What’s covered
In order to receive the best possible health care, your employer is offering both medical and pharmacy benefits. By working with your doctor and pharmacist, you can focus on your overall health and make the right decisions when it comes to your prescriptions.

Your Rx benefits

Safe and cost-effective with a large network of pharmacies to choose from—that’s your prescription plan. As a CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc. (collectively, CareFirst) member, you have access to:

- A network with more than 60,000 participating pharmacies located nationwide
- Broad access to over 5,000 drugs with no brand exclusions
- Mail Service Pharmacy, our convenient, fast and accurate mail order drug program
- Coordinated medical and pharmacy care management programs to improve overall health and costs
- Care management notices about cost savings opportunities, safety alerts and other important drug information

How your plan works

The prescription drugs found on the CareFirst Formulary (drug list) are divided into tiers and count towards your in-network out-of-pocket maximum. The formulary includes $0 drugs, generic, preferred brand and non-preferred brand tiers.

Talk to your doctor to make sure you are using drugs on CareFirst’s Preferred Drug List. Remember, you’ll save the most money when using Tier 1 or Tier 2 drugs.
Rx Drug Program—3 Tiers
A Total Prescription for Health

<table>
<thead>
<tr>
<th>Drug tier (Cost-share)</th>
<th>Definition</th>
<th>More information</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 Cost-share drugs</td>
<td>The Affordable Care Act (ACA) classifies certain drug therapies as “preventive” if they reduce the risk of some serious health conditions. Oral chemotherapy drugs and diabetic supplies (needles, lancets, test strips, alcohol swabs) covered under the pharmacy benefit are included in this tier.</td>
<td>Preventive drugs are available at no cost if prescribed under certain medical criteria by your doctor. Oral chemotherapy drugs and diabetic supplies covered under the pharmacy benefit are also available at no cost for non-Health Savings Account (HSA) plans. If you have an HSA, you must first meet your deductible.</td>
</tr>
<tr>
<td><strong>Tier 1</strong>*</td>
<td>You pay: lowest copay ($)</td>
<td>All generic drugs on the Preferred Drug List will be in Tier 1.</td>
</tr>
<tr>
<td><strong>Tier 2</strong>*</td>
<td>You pay: higher copay ($$)</td>
<td>If a generic version of a Tier 2 drug is released then:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ The generic drug is added to Tier 1.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ The brand drug moves to Tier 3 and becomes a non-preferred brand drug.</td>
</tr>
<tr>
<td><strong>Tier 3</strong></td>
<td>You pay: highest copay ($$$)</td>
<td>Drugs in this tier will cost the most.</td>
</tr>
</tbody>
</table>

* Part of CareFirst’s Preferred Drug List.
** Self-Injectable drugs are covered under Tier 2 or Tier 3 in three-tier designs.

And, remember if the cost of your medication is less than your copay or coinsurance, you only pay the cost of the medication. Once you meet your deductible (if applicable to your plan), you may pay a different copay or coinsurance amount for drugs depending on if you use generic, preferred brand or non-preferred brand drugs.

Preferred Drug List
We have also identified a Preferred Drug List of generic and preferred brand drugs that have been selected for their effectiveness and price. You can rest easy knowing that the drugs on the Preferred Drug List have been reviewed for quality, effectiveness, safety and cost by an independent CVS/caremark1 national Pharmacy and Therapeutics (P&T) committee.

■ By using the CareFirst Preferred Drug List, you can work with your doctor or pharmacists to make safe and cost-effective decisions to better manage your health care and costs.

■ Even though non-preferred drugs aren't part of the Preferred Drug List, they're still covered, but at the highest cost-share. Go to www.carefirst.com/rx and refer to the Drug Search section to view the entire formulary.

Care Management Criteria
In addition, some medications are only intended to be used in limited quantities; others require that your doctor obtain prior authorization through CareFirst before they can be filled. These drug provisions are indicated on the formulary found in the Drug Search section on www.carefirst.com/rx.

■ Quantity limits have been placed on the use of selected drugs for quality, safety or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

■ Prior authorization is required before you fill prescriptions for certain drugs. Your doctor must obtain prior authorization from CareFirst before these drugs are covered.

1CVS/caremark is an independent company that provides benefit management services.
Rx Drug Program–3 Tiers
A Total Prescription for Health

- **Step therapy** asks that you try lower-cost, equally effective drugs that treat the same medical condition before trying a higher-cost alternative. Your physician can speak to your experience with these alternatives prior to dispensing a more expensive drug.

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

Filling your prescriptions

Your prescription drug benefits can be used for both maintenance and non-maintenance prescriptions. You can receive up to a one-month supply of medication through mail order or a retail pharmacy. You may also request a three-month supply of your maintenance medication(s) and only pay 2x the appropriate copay amount, depending on the tier level of your medication. If your plan requires coinsurance, the coinsurance percentage is the same regardless of the quantity you order, but mail service offers lower prices.

Retail pharmacies

Simply present your member ID card at a participating pharmacy and pay a copay or coinsurance for your medication. And with access to over 60,000 pharmacies nationwide, you can use the Find a Pharmacy tool located in the Tools that put you in control section on www.carefirst.com/rx to choose a location convenient for you.

Mail Service Pharmacy

Mail Service Pharmacy gives you a convenient way to fill your prescriptions with fast, accurate home delivery. Plus, it’s an easy way to save on your maintenance medications. You can register three ways – online through My Account, by phone or by mail. Once you register you’ll have access to:

- Convenient home or office delivery service
- Consulting pharmacists available by phone 24 hours a day, seven days a week
- Refill options available online, by phone or by email

Automated phone system to check account balances and make payments 24 hours a day, seven days a week

Email notification of order status

E-prescribing capabilities available to your physician

Multiple payment options – credit or debit card, electronic check, Bill Me Later®, or money order (CASH is not accepted)

Automatic refills with our ReadyFill at Mail® program

Maximizing your benefits

Take advantage of the free programs and resources available with your CareFirst prescription drug plan.

