible amount. The family deductible must be met before the remaining family members can start receiving benefits.
- 5 For Family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit.
- 6 Plan has separate out-of-pocket maximums for medical and drug expenses which accumulate independently.
- 7 "Telemedicine services" refers to the use of interactive audio, including audio-only telephone conversation between a health care provider and the Member when required by law, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Use of e-mail, online questionnaires or Fax is not considered a telemedicine service. Providers will use their professional judgment to determine if a telemedicine visit is appropriate or if an in-person visit is required.
- 8 CloseKnit is a registered Trademark owned by, and is the trade name of, Atlas Health, LLC. Atlas Health, LLC d/b/a CloseKnit does not provide Blue Cross Blue Shield products or services and is providing telehealth services to CareFirst members.
- 9 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.

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/CF/GC (R. 1/13); VA/CF/BP/EOC (7/08); VA/CF/BP/DOCS (7/08); VA/CF/BP/SOB (7/08); VA/CF/SOB-CDH (7/08); VA/CF/BLCRD (R. 1/17); VA/CF/MEM/BLCRD (R. 1/17); VA/CF/VISION (R. 1/12); VA/CF/RX3 (R. 1/18); VA/CF/ATTC (R. 1/10) and any amendments.



CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. which is an independent licensee of the Blue Cross and Blue Shield Association. The Blue Cross® and Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.



Exclusions and Limitations

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. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.
- N. 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.
- O. Medical and surgical treatment for obesity and weight reduction, except in the instance of Morbid Obesity.
- P. 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.
- Q. Services solely based on a court order or as a condition of parole or probation, unless approved by CareFirst.
- R. Health education classes and self-help programs, other than birthing classes or those for the treatment of diabetes.
- S. Acupuncture services, except when approved or authorized by CareFirst when used for anesthesia.
- T. 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.
- U. Any service received at no charge to the Member in any federal hospital or facility, or through any federal, state, or local governmental agency or department, not including Medicaid. (This exclusion does not apply to care received in a Veteran's hospital or facility unless that care is rendered for a condition that is a result of the Member's military service.)
- V. Private Duty Nursing.
- W. Non-medical, 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.
- X. 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.
- Y. 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.
- Z. 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.
- AA. 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.
- BB. 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.
- CC. Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.
- DD. Services, drugs, or supplies the Member receives without charge while in active military service.
- EE. Habilitative Services delivered through early intervention and school services.
- FF. Custodial Care.
- GG. Coverage does not include non-medical Ancillary Services, such as vocational rehabilitation, employment counseling, or educational therapy.
- HH. Services or supplies received before the effective date of the Member's coverage under this Evidence of Coverage.
 - II. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
 - JJ. Services required solely for administrative purposes, for example: employment, insurance, foreign travel, school, camp admissions or participation in sports activities.
- KK. 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, hoist 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.

Pharmacy Program Summary of Benefits

Arlington Public Schools High Option RX Plan

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.
Out-of-Pocket Maximum	See medical summary of benefits for annual out-of-pocket amount	If you reach your out-of-pocket maximum, CareFirst or CareFirst BlueChoice will pay 100% of the applicable allowed benefit for most covered services for the remainder of the year. 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 30-day supply)	\$0	A preventive drug is a prescribed medication or item on CareFirst's Preventive Drug List at carefirst.com/rx .
Oral Chemotherapy Drugs (up to a 30-day supply)	\$0	Oral chemotherapy drugs are covered at this copay level.
Diabetic Supplies (up to a 30-day supply)	\$0	Diabetic supplies include needles, syringes, lancets, test strips and alcohol swabs.
Insulin (up to a 30-day supply)	Preferred Brand: \$0 Non-preferred Brand: \$50	Preferred insulin is covered at \$0 copay and non-preferred insulin is covered at \$50 copay for a one-month supply.
Generic Drugs (Tier 1) (up to a 30-day supply)	\$4	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (up to a 30-day supply)	\$25	All preferred brand drugs are covered at this copay level.
Non-preferred Brand Drugs (Tier 3) (up to a 30-day supply)	\$45	All non-preferred brand drugs on this copay level are not on the Preferred Drug List at carefirst.com/rx . Discuss using alternatives with your doctor or pharmacist.
Maintenance Drugs (up to a 90-day supply)	Generic: \$0 Preferred Brand: \$50 Non-preferred Brand: \$90	Maintenance generic, preferred brand and non-preferred brand drugs up to a 90-day supply are available for the cost of two one-month supply copays through Mail Service Pharmacy or a retail pharmacy.
Restricted Generic Substitution	If your doctor prescribes a non-preferred brand drug when a generic is available, you will pay the non-preferred brand copay or coinsurance 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 or coinsurance. 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 copay or coinsurance.	
 Visit carefirst.com/rx 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. 1/18) • VA/CF/RX3 (R. 1/18)