Specialty Pharmacy Coordination Program

With this program, our expert Specialty Customer Care Team, in coordination with our care management program, addresses the unique clinical needs of those taking high-cost specialty drugs for such disease states as multiple sclerosis, hepatitis C and hemophilia. It helps to improve medication adherence and safety, thereby improving the patient’s overall health and costs. And, members have access to the following services:

- Specialty drug coordination with a condition management registered nurse
- Comprehensive assessment at program initiation
- Integration of care coordination team with your primary care provider
- Access to specialty drugs through Mail Service Pharmacy or a participating retail pharmacy
- Drug and condition-specific education and counseling
- Drug interaction review
- Refill reminders and inventory coordination to reduce drug waste
- On-call pharmacist 24 hours a day, seven days a week

To maximize the effectiveness of this program, your medications must be filled through the CareFirst Exclusive Specialty Pharmacy network (CVS/caremark Specialty Pharmacy and OncoSource Rx Specialty Pharmacy)4.

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1 Maintenance drugs are drugs taken for six months or more to treat chronic conditions.

2 Please note that you must meet your annual deductible (if applicable to your plan) before paying only a copay for any of your prescription medications. Self-administered injectables (excluding insulin) require coinsurance, up to a maximum payment.

3 May not apply in VA or for MD PPO plans. Check your plan for more information.
Through this network you get access to medication therapy more quickly and get personalized support from clinical experts.

Comprehensive Medication Review (CMR)

Designed for members with the highest potential for medication-related issues, the Comprehensive Medication Review program uses a dedicated team of pharmacists that work with members and their provider(s) to address the importance of prescription management. Beginning January 1, 2015 members will be identified for outreach either through care management program referrals or automatically through claims analysis. The goal of this program is to lower overall medical spend and improve outcomes through specialized pharmacy interventions aimed to reduce drug-related complications, ensure the therapeutic regimen is the most appropriate, identify and resolve issues with barriers to adherence and address under/over utilization of medications.

Online tools and resources

To get the most from your prescription drug plan, you need to stay informed. Our easy-to-use, interactive tools are available 24 hours a day, seven days a week. Use these tools to check coverage, find a pharmacy, and learn more about your medications at www.carefirst.com/rx.

■ Drug Search Tool
■ Drug Information
■ Find a Pharmacy
■ Drug Reference and Interactions
■ Drug Forms
■ Identify a Medication

Once you’re a member you have access to even more tools through www.carefirst.com/myaccount.

■ Drug Pricing Tool
■ Refill and mail order information
■ Claims History Tool

Keeping you informed

Our Pharmacy Benefit Manager, CVS/caremark keeps you informed about your prescription drug coverage and provides you with periodic updates about your plan through targeted mailings. You could get notices about lower cost drug alternatives, alerts about possible safety concerns, drug tier changes and more.

Talk to your doctor to make sure you are using generic and preferred brand drugs on CareFirst's Preferred Drug List. Remember, you'll save the most money when using generic and preferred brand drugs.
### Summary of Benefits

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>Amount (In and out of network)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Deductible</td>
<td>None</td>
<td>Your benefit does not have a deductible.</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>None</td>
<td>Your benefit does not have a family deductible.</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>$1,000 Individual, $2,000 Individual Plus One, $3,000 Family</td>
<td>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.</td>
</tr>
<tr>
<td>Preventive Drugs (Affordable Care Act)</td>
<td>$0</td>
<td>A preventive drug is a prescribed medication or item on CareFirst’s Preventive Drug List (ACA) (examples: Folic Acid, Fluoride and FDA approved contraceptives for women).</td>
</tr>
<tr>
<td>Oral Chemotherapy Drugs</td>
<td>$0</td>
<td>Diabetic supplies include needles, lancets, test strips and alcohol swabs.</td>
</tr>
<tr>
<td>Diabetic Supplies (up to a 34-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Drugs (Tier 1)</td>
<td>$10</td>
<td>Generic drugs are covered at this copay level.</td>
</tr>
<tr>
<td>(up to a 34-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred Brand Drugs (Tier 2)</td>
<td>$30</td>
<td>All preferred brand drugs are covered at this copay level.</td>
</tr>
<tr>
<td>(up to a 34-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-preferred Brand Drugs (Tier 3)</td>
<td>$50</td>
<td>All non-preferred brand drugs on this copay level are not on the Preferred Drug List. Discuss using alternatives with your physician or pharmacist.</td>
</tr>
<tr>
<td>(up to a 34-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance Drugs</td>
<td>Generic: $20, Preferred Brand: $60, Non-preferred Brand: $100</td>
<td>Maintenance drugs of up to a 90-day supply are available for twice the copay only through Mail Service Pharmacy or a retail pharmacy.</td>
</tr>
<tr>
<td>(up to a 90-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restricted Generic Substitution</td>
<td>Yes</td>
<td>If a provider 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.</td>
</tr>
</tbody>
</table>

Access [www.carefirst.com/rxgroup](http://www.carefirst.com/rxgroup) for the most up-to-date list of covered drugs.

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

**Policy Form Numbers:** VA/CFBC/RX3 (R. 8/12) • VA/CF/RX3 (R. 8/12)
Below are limitations and exclusions contained in your CareFirst BlueChoice or CareFirst medical policy to which the prescription rider is attached.

Medical Limitations and Exclusions – CareFirst BlueChoice

10.1 Coverage is Not Provided For:

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

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

C. The cost of services that:
   1. Are furnished without charge; or
   2. Are normally furnished without charge to persons without health insurance coverage; or
   3. Would have been furnished without charge if the Member was not covered under the Evidence of Coverage or under any health insurance.

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

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

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

G. Except for treatment for Accidental Injury or benefits for Oral Surgery as described above, dental care including extractions; treatment of cavities; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia, except for the treatment of a cleft lip or cleft palate; false teeth; or any other dental services or supplies. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.

H. Benefits will not be provided for cosmetic surgery (except as specifically provided for reconstructive breast surgery and reconstructive surgery as listed above) or other services primarily intended to correct, change or improve appearances.

I. Treatment rendered by a health care provider who is a member of the Member’s family (parents, spouse, brothers, sisters, children).

J. Any prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage. Medications that can be self-administered or do not medically require administration by or under the direction of a physician are not covered even though they may be dispensed or administered in a physician office or provider facility. Benefits for prescription drugs may be available through a rider purchased by the Group and attached to the Evidence of Coverage.

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

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

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

N. All assisted reproductive technologies (except artificial insemination and intrauterine insemination), including in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same unless covered under a rider purchased by the Group and attached to the Evidence of Coverage.

O. Fees or charges relating to fitness programs, weight loss or weight control programs; physical conditioning; pulmonary rehabilitation programs; exercise programs; and use of passive or patient-activated exercise equipment.

P. Treatment for obesity except for the surgical treatment of Morbid Obesity.

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

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

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

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

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

V. Any service related to recreational activities. This includes, but is not limited to, sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst BlueChoice even though they may have therapeutic value or be provided by a health care provider.

W. Coverage under this Description of Covered Services does not include the cost of services or payment for services for any illness, injury or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:
   1. Under any federal, state, county or municipal workers’ compensation or employer’s liability law or other similar program;
   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.

X. Private duty nursing.

Y. Non-medical, health care provider services, including, but not limited to:
   1. Telephone consultations, failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the health care practitioner or the healthcare practitioner’s staff.
   2. Administrative fees charged by a physician or medical practice to a Member to retain the physician’s or medical practices services, e.g., “concierge fees” or boutique medical practice membership fees.

BB. Routine eye examinations, frames and lenses or contact lenses. Benefits for routine eye examinations, frames and lenses or contact lenses.

AA. Vocational rehabilitation and employment counseling.

BB. Educational therapies intended to improve academic performance.

Z. Benefits for educational therapies intended to improve academic performance.

Pharmacy Program

Below are limitations and exclusions contained in your CareFirst BlueChoice or CareFirst medical policy to which the prescription rider is attached.
lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.

CC. Custodial, personal, or domiciliary care that is provided to meet the activities of daily living, e.g., bathing, toileting and eating (care which may be provided by persons without professional medical skills or training).

DD. Work hardening programs. Work hardening programs are highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

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

FF. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst BlueChoice, and CareFirst BlueChoice approved services listed in the Transplants section of this Description of Covered Services).

GG. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.

HH. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

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

10.3 Organ and Tissue Transplants.
Benefits will not be provided for the following:
A. Non-human organs and their implantation.
B. Any Hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.
C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst BlueChoice.
D. Services for a Member who is an organ donor when the recipient is not a Member.
E. Benefits will not be provided for donor search services.
F. Any service, supply or device related to a transplant that is not listed as a benefit in this Description of Covered Services.

10.4 Inpatient Hospital Services.
Coverage is not provided for the following:
A. Private room, unless Medically Necessary and authorized or approved by CareFirst BlueChoice. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.
B. Non-medical items and convenience items, such as television, phone rentals, guest trays and laundry charges.
C. Except for covered Emergency Services and Childbirth, a Hospital admission or any portion of a Hospital admission that had not been authorized or approved by CareFirst BlueChoice, whether or not services are Medically Necessary and/or meet all other conditions for coverage.
D. Private duty nursing.

10.5 Home Health Services.
Coverage is not provided for:
A. Private duty nursing.
B. Custodial Care.
C. Services in the Member’s home if it is outside the Service Area.

10.6 Hospice Benefits.
Coverage is not provided for:
A. Services, visits, medical equipment or supplies that are not included in the CareFirst BlueChoice-approved plan of treatment.
B. Services in the Member’s home if it is outside the Service Area.
C. Financial and legal counseling.
D. Any service for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.
E. Chemotherapy or radiation therapy, unless used for symptom control.
F. Services, visits, medical/surgical equipment or supplies; including equipment and medication not required to maintain the comfort and to manage the pain of the terminally ill Member.
G. Reimbursement for volunteer services.
H. Custodial Care, domestic or housekeeping services.
I. Meals on Wheels or similar food service arrangements.
J. Rental or purchase of renal dialysis equipment and supplies.
K. Private duty nursing.

10.7 Outpatient Mental Health and Substance Abuse.
Coverage is not provided for:
A. Psychological testing, unless Medically Necessary, as determined by CareFirst BlueChoice, and appropriate within the scope of Covered Services.
B. Services solely on court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.
C. Mental retardation, after diagnosis.
D. Psychoanalysis.

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

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

10.10 Medical Devices and Supplies.
Coverage is not provided for:
A. Convenience Item. Any item that increases physical comfort or convenience without serving a Medically Necessary purpose, e.g. elevators, hoist/or stool 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.
Pharmacy Program

D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home, e.g. parallel bars.