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The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can see the Glossary at www.carefirst.com/sbcg or call 1-855-258-6518 to request a copy. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.carefirst.com.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-Network: \$300 individual/\$600 family; Out-of-Network: \$750 individual/\$1,500 family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family member(s) on the plan , each family member may need to meet their own individual deductible , OR all family members may combine to meet the overall family deductible before the plan begins to pay, depending upon plan coverage. Please refer to your contract for further details.
Are there services covered before you meet your deductible ?	Yes, all In-Network preventive care services, as well as the following (non-hospital facilities only, when applicable): Primary care, Specialist, Retail health, Diagnostic testing, Prescription drugs, Emergency room, Urgent care and Mental health outpatient services	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Medical and Prescription Drug combined: In-Network: \$3,000 individual/\$6,000 family; Out-of-Network: \$3,750 individual/\$7,500 family.	The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family member(s) on the plan , each family member may need to meet their own out-of-pocket limits , OR all family members may combine to meet the overall family out-of-pocket limit , depending upon plan coverage. Please refer to your contract for further details.
What is not included in the out-of-pocket limit ?	Premiums, balance-billing charges, health care this plan doesn't cover, copayments for certain services, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

Will you pay less if you use a network provider?	Yes. See www.carefirst.com or call 855-258-6518 for a list of Network providers.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Provider: \$20 copay per visit Hospital Facility: Deductible, then \$100 copay per visit, then 10% of Allowed Benefit	Provider: Deductible, then 30% of Allowed Benefit Hospital Facility: Deductible, then \$100 copay per visit, then 30% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Specialist visit	Provider: \$40 copay per visit Hospital Facility: Deductible, then \$100 copay per visit, then 10% of Allowed Benefit	Provider: Deductible, then 30% of Allowed Benefit Hospital Facility: Deductible, then \$100 copay per visit, then 30% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Retail health clinic	\$20 copay per visit	Deductible, then 30% of Allowed Benefit	None
	Preventive care/screening/immunization	No Charge	Deductible, then 30% of Allowed Benefit	Some services may have limitations or exclusions based on your contract