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

F. Eyeglasses, contact lenses, dental prostheses or appliances, or hearing aids. Benefits for eyeglasses and contact lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.

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

H. Medical equipment/supplies of an expendable nature, except those specifically listed as a Covered Medical Supply in this Description of Covered Services. Non-covered supplies include incontinence pads or ace bandages.

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

Prescription Drug Exclusions

Benefits will not be provided under this rider for:

1. Any device, appliances, supplies, and equipment except as otherwise provided in the Evidence of Coverage.

2. Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities.

3. Prescription Drugs for cosmetic use.

4. Prescription Drugs administered by a physician or dispensed in a physician's office.

5. Drugs, drug therapies or devices that are considered Experimental/Investigational by CareFirst BlueChoice.

6. Except for items included on the Preferred Preventive Drug List, Over-the-Counter medications or supplies lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a Prescription Drug.

7. Vitamins, except CareFirst BlueChoice will provide a benefit for Prescription Drug:
   a. Prenatal vitamins.
   b. Fluoride and fluoride containing vitamins.
   c. Single entity vitamins, such as Rocaltrol and DHT.
   d. Vitamins included on the Preferred Preventive Drug List.

8. Infertility drugs and agents for use in connection with infertility services or treatments that are excluded from coverage under the Evidence of Coverage to which this rider is attached.

9. Any portion of a Prescription Drug that exceeds:
   a. a thirty-four (34) day supply for Prescription Drugs; or,
   b. a ninety (90) day supply for Maintenance Drugs unless authorized by CareFirst BlueChoice.

10. Prescription Drugs that are administered or dispensed by a healthcare facility for a Member who is a patient in the health care facility. This exclusion does not apply to Prescription Drugs that are dispensed by a Pharmacy on the health care facility's premises for a Member who is not a patient in the health care facility.

11. Prescription Drugs for weight loss.


13. Blood and blood products. (May be covered under the medical benefits in the Evidence of Coverage to which this rider is attached.)

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

Medical Limitations and Exclusions – CareFirst BlueCross BlueShield

10.1 General Exclusions

Coverage is not provided for the following:

A. Any service, test, procedure, supply, or item which CareFirst determines not necessary for the prevention, diagnosis or treatment of the Member's illness, injury, or condition. Although a service may be listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in the Member's particular case.

B. Any treatment, procedure, facility, equipment, drug, drug usage, device, or supply which, in the judgment of CareFirst, is Experimental/Investigational, or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment, except for covered benefits for Clinical Trials.

C. The cost of services that are furnished without charge or are normally furnished without charge if a Member was not covered under the Evidence of Coverage or under any health insurance, or any charge or any portion of a charge which by law the provider is not permitted to bill or collect from the Member directly.

D. Any service, supply, or procedure that is not specifically listed in the Member's Evidence of Coverage as a covered benefit or that does not meet all other conditions and criteria for coverage as determined by CareFirst.

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

F. Routine foot care, including services related to hygiene or any services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet, or partial removal of a nail without the removal of its matrix. However, benefits will be provided for these services if CareFirst determines that medical attention was needed because of a medical condition affecting the feet, such as diabetes and, that all other conditions for coverage have been met.

G. Any type of dental care (except treatment of accidental injuries, oral surgery, and cleft lip, cleft palate, or 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
 Pharmacy Program

a rider or amendment purchased by the Group and attached to the Evidence of Coverage.

K. All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies routinely obtained and self-administered by the Member, except for the CareFirst benefits described in this Evidence of Coverage and diabetic supplies.

L. Food and formula consumed as a sole source or supplemental nutrition, except as listed as a Covered Service in this Description of Covered Services.

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

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

O. Fees and charges relating to fitness programs, weight loss or weight control programs, physical, pulmonary conditioning programs or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education, except for diabetes outpatient self-management training and educational services. Cardiac rehabilitation programs are covered as described in this Evidence of Coverage.

P. Medical and surgical treatment for obesity and weight reduction, except in the instance of Morbid Obesity.

Q. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof. Benefits for vision may be available through a rider or amendment purchased by the Group and attached to the Evidence of Coverage.

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

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

T. Acupuncture services, except when approved or authorized by CareFirst when used for anesthesia.

U. Any service related to recreational activities. This includes, but is not limited to, sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst even though they may have therapeutic value or be provided by a Health Care Practitioner.

V. Any service received at no charge to the Member in any federal hospital or facility, or through any federal, state, or local governmental agency or department, not including Medicaid. (This exclusion does not apply to care received in a Veteran's hospital or facility unless that care is rendered for a condition that is a result of the Member's military service.)

W. Private Duty Nursing.

X. Non-medical, provider services, including but not limited to:
   1. Telephone consultations, failure to keep a scheduled visit, completion of forms, copying charges, or other administrative services provided by the Health Care Practitioner or the Health Care Practitioner's staff.
   2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Evidence of Coverage are available for Covered Services rendered to the Member by a Health Care Provider.

Y. Speech Therapy, Occupational Therapy, or Physical Therapy, unless CareFirst determines that the condition is subject to improvement. Coverage does not include non-medical Ancillary Services such as vocational rehabilitation, employment counseling, or educational therapy.

Z. Services or supplies for injuries or diseases related to a covered person's job to the extent the covered person is required to be covered by a workers' compensation law.

AA. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst, and services listed under the Section 2.14 Transplants Section of this Description of Covered Services), whether or not recommended by an Eligible Provider.

BB. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.

CC. Contraceptive drugs or devices, unless specifically identified as covered in this Evidence of Coverage, or in a rider or amendment to this Evidence of Coverage.