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	Lab Tests: Non-Hospital: \$20 PCP/\$40 Specialist copay per visit Hospital: No Charge X-Ray: Non-Hospital: \$20 PCP/\$40 Specialist copay per visit Hospital: No Charge	Lab Tests: Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit X-Ray: Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	None
	Imaging (CT/PET scans, MRIs)	Non-Hospital: \$100 copay per visit Hospital: Deductible, then \$100 copay per visit, then 10% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.carefirst.com/rxgroup	Generic drugs	\$4 copay	Paid As In-Network	For all prescription drugs: Prior authorization may be required for certain drugs; No Charge for preventive drugs or contraceptives; Copay applies to up to 30-day supply; Up to 90-day supply of maintenance drugs is 2 copays; Specialty Drugs: Participating Providers: covered when purchased through the Exclusive Specialty Pharmacy Network Non-Participating Providers: Not Covered
	Preferred brand drugs	\$25 copay	Paid As In-Network	
	Non-preferred brand drugs	\$45 copay	Paid As In-Network	
	Preferred Specialty drugs	\$4/\$25/\$45 copay	Not Covered	
	Non-preferred Specialty drugs	\$4/\$25/\$45 copay	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-Hospital & Hospital: Deductible, then \$100 copay per visit, then 10% of Allowed Benefit	Non-Hospital: Deductible, then 30% of Allowed Benefit Hospital: Deductible, then \$100 copay per visit, then 30% of Allowed Benefit	None
	Physician/surgeon fees	Non-Hospital & Hospital: Deductible, then 10% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	None
If you need immediate medical attention	Emergency room care	\$200 copay per visit	Paid As In-Network	Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply; Copay waived if admitted
	Emergency medical transportation	Deductible, then 10% of Allowed Benefit	Paid As In-Network	None
	Urgent care	\$50 copay per visit	\$50 copay per visit	Limited to unexpected, urgently required services; Copay waived if admitted
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then \$250 copay per admission, then 10% of Allowed Benefit	Deductible, then \$250 copay per admission, then 30% of Allowed Benefit	Prior authorization is required
	Physician/surgeon fees	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$20 copay per visit Hospital Facility: No Charge	Office Visit & Hospital Facility: Deductible, then 30% of Allowed Benefit	For treatment at an Outpatient Hospital Facility, additional charges may apply
	Inpatient services	Deductible, then \$250 copay per admission, then 10% of Allowed Benefit	Deductible, then \$250 copay per admission, then 30% of Allowed Benefit	Prior authorization is required; Additional professional charges may apply
If you are pregnant	Office visits	No Charge	Deductible, then 30% of Allowed Benefit	For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
	Childbirth/delivery professional services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Childbirth/delivery facility services	Deductible, then \$250 copay per admission, then 10% of Allowed Benefit	Deductible, then \$250 copay per admission, then 30% of Allowed Benefit	Additional professional charges may apply
If you need help recovering or have other special health needs	Home health care	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required Benefits are limited to 120 days per benefit period: Dialysis visits do not accumulate towards Home Health Care visit limit; Includes Private Duty Nursing when medically necessary
	Rehabilitation services	Provider & Hospital Facility: Deductible, then 10% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 30% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply Benefits for Physical Therapy are limited to 75 visits per benefit period, including Pulmonary Rehabilitation
	Habilitation services	Provider & Hospital Facility: Deductible, then 10% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 30% of Allowed Benefit	Prior authorization is required If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Skilled nursing care	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required Benefits are limited to 120 days per benefit period

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	Deductible, then No Charge	Deductible, then 30% of Allowed Benefit	None
	Hospice services	Inpatient and Outpatient Facility: Deductible, then No Charge	Inpatient and Outpatient Facility: Deductible, then 30% of Allowed Benefit	Prior authorization is required
If your child needs dental or eye care	Children's eye exam	\$10 copay per visit	Plan pays \$33; Member pays balance	Benefits are limited to 1 visit per benefit period
	Children's glasses	Discount programs available to all Members	Not Covered	Benefits are limited to 1 set of glasses/lenses per benefit period
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery • Dental care (Adult)	• Long-term care	• Routine foot care • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion • Acupuncture • Bariatric surgery • Chiropractic care	• Coverage provided outside the US. See www.carefirst.com • Hearing aids	• Infertility treatment • Non-emergency care when travelling outside the US • Private-duty nursing • Routine eye care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-258-6518.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-258-6518.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$300
■ Specialist Copayment	\$40
■ Hospital (facility) Copayment	\$250
■ Other Copayment	\$20

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$620
Coinsurance	\$800
What isn't covered	
Limits or exclusions	\$10
The total Peg would pay is	\$1,730

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$300
■ Specialist Copayment	\$40
■ Hospital (facility) Copayment	\$250
■ Other Copayment	\$0

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$565
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$865

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$300
■ Specialist Copayment	\$40
■ Hospital (facility) Copayment	\$200
■ Other Copayment	\$20

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$484
Coinsurance	\$60
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$844

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

BluePreferred Low Option Plan 80/60 Summary of Benefits

Arlington Public Schools

Services	In-Network You Pay ^{1,2}	Out-of-Network You Pay ^{1,3}
	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.	
WELLBEING PROGRAM		
Visit www.carefirst.com/myaccount for more information.	You have access to a comprehensive wellness program as part of your medical plan	
ANNUAL DEDUCTIBLE (Benefit period) ⁴		
Individual	\$400	\$800
Family	\$800	\$1,600
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period) ⁵		
Medical ⁶	\$3,000 Individual/\$6,000 Family	\$5,000 Individual/\$10,000 Family
Prescription Drug ⁶	All drug costs are subject to in-network out-of-pocket maximum	All drug costs are subject to in-network out-of-pocket maximum
LIFETIME MAXIMUM BENEFIT		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	Deductible, then 40% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	No charge*	Deductible, then 40% of Allowed Benefit
Breast Cancer Screening	No charge*	40% of Allowed Benefit
Pap Test	No charge*	Deductible, then 40% of Allowed Benefit
Prostate Cancer Screening	No charge*	Deductible, then 40% of Allowed Benefit
Colorectal Cancer Screening	No charge*	Deductible, then 40% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness ^{7,8}	Virtual Connect through CloseKnit- No charge* (closeknithealth.com) All other providers - \$30 PCP/\$60 Specialist copay	Deductible, then 40% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans)	\$100 copay, deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Lab	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
X-ray	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Allergy Testing	\$30 PCP/\$60 Specialist copay	Deductible, then 40% of Allowed Benefit
Allergy Shots	\$30 PCP/\$60 Specialist copay	Deductible, then 40% of Allowed Benefit
Physical, Speech and Occupational Therapy (Speech therapy and occupational therapy-unlimited visits. Physical Therapy and Pulmonary Rehabilitation therapy limited to 95 visits per benefit period)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Chiropractic (limited to 20 visits per benefit period)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Acupuncture	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit

BluePreferred Low Option Plan 80/60 Summary of Benefits

Services	In-Network You Pay ^{1,2}	Out-of-Network You Pay ^{1,3}
EMERGENCY SERVICES		
Urgent Care Center	\$50 per visit	\$50 per visit
Emergency Room—Facility Services	\$250 per visit (waived if admitted)	\$250 per visit (waived if admitted)
Emergency Room—Physician Services	No charge*	No charge*
Ambulance (if medically necessary)	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
HOSPITALIZATION—(Members are responsible for applicable physician and facility fees)		
Outpatient Facility Services	\$100 per visit, deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Outpatient Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Inpatient Facility Services	\$250 per admission copay, deductible, then 20% of Allowed Benefit	\$250 per admission copay, deductible, then 40% of Allowed Benefit
Inpatient Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care	No charge*	Deductible, then 40% of Allowed Benefit
Hospice	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Skilled Nursing Facility (limited to 120 days/benefit period)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then 40% of Allowed Benefit
Delivery and Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Nursery Care of Newborn	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Artificial and Intrauterine Insemination ⁹	\$100 copay per visit, deductible, then 20% of Allowed Benefit	\$100 copay per visit, deductible, then 40% of Allowed Benefit
In Vitro Fertilization Procedures ⁹	\$100 copay per visit, deductible, then 20% of Allowed Benefit	\$100 copay per visit, deductible, then 40% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	\$250 per admission copay, deductible, then 20% of Allowed Benefit	\$250 per admission copay, deductible, then 40% of Allowed Benefit
Inpatient Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Outpatient Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Outpatient Physician Services	\$30 per visit	Deductible, then 40% of Allowed Benefit
Office Visits ^{7,8}	Virtual Connect through CloseKnit No charge* (closeknithealth.com) All other providers - \$30 copay	Deductible, then 40% of Allowed Benefit
Medication Management	\$30 copay	Deductible, then 40% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Hearing Aids for ages 0-18 (limited to 1 hearing aid per hearing impaired ear every 36 months)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
VISION		
Routine Exam (limited to 1 visit/benefit period)	\$10 per visit at participating vision provider	Total charge minus \$33
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers	Not covered

BluePreferred Low Option Plan 80/60 Summary of Benefits

Note: Allowed Benefit is the fee that participating providers in the network have agreed to accept for a particular service. The participating 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-network: When covered services are rendered by a provider in the Preferred Provider network, care is reimbursed at the in-network level. In-network coinsurances are based on a percentage of the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that Preferred Providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueCross BlueShield (CareFirst), however, in certain circumstances, the Allowed Benefit for a Preferred Provider may be established by law.
- 3 Out-of-network: When covered services are rendered by a provider not in the Preferred Provider network, care is reimbursed as out-of-network. Out-of-network coinsurances are based on a percentage of the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that Preferred Providers have agreed to accept as payment of covered services. These payments are established by CareFirst, however, in certain circumstances, the Allowed Benefit for an out-of-network provider may be established by law. When services are rendered by Non-Preferred Providers, charges in excess of the Allowed Benefit are the member's responsibility.
- 4 For family coverage only: When one family member meets the individual deductible, they can start receiving benefits. Each family member cannot contribute more than the individual deductible amount. The family deductible must be met before the remaining family members can start receiving benefits.
- 5 For Family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit.
- 6 Plan has separate out-of-pocket maximums for medical and drug expenses which accumulate independently.
- 7 "Telemedicine services" refers to the use of interactive audio, including audio-only telephone conversation between a health care provider and the Member when required by law, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Use of e-mail, online questionnaires or Fax is not considered a telemedicine service. Providers will use their professional judgment to determine if a telemedicine visit is appropriate or if an in-person visit is required.
- 8 CloseKnit is a registered Trademark owned by, and is the trade name of, Atlas Health, LLC. Atlas Health, LLC d/b/a CloseKnit does not provide Blue Cross Blue Shield products or services and is providing telehealth services to CareFirst members.
- 9 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.

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/CF/GC (R. 1/13); VA/CF/BP/EOC (7/08); VA/CF/BP/DOCS (7/08); VA/CF/BP/SOB (7/08); VA/CF/SOB-CDH (7/08); VA/CF/BLCRD (R. 1/17); VA/CF/MEM/BLCRD (R. 1/17); VA/CF/VISION (R. 1/12); VA/CF/RX3 (R. 1/18); VA/CF/ATTC (R. 1/10) and any amendments.



CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. which is an independent licensee of the Blue Cross and Blue Shield Association. The Blue Cross® and Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.



Exclusions and Limitations

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. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.
 - N. 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.
 - O. Medical and surgical treatment for obesity and weight reduction, except in the instance of Morbid Obesity.
 - P. 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.
 - Q. Services solely based on a court order or as a condition of parole or probation, unless approved by CareFirst.
 - R. Health education classes and self-help programs, other than birthing classes or those for the treatment of diabetes.
 - S. Acupuncture services, except when approved or authorized by CareFirst when used for anesthesia.
 - T. 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.
 - U. Any service received at no charge to the Member in any federal hospital or facility, or through any federal, state, or local governmental agency or department, not including Medicaid. (This exclusion does not apply to care received in a Veteran's hospital or facility unless that care is rendered for a condition that is a result of the Member's military service.)
 - V. Private Duty Nursing.
 - W. Non-medical, 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.
 - X. 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.
 - Y. 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.
 - Z. 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.
 - AA. 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.
 - BB. 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.
 - CC. Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.
 - DD. Services, drugs, or supplies the Member receives without charge while in active military service.
 - EE. Habilitative Services delivered through early intervention and school services.
 - FF. Custodial Care.
 - GG. Coverage does not include non-medical Ancillary Services, such as vocational rehabilitation, employment counseling, or educational therapy.
 - HH. Services or supplies received before the effective date of the Member's coverage under this Evidence of Coverage.
 - II. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
 - JJ. Services required solely for administrative purposes, for example: employment, insurance, foreign travel, school, camp admissions or participation in sports activities.
 - KK. 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, hoist 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.

Pharmacy Program Summary of Benefits

Arlington Public Schools Low Option RX Plan

Formulary 2 ■ 3-Tier ■ \$0 Deductible ■ \$4/35/50

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.
Out-of-Pocket Maximum	See medical summary of benefits for annual out-of-pocket amount	If you reach your out-of-pocket maximum, CareFirst or CareFirst BlueChoice will pay 100% of the applicable allowed benefit for most covered services for the remainder of the year. 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 30-day supply)	\$0	A preventive drug is a prescribed medication or item on CareFirst's Preventive Drug List at carefirst.com/rx .
Oral Chemotherapy Drugs (up to a 30-day supply)	\$0	Oral chemotherapy drugs are covered at this copay level.
Diabetic Supplies (up to a 30-day supply)	\$0	Diabetic supplies include needles, syringes, lancets, test strips and alcohol swabs.
Insulin (up to a 30-day supply)	Preferred Brand: \$0 Non-preferred Brand: \$50	Preferred insulin is covered at \$0 copay and non-preferred insulin is covered at \$50 copay for a one-month supply.
Generic Drugs (Tier 1) (up to a 30-day supply)	\$4	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (up to a 30-day supply)	Covered at 35% with a minimum copay of \$35 and a maximum copay of \$50	All preferred brand drugs are covered at this copay level.
Non-preferred Brand Drugs (Tier 3) (up to a 30-day supply)	Covered at 50% with a minimum copay of \$50 and a maximum copay of \$100	All non-preferred brand drugs on this copay level are not on the Preferred Drug List at carefirst.com/rx . Discuss using alternatives with your doctor or pharmacist.
Maintenance Drugs (up to a 90-day supply)	Generic: \$0 Preferred Brand: Covered at 35% with a minimum copay of \$70 and a maximum copay of \$140 Non-preferred Brand: Covered at 50% with a minimum copay of \$100 and a maximum copay of \$200	Maintenance generic, preferred brand and non-preferred brand drugs up to a 90-day supply are available for the cost of two one-month supply copays through Mail Service Pharmacy or a retail pharmacy.
Restricted Generic Substitution	If your doctor prescribes a non-preferred brand drug when a generic is available, you will pay the non-preferred brand copay or coinsurance 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 or coinsurance. 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 copay or coinsurance.	