DD. Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.

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

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

GG. Custodial Care.

HH. Coverage does not include non-medical Ancillary Services, such as vocational rehabilitation, employment counseling, or educational therapy.

II. Services or supplies received before the effective date of the Member's coverage under this Evidence of Coverage.

JJ. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.

KK. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

LL. Work Hardening Programs. Work Hardening Program means a highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

10.2 Infertility Services

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

10.3 Transplants

Benefits will not be provided for the following:

A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary non-Experimental/Investigational skin grafts.

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

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

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

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

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

10.4 Inpatient Hospital Services

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

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

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

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

D. Private Duty Nursing.

10.5 Home Health Services

Coverage is not provided for:

A. Private Duty Nursing.

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

10.7 Medical Devices and Supplies
Benefits will not be provided for purchase, rental, or repair of the following:
A. Convenience items. Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for a Member (e.g., an exercycle or other physical fitness equipment, elevators, 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.

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

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

Not all services and procedures are covered by your benefits contract. This list is a summary and is not intended to itemize every procedure not covered by CareFirst BlueCross BlueShield. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.
Maintenance Choice offers you options and savings when it comes to filling your maintenance medications. Maintenance medications are drugs taken regularly for an ongoing condition such as high blood pressure, diabetes, etc. With Maintenance Choice, you can get up to a three-month supply of your maintenance drugs for the cost of a two-month supply. There are two ways to save when filling your maintenance drug prescriptions.

**CVS Mail Service Pharmacy**
- Enjoy convenient home delivery service
- Refill your prescriptions online, by phone or email
- Check account balances and make payments through an automated phone system
- Sign up to receive email notifications of order status
- Access a consulting pharmacist by phone 24 hours a day

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

You will be allowed to fill a one-month prescription two times at any retail pharmacy as we transition to Maintenance Choice. Before you reach your fill limit, CVS/caremark* will contact you to help you get started with Maintenance Choice. We’ll then help you get a new prescription from your doctor so you can choose to fill it through CVS Mail Service Pharmacy or at a CVS retail pharmacy. For more information, call us toll-free at 800-241-3371.

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<table>
<thead>
<tr>
<th>If you would like...</th>
<th>Then...</th>
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</thead>
<tbody>
<tr>
<td>To pick up at a CVS retail pharmacy or register for CVS Mail Service Pharmacy</td>
<td><strong>Please let us know.</strong> You can do so quickly and easily. Choose the option that works best for you:</td>
</tr>
<tr>
<td></td>
<td>- Go to <a href="http://www.carefirst.com">www.carefirst.com</a> and log into My Account from your computer, tablet or smartphone. Click on My Coverage, select Drug and Pharmacy Resources, select My Drug Home and Order Prescriptions to select a CVS pharmacy location for pick up or register for CVS Mail Service Pharmacy.</td>
</tr>
<tr>
<td></td>
<td>- Visit your local CVS retail pharmacy and talk to the pharmacist</td>
</tr>
<tr>
<td></td>
<td>- Call us toll-free using the number on the back of your member ID card, and we’ll handle the rest</td>
</tr>
<tr>
<td>To continue with CVS Mail Service Pharmacy</td>
<td><strong>You don’t have to do anything.</strong> We’ll continue to send your medications to your location of choice.</td>
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</tbody>
</table>

*CVS/caremark is an independent company that provides pharmacy benefit management services.*
Do you have a chronic condition that requires specialty medications? Our CareFirst Specialty Pharmacy Coordination Program can help you achieve better results from your medication therapy through personalized care, support and services designed to help manage your condition.

Through this program CareFirst addresses the unique clinical needs of members who take high-cost specialty drugs for certain conditions like multiple sclerosis, hepatitis C and hemophilia. We recognize that members taking specialty drugs require high-touch, high-quality care coordination and support to assure the best possible outcomes. With this program you have access to the following services:

- Comprehensive assessment of the patient at program initiation
- Coordination between the specialty care coordination team and the patient’s primary care provider (PCP)
- Drug interaction review
- Drug and condition-specific education and counseling on medication adherence, side effects and safety
- Refill reminders and inventory coordination to reduce drug waste
- On call pharmacists 24 hours a day, seven days a week for assistance
- Specialty drug care coordination with a registered nurse specializing in select disease states (multiple sclerosis, hemophilia, hepatitis C and select intravenous immunoglobulin conditions)

In order to maximize the effectiveness of the Specialty Pharmacy Coordination Program, your specialty medications must be filled through an exclusive specialty pharmacy in the CareFirst network—CVS/caremark Specialty Pharmacy and OncoSource Rx Specialty Pharmacy, depending on your health condition.

By using the CareFirst Exclusive Specialty Pharmacy network, you get specialty medications and personalized pharmacy care management services from a team of clinical experts specially trained in your health condition as well as access to:

- Drug and condition-specific education and counseling
- Confidential, professional and personal care
- On-call pharmacist 24 hours a day, seven days a week
- Insurance and financial coordination assistance
- Online support and resources

Our Specialty Customer Care Team addresses your unique clinical needs, and helps improve adherence, persistency to prescribed therapies and safety, thereby improving your overall health and costs.
Under the Affordable Care Act, also known as health care reform, certain categories of drugs and other products were identified as preventive and are available to members at no cost. The following list of drugs and other products are not subject to any copay or deductible when a prescription is written by a provider for members meeting the eligibility criteria below. This list is subject to change, so please check [www.carefirst.com/rx](http://www.carefirst.com/rx) regularly for the most up-to-date list.