Visit carefirst.com/rx 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. 1/18) • VA/CF/RX3 (R. 1/18)



CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield Medicare Advantage is the shared business name of CareFirst Advantage, Inc., CareFirst Advantage PPO, Inc. and CareFirst Advantage DSNP, Inc. CareFirst BlueCross BlueShield Community Health Plan Maryland is the business name of CareFirst Community Partners, Inc. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst Advantage, Inc., CareFirst Advantage PPO, Inc., CareFirst Advantage DSNP, Inc., CareFirst Community Partners, Inc., CareFirst BlueCross BlueShield Community Health Plan District of Columbia, CareFirst BlueChoice, Inc., First Care, Inc., and The Dental Network, Inc. are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can see the Glossary at www.carefirst.com/sbcg or call 1-855-258-6518 to request a copy. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.carefirst.com.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-Network: \$400 individual/\$800 family; Out-of-Network: \$800 individual/\$1,600 family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family member(s) on the plan , each family member may need to meet their own individual deductible , OR all family members may combine to meet the overall family deductible before the plan begins to pay, depending upon plan coverage. Please refer to your contract for further details.
Are there services covered before you meet your deductible ?	Yes, all In-Network preventive care services, as well as the following (non-hospital facilities only, when applicable): Primary care, Specialist, Retail health, Diagnostic testing, Prescription drugs, Emergency room, Urgent care, Mental health outpatient services and Home health care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Medical and Prescription Drug combined: In-Network: \$3,000 individual/\$6,000 family; Out-of-Network: \$5,000 individual/\$10,000 family.	The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family member(s) on the plan , each family member may need to meet their own out-of-pocket limits , OR all family members may combine to meet the overall family out-of-pocket limit , depending upon plan coverage. Please refer to your contract for further details.
What is not included in the out-of-pocket limit ?	Premiums, balance-billing charges, health care this plan doesn't cover, copayments for certain services, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

Will you pay less if you use a network provider?	Yes. See www.carefirst.com or call 855-258-6518 for a list of Network providers.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Provider: \$30 copay per visit Hospital Facility: Deductible, then \$100 copay per visit, then 20% of Allowed Benefit	Provider: Deductible, then 40% of Allowed Benefit Hospital Facility: Deductible, then \$100 copay per visit, then 40% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Specialist visit	Provider: \$60 copay per visit Hospital Facility: Deductible, then \$100 copay per visit, then 20% of Allowed Benefit	Provider: Deductible, then 40% of Allowed Benefit Hospital Facility: Deductible, then \$100 copay per visit, then 40% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Retail health clinic	\$30 copay per visit	Deductible, then 40% of Allowed Benefit	None
	Preventive care/screening/immunization	No Charge	Deductible, then 40% of Allowed Benefit	Some services may have limitations or exclusions based on your contract