### Aspirin Drugs
- Aspirin
- Aspirin Buffered
- Aspirin EC
- Children's Aspirin
- Low Dose Aspirin

#### Eligibility Criteria
Men and women who are 45 and over and who are at risk for cardiovascular disease

### FDA Approved Contraceptives
- Female Condom (OTC*)
- Diaphragm (P) with Spermicide (OTC*)
- Sponge (OTC*) with Spermicide (OTC*)
- Cervical Cap (P) with Spermicide (OTC*)
- Spermicide (OTC*)
- Oral Contraceptive (generics) (P)
- Oral Contraceptive (brand name (P) only when generic equivalent drug is medically inappropriate, as determined by the individual's health care provider). Pre-authorization and medical review of brand oral contraceptives is required.
- Contraceptive Patch (P)
- Contraceptive Ring (P)
- Shot/Injection (generic only, except includes brand-name Depo-SubQ Provera 104 injection) (P)
- Morning After Pill (generic only) (OTC*)
- IUD (inserted by doctor)
- Contraceptive Implant System (inserted by doctor)
- Sterilization Implant
- Sterilization Surgery

#### Eligibility Criteria
- Females ages 10-65 years

### Folic Acid Drugs
- Biocel
- Maxinate
- Protect Natal
- Triveen-Ten
- Urosex
- Vitacel
- VitaMedMD

#### Eligibility Criteria
Women planning to become, or capable of becoming pregnant
## Preventive Drug List (Affordable Care Act)

### $0 Copays

### Iron Supplementation Drugs
- Carbonyl Iron Oral Suspension
- Ferrous Sulfate Drops
- Ferrous Sulfate Oral Suspension

#### Eligibility Criteria
Asymptomatic children who are 2 years old or younger and who are at increased risk for iron deficiency anemia

### Oral Fluoride Drugs
- Multivitamins with Fluoride
- Multivitamins with Fluoride & Iron
- Polyvitamin with Iron & Fluoride
- Sodium Fluoride
- Tri-Vit with Fluoride & Iron
- Tri-Vitamin with Fluoride

#### Eligibility Criteria
Children 6 years old or younger whose primary water source is deficient in fluoride

### Smoking Cessation Products
- Chantix
- Nicotine Gum
- Nicotine Lozenges
- Nicotine Patch
- Nicotine Spray
- Zyban

#### Eligibility Criteria
Tobacco users who want to quit smoking

### Vitamin D Drugs
- Ergocalciferol
- Cholecalciferol

#### Eligibility Criteria
Adults age 65 years and older

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*Your coverage may not include these benefits. Refer to your Evidence of Coverage for details.

(P) Prescription Required

(OTC) Over the Counter

* Requires a prescription from a physician and must be purchased at a pharmacy to obtain the zero-cost share.
Preferred Drug List—3 Tiers

Manage Your Prescriptions and Save

We understand that the cost of prescriptions can really add up during the year. However, by using the Preferred Drug List, you can work with your doctor or pharmacist to make safe and cost-effective decisions to better manage your health care.

At CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively, CareFirst) we want you to know what the Preferred Drug List is, and how to use it, so you can make informed choices about your prescription drugs.

What is a Preferred Drug List?

This is a list of covered Preferred Brand and Generic prescription drugs. With your plan, drugs will fall into 1 of 3 Tiers. Tiers 1 and 2 are part of CareFirst’s Preferred Drug List and have been selected for their price and effectiveness. Even though Tier 3 drugs aren’t part of the Preferred Drug List, they’re still covered by your benefits, but at the highest copay.

Talk to your doctor to make sure you’re using drugs on CareFirst’s Preferred Drug List. Remember, you’ll save the most money when you use Tier 1 or Tier 2 drugs. To view CareFirst’s Preferred Drug List, please visit www.carefirst.com/rx.

How do drugs get on the Preferred Drug List?

You can rest easy knowing your medications have been reviewed for quality, effectiveness, safety and cost by a committee of doctors and pharmacists who serve the CareFirst region. The Preferred Drug List changes frequently in response to Food and Drug Administration (FDA) requirements and is also adjusted when a Generic drug is introduced for a Brand drug. When that happens, the Generic drug will be added to Tier 1 and the Brand drug will automatically move from Tier 2 to Tier 3.

<table>
<thead>
<tr>
<th>Tier 1*</th>
<th>You Pay: Lowest Copay ($)</th>
<th>Generic Drugs</th>
<th>All Generic drugs on the Preferred Drug List will be in Tier 1.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 2*</td>
<td>You Pay: Higher Copay ($$)</td>
<td>Preferred Brand Drugs</td>
<td>If a Generic version of a Tier 2 drug is released then:</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>■ The Generic drug is added to Tier 1.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>■ The Brand drug moves to Tier 3 and becomes a</td>
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<td></td>
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<td></td>
<td>Non-preferred Brand drug.</td>
</tr>
<tr>
<td>Tier 3**</td>
<td>You Pay: Highest Copay ($$$)</td>
<td>Non-preferred Brand Drugs</td>
<td>Some plans require members who choose a Tier 3 drug over the</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Generic version to:</td>
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<td></td>
<td></td>
<td>■ Pay the highest copay, and</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>■ Pay the cost difference between the Preferred Brand drug</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>and its Generic.</td>
</tr>
</tbody>
</table>

* Part of CareFirst’s Preferred Drug List.

** Self-injectable drugs are covered under Tier 2 or Tier 3 in three-tier designs.
Rx Authorize

Some medications are only intended to be used in limited quantities, while others require advanced approval. With Rx Authorize, you have access to a program that can help monitor your drug therapy, while promoting the use of clinically approved and cost effective prescription medications.

- **Step Therapy/Prior Authorization**—Step Therapy is used to ensure that you meet the necessary medical criteria to obtain a particular drug. To find out if any of your prescriptions require advance approval (prior authorization) before they can be filled, visit our pharmacy website at [www.carefirst.com/rx](http://www.carefirst.com/rx). Please note this list is subject to your benefit plan and may change periodically.

If you require a prescription for one of these drugs, you or your pharmacist should explain to your doctor that prior authorization is needed before benefits will be available to you and that they must call to begin the process. Without proper authorization, you’ll pay the full price of the prescription, rather than only your copay or coinsurance amount.

- **Quantity Limits**—Certain prescription drugs can only be prescribed in limited quantities. These limits are set to ensure that alternative drugs are regularly reconsidered by your doctor. For the most up-to-date list of drugs with quantity limits, visit our pharmacy website at [www.carefirst.com/rx](http://www.carefirst.com/rx). This list is subject to change and will be periodically updated.

Maintenance drugs

A maintenance drug is a prescription drug anticipated to be required for 6 months or more to treat a chronic condition. Maintenance drugs can be ordered up to a 90-day supply through retail or Mail Service Pharmacy. The most up-to-date list of maintenance medications can be found on our pharmacy website at [www.carefirst.com/rx](http://www.carefirst.com/rx).
Take advantage of Mail Service Pharmacy, a fast and accurate home delivery service that offers a way for you to save both time and money on your long-term (maintenance) prescriptions.*

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

- Convenient, dependable delivery service to your home or location of choice at no additional cost
- Consulting pharmacists available by phone 24 hours a day, seven days a week when you have questions about your prescription
- Refill options online, by phone or by email
- An automated phone system to check account balances and make payments
- Email notifications of your order status
- Automatic refills with our ReadyFill at Mail® program
- Multiple payment options — credit or debit card, check, electronic check, Bill Me Later®, or money order (CASH is not accepted)

Benefit from ReadyFill at Mail®

Save more time when you sign up for our ReadyFill at Mail® program. With this program you can have your refills automatically sent to you at the appropriate time for no additional cost. We do the refill ordering for you, so you don't have to spend time online, on the phone or filling out a form. If your prescription is about to expire or the last refill has been used we will contact your doctor for you.

This automatic refill option helps you stay on track with your medication therapy regimen so there is less risk of a missed dose of your maintenance medications.

It’s easy to start using mail service

Choose one of the following three ways:

- **Online**
  Go to www.carefirst.com and log in to My Account, click on My Coverage, select Drug and Pharmacy Resources, click on My Drug Home and select Order Prescriptions to set up an account. **Once your account is set up we’ll contact your doctor for a prescription.**

- **By phone**
  Call the toll-free phone number on the back of your member ID card. Our Customer Care representatives can walk you through the process. **We can contact your doctor directly for a prescription and mail your medications directly to you.**

- **By mail**
  If you already have your prescription, you can send it to us with a completed Mail Service Pharmacy Order Form. You can download the form by visiting the Ways to Save section of www.carefirst.com/rx.

* Long-term or maintenance medications are prescription drugs anticipated to be required for 6 months or more to treat a chronic or ongoing condition such as diabetes, high blood pressure or asthma.
Getting the most from your plan
View personalized information on your claims and out-of-pocket costs online with My Account. Simply log on to www.carefirst.com/myaccount for real-time information about your plan.

Features of My Account

- View your deductible status and out-of-pocket costs for your current and previous plan year.
- Review up to one year of medical claims—total charges, benefits paid and costs for a specific date range.
- Request an ID card.
- Sign up for electronic communications and get your information faster and more securely.

Signing up is easy

Visit www.carefirst.com/myaccount, click on Register Now and set up your User ID and Password. You'll just need information from your member ID card.

Additional tools

Depending on your specific health plan, you may have access to the following services through My Account:

- Find out the exact dollar amount you’ll pay at a particular pharmacy.
- View a side-by-side comparison of costs at local pharmacies.
- Download claim forms.
- Find in-network providers.

Mobile access

View the most-visited information in My Account on your smartphone or tablet.

Our mobile site is available from any browser-equipped mobile device. To try out the app, visit your favorite app store, search for “CareFirst” and install the CareFirst app on your device.

Enjoy access to:

- Find A Provider.
- Search for nearby urgent care and ER facilities, based on your current location (as determined by your device’s GPS).
- Searchable claims information.
- Who’s eligible and covered under your policy.
- View your ID cards (App users can also print and email ID cards).
- Register for My Account and maintain your security and notification preferences.

For more information on our mobile site and app, visit www.carefirst.com/mobileaccess.
Notice of privacy practices

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively, CareFirst) are committed to keeping the confidential information of members private. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to send our Notice of Privacy Practices to members of fully insured groups only. The notice outlines the uses and disclosures of protected health information, the individual's rights and CareFirst's responsibility for protecting the member’s health information.

To obtain a copy of our Notice of Privacy Practices, go to www.carefirst.com and click on Privacy Statement at the bottom of the page, click on Health Information then click on Notice of Privacy Practices. Or call the Member Services telephone number on your member ID card. Members of self-insured groups should contact their Human Resources department for a copy of their Notice of Privacy Practices. If you don’t know whether your employer is self-insured, please contact your Human Resources department.