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	Lab Tests: Non-Hospital: \$30 PCP/\$60 Specialist copay per visit Hospital: Deductible, then 20% of Allowed Benefit X-Ray: Non-Hospital: \$30 PCP/\$60 Specialist copay per visit Hospital: Deductible, then 20% of Allowed Benefit	Lab Tests: Non-Hospital & Hospital: Deductible, then 40% of Allowed Benefit X-Ray: Non-Hospital & Hospital: Deductible, then 40% of Allowed Benefit	None
	Imaging (CT/PET scans, MRIs)	Non-Hospital: \$100 copay per visit Hospital: Deductible, then \$100 copay per visit, then 20% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 40% of Allowed Benefit	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.carefirst.com/rxgroup	Generic drugs	\$4 copay	Paid As In-Network	For all prescription drugs: Prior authorization may be required for certain drugs; No Charge for preventive drugs or contraceptives; Copay applies to up to 30-day supply; Up to 90-day supply of maintenance drugs is 2 copays; Specialty Drugs: Participating Providers: covered when purchased through the Exclusive Specialty Pharmacy Network Non-Participating Providers: Not Covered
	Preferred brand drugs	35% of Allowed Benefit up to a minimum of \$35 and maximum of \$50	Paid As In-Network	
	Non-preferred brand drugs	50% of Allowed Benefit up to a minimum of \$50 and maximum of \$100	Paid As In-Network	
	Preferred Specialty drugs	35% of Allowed Benefit up to a minimum of \$35 and maximum of \$50/50% of Allowed Benefit up to a minimum of \$50 and maximum of \$100	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred Specialty drugs	35% of Allowed Benefit up to a minimum of \$35 and maximum of \$50/50% of Allowed Benefit up to a minimum of \$50 and maximum of \$100	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-Hospital & Hospital: Deductible, then \$100 copay per visit, then 20% of Allowed Benefit	Non-Hospital: Deductible, then 40% of Allowed Benefit Hospital: Deductible, then \$100 copay per visit, then 40% of Allowed Benefit	None
	Physician/surgeon fees	Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 40% of Allowed Benefit	None
If you need immediate medical attention	Emergency room care	\$250 copay per visit	Paid As In-Network	Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply; Copay waived if admitted
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Paid As In-Network	None
	Urgent care	\$50 copay per visit	\$50 copay per visit	Limited to unexpected, urgently required services; Copay waived if admitted
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then \$250 copay per admission, then 20% of Allowed Benefit	Deductible, then \$250 copay per admission, then 40% of Allowed Benefit	Prior authorization is required
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$30 copay per visit Hospital Facility: 20% of Allowed Benefit	Office Visit & Hospital Facility: Deductible, then 40% of Allowed Benefit	For treatment at an Outpatient Hospital Facility, additional charges may apply
	Inpatient services	Deductible, then \$250 copay per admission, then 20% of Allowed Benefit	Deductible, then \$250 copay per admission, then 40% of Allowed Benefit	Prior authorization is required; Additional professional charges may apply
If you are pregnant	Office visits	No Charge	Deductible, then 40% of Allowed Benefit	For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
	Childbirth/delivery professional services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
	Childbirth/delivery facility services	Deductible, then \$250 copay per admission, then 20% of Allowed Benefit	Deductible, then \$250 copay per admission, then 40% of Allowed Benefit	Additional professional charges may apply
If you need help recovering or have other special health needs	Home health care	No Charge	Deductible, then 40% of Allowed Benefit	Prior authorization is required
	Rehabilitation services	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 40% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply Benefits for Physical Therapy are limited to 95 visits per benefit period, including Pulmonary Rehabilitation
	Habilitation services	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 40% of Allowed Benefit	Prior authorization is required If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required Benefits are limited to 120 days per benefit period
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	Inpatient Facility: Deductible, then 20% of Allowed Benefit Outpatient Facility: No Charge	Inpatient and Outpatient Facility: Deductible, then 40% of Allowed Benefit	Prior authorization is required
If your child needs dental or eye care	Children's eye exam	\$10 copay per visit	Plan pays \$33; Member pays balance	Benefits are limited to 1 visit per benefit period
	Children's glasses	Discount programs available to all Members	Not Covered	Benefits are limited to 1 set of glasses/lenses per benefit period
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Abortion
- Acupuncture
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the US. See www.carefirst.com
- Hearing aids
- Infertility treatment
- Non-emergency care when travelling outside the US
- Private-duty nursing
- Routine eye care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-258-6518.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-258-6518.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$400
■ Specialist Copayment	\$60
■ Hospital (facility) Copayment	\$250
■ Other Copayment	\$30

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$400
Copayments	\$650
Coinsurance	\$1,600
What isn't covered	
Limits or exclusions	\$10
The total Peg would pay is	\$2,660

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$400
■ Specialist Copayment	\$60
■ Hospital (facility) Copayment	\$250
■ Other Coinsurance	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$400
Copayments	\$775
Coinsurance	\$1,102
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,277

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$400
■ Specialist Copayment	\$60
■ Hospital (facility) Copayment	\$250
■ Other Copayment	\$30

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$400
Copayments	\$674
Coinsurance	\$158
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,232

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.