Member satisfaction

CareFirst wants to hear your concerns and/or complaints so that they may be resolved. We have procedures that address medical and non-medical issues. If a situation should occur for which there is any question or difficulty, here’s what you can do:

- If your comment or concern is regarding the quality of service received from a CareFirst representative or related to administrative problems (e.g., enrollment, claims, bills, etc.) you should contact Member Services. If you send your comments to us in writing, please include your member ID number and provide us with as much detail as possible regarding any events. Please include your daytime telephone number so that we may contact you directly if we need additional information.

- If your concern or complaint is about the quality of care or quality of service received from a specific provider, contact Member Services. A representative will record your concerns and may request a written summary of the issues. To write to us directly with a quality of care or service concern, you can:
  - Send an email to: quality.care.complaints@carefirst.com
  - Fax a written complaint to: (301) 470-5866
  - Write to: CareFirst BlueCross BlueShield
    Quality of Care Department, P.O. Box 17636
    Baltimore, MD 21297
If you send your comments to us in writing, please include your identification number and provide us with as much detail as possible regarding the event or incident. Please include your daytime telephone number so that we may contact you directly if we need additional information. Our Quality of Care Department will investigate your concerns, share those issues with the provider involved and request a response. We will then provide you with a summary of our findings. CareFirst member complaints are retained in our provider files and are reviewed when providers are considered for continuing participation with CareFirst. These procedures are also outlined in your Evidence of Coverage.

If you wish, you may also contact the appropriate jurisdiction’s regulatory department regarding your concern:

**VIRGINIA:**
Complaint Intake, Office of Licensure and Certification, Virginia Department of Health, 9960 Maryland Drive, Suite 401, Richmond, VA 23233-1463
Phone #: (800) 955-1819 or (804) 367-2106
Fax #: (804) 527-4503
Office of the Managed Care Ombudsman, Bureau of Insurance, P.O. Box 1157, Richmond, VA 23218
Phone #: 1-877-310-6560 or (804) 371-9032

**DISTRICT OF COLUMBIA:**
Department of Insurance, Securities and Banking
801 1st Street, NE, Suite 701, Washington, DC 20002
Phone #: (202) 727-8000

**Hearing impaired**
To contact a Member Services representative, please choose the appropriate hearing impaired assistance number below, based on the region in which your coverage originates.

Maryland Relay Program: (800) 735-2258
National Capital Area TTY: (202) 479-3546
*Please have your Member Services number ready.*

**Language assistance**
Interpreter services are available through Member Services. When calling Member Services, inform the representative that you need language assistance.

*Please Note:* CareFirst appreciates the opportunity to improve the level of quality of care and services available for you. As a member, you will not be subject to disenrollment or otherwise penalized as a result of filing a complaint or appeal.

**Confidentiality of subscriber/member information**
All health plans and providers must provide information to members and patients regarding how their information is protected. You will receive a Notice of Privacy Practices from CareFirst or your health plan, and from your providers as well, when you visit their office.

CareFirst has policies and procedures in place to protect the confidentiality of member information. Your confidential information includes Protected Health Information (PHI), whether oral, written or electronic, and other nonpublic financial information. Because we are responsible for your insurance coverage, making sure your claims are paid, and that you can obtain any important services related to your health care, we are permitted to use and disclose (give out) your information for these purposes. Sometimes we are even required by law to disclose your information in certain situations. You also have certain rights to your own protected health information on your behalf.

**Our responsibilities**
We are required by law to maintain the privacy of your PHI, and to have appropriate procedures in place to do so. In accordance with the federal and state Privacy laws, we have the right to use and disclose your PHI for treatment, payment activities and health care operations as explained in the Notice of Privacy Practices. We may disclose your protected health information to the plan sponsor/employer to perform plan administration function. The Notice is sent to all policy holders upon enrollment.

**Your rights**
You have the following rights regarding your own Protected Health Information. You have the right to:

- Request that we restrict the PHI we use or disclose about you for payment or health care operations.
- Request that we communicate with you regarding your information in an alternative
manner or at an alternative location if you believe that a disclosure of all or part of your PHI may endanger you.

- Inspect and copy your PHI that is contained in a designated record set including your medical record.
- Request that we amend your information if you believe that your PHI is incorrect or incomplete.
- An accounting of certain disclosures of your PHI that are for some reasons other than treatment, payment, or health care operations.
- Give us written authorization to use your protected health information or to disclose it to anyone for any purpose not listed in this notice.

Inquiries and complaints
If you have a privacy-related inquiry, please contact the CareFirst Privacy Office at (800) 853-9236 or send an email to privacy.office@carefirst.com.

Members’ rights and responsibilities statement

Members have the right to:

- Be treated with respect and recognition of their dignity and right to privacy.
- Receive information about the health plan, its services, its practitioners and providers, and members’ rights and responsibilities.
- Participate with practitioners in decision-making regarding their health care.
- Participate in a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Make recommendations regarding the organization’s members’ rights and responsibilities.
- Voice complaints or appeals about the health plan or the care provided.

Members have a responsibility to:

- Provide, to the extent possible, information that the health plan and its practitioners and providers need in order to care for them.
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Follow the plans and instructions for care that they have agreed on with their practitioners.
- Pay copayments or coinsurance at the time of service.
- Be on time for appointments and to notify practitioners/providers when an appointment must be canceled.

Eligible individuals’ rights
statement wellness and health promotion services

Eligible individuals have a right to:

- Receive information about the organization, including wellness and health promotion services provided on behalf of the employer or plan sponsors; organization staff and staff qualifications; and any contractual relationships.
- Decline participation or disenroll from wellness and health promotion services offered by the organization.
- Be treated courteously and respectfully by the organization’s staff.
- Communicate complaints to the organization and receive instructions on how to use the complaint process that includes the organization’s standards of timeliness for responding to and resolving complaints and quality issues.