Pharmacy Program

Integrated Deductible

See Annual Deductible on Medical Summary of Benefits
$0/0/25/45 Retail Copays ■ 50% Injectables Coinsurance

Summary of Benefits

Plan Feature	Amount	Description
Deductible	See medical summary of benefit for annual deductible amount	If you meet your combined medical and drug deductible, you will pay a different copay or coinsurance depending on the drug tier. Drugs not subject to any medical or drug deductible are noted below.
Out-of-Pocket Maximum	See medical summary of benefit for annual out-of-pocket amount	If you reach your out-of-pocket maximum, 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 (Affordable Care Act) (up to a 34-day supply)	$0 (Not subject to deductible)	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).
Oral Chemotherapy Drugs Diabetic Supplies (up to a 34-day supply)	$0 (Not subject to deductible except for HSA plans)	Diabetic supplies include needles, lancets, test strips and alcohol swabs.
Generic Drugs (Tier 1) – HealthyBlue Select Generics (up to a 34-day supply)	$0 (Not subject to deductible)	See complete list of HealthyBlue generic drugs at **www.carefirst.com/hbselectgenerics** or call 800-241-3371.
Generic Drugs (Tier 1) (up to a 34-day supply)	$0	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (up to a 34-day supply)	$25	All preferred brand drugs are covered at this copay level.
Non-preferred Brand Drugs (Tier 3) (up to a 34-day supply)	$45	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Discuss using alternatives with your physician or pharmacist.
Self-administered Injectables (excluding insulin) **(Tier 4)** (up to a 34-day supply)	50% coinsurance up to a maximum payment of $75	All self-administered injectable drugs (excluding insulin) are covered at this payment level. Insulin is covered at appropriate copay level.
Maintenance Drugs (up to a 90-day supply)	Generic: $0 Preferred Brand: $50 Non-preferred Brand: $90 Self-administered injectables: 50% coinsurance, up to a maximum payment of $150	Maintenance drugs of up to a 90-day supply are available for twice the copay through Mail Service Pharmacy or a retail pharmacy. Injectables are covered at 50% coinsurance up to a maximum payment of $150.
Restricted Generic Substitution	Yes	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.

Visit **www.carefirst.com/rx** *for the most up-to-date Preferred Drug List and Formulary (list of covered drugs), including the prescription guidelines. Prescription guidelines indicate drugs that require your doctor to obtain prior authorization from CareFirst before they can be filled and drugs that can be filled in limited quantities.*

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

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

CareFirst
The CareFirst BlueCross BlueShield family of health care plans

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

12.1 Coverage is not provided for:

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

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

C. The cost of services that are furnished without charge or are normally furnished without charge if a Member was not covered under this 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 do not meet all other conditions and criteria for coverage as determined by CareFirst BlueChoice.

E. 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.

F. Any type of dental care (except treatment of accidental bodily injuries or oral surgery, 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 and periodontal disease, removal of teeth, orthodontics, replacement of teeth, or any other dental services or supplies, unless provided in a separate rider or amendment to this Evidence of Coverage. All other procedures involving the teeth or areas and structures surrounding and/or supporting the teeth, including surgically altering the mandible or maxillae (orthognathic surgery) for Cosmetic purposes or for correction of malocclusion unrelated to a documented functional impairment are excluded.

G. Benefits will not be provided for Cosmetic surgery (except as specifically provided for Reconstructive Breast Surgery and Reconstructive Surgery and services for cleft lip or cleft palate or both, as listed above) or other services primarily intended to correct, change or improve appearances.

H. Treatment rendered by a health care provider who is a member of the Member's family (e.g., parents, Spouse, brothers, sisters, and children).

I. 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 except as otherwise provided in this Description of Covered Services. Benefits for prescription drugs may be available through a rider attached to the Evidence of Coverage.

J. 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 or the Prescription Drug Benefits Rider attached to this Evidence of Coverage. 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, except for Over-the-Counter medication or supply dispensed under a written prescription by a health care provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B".

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

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

M. All assisted reproductive technologies including artificial insemination and intrauterine insemination, in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same.

N. Fees or charges relating to fitness programs, weight loss or weight control programs; physical conditioning; exercise programs; and use of passive or patient-activated exercise equipment other than Medically Necessary and approved Cardiac Rehabilitation and pulmonary rehabilitation programs.

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

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 Evidence of Coverage 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, except as provided for telemedicine services in Section 1.1 Y, failure to keep a scheduled visit, completion of forms (except for forms that may be required by CareFirst BlueChoice), 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 Evidence of Coverage 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 attached to the Evidence of Coverage. This exclusion does not apply to evidence-informed preventive care and screenings, including oral and vision care, provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for infants, children, and adolescents.
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, drug 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 Section 1.3, Organ and Tissue Transplants).
FF. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
GG. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

12.2 Autism Spectrum Disorder. Coverage is not provided for:
Services delivered through school services;
Members under age two (2); and
Members over age seven (7), unless approved and authorized by CareFirst BlueChoice for continued care.

12.3 Organ and Tissue Transplants. Coverage is not provided for:
A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary, non-experimental skin grafts that are covered under the Evidence of Coverage.
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 that are not for the recipient Member and a companion (or two companions if the Member is under age 18).
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 Evidence of Coverage.

12.4 Inpatient Hospital Services. Coverage is not provided for:
A. Private room, unless Medically Necessary and authorized or approved by CareFirst BlueChoice. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.
B. Non-medical items and convenience items, such as television and phone rentals, guest trays and laundry charges.
C. Except for covered Emergency Services and Maternity Care, a hospital admission or any portion of a hospital admission that had not been authorized or approved by CareFirst BlueChoice, whether or not services are Medically Necessary and/or meet all other conditions for coverage.
D. Private duty nursing.
E. Admissions to a facility that is a convalescent home, convalescent rest or nursing facilities, facilities primarily affording custodial, educational or rehabilitative care, or facilities for the aged, drug addicts or alcoholics.

12.5 Home Health Services. Coverage is not provided for:
A. Private duty nursing.
B. Custodial Care.

12.6 Hospice Benefits. Coverage is not provided for:
A. Services, visits, medical equipment or supplies that are not included in CareFirst BlueChoice-approved plan of treatment.
B. Financial and legal counseling.
C. Any service for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.
D. Chemotherapy or radiation therapy, unless used for symptom control.
E. 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.
F. Reimbursement for volunteer services.
G Custodial Care; domestic or housekeeping services.
H. Meals on Wheels or similar food service arrangements.
I. Rental or purchase of renal dialysis equipment and supplies.
J. Private duty nursing.

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

12.8 Inpatient Mental Health and Substance Abuse. Coverage is not provided for:
A. Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.
B. Custodial Care.
C. Observation or isolation.

12.9 Emergency Services and Urgent Care. Benefits for Emergency Services and Urgent Care will not be provided for:
A. Charges for services when the claims filing and notice procedures stated in Section 7 of the Evidence of Coverage have not been followed by the Member.
B. Except for covered ambulance services, travel, including travel required to return to the Service Area, whether or not recommended by the Member's treating physician.

12.10 Medical Devices and Supplies. Coverage is not provided for:
A. Convenience item. Any item that increases physical comfort or convenience without serving a Medically Necessary purpose, e.g. elevators, hoyer/stair lifts, ramps, shower/bath bench.
B. Furniture items. Movable articles or accessories which serve as a place upon which to rest (people or things) or in which things are placed or stored, e.g. chair or dresser.
C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body, e.g. exercycle or other physical fitness equipment.
D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home, e.g. parallel bars.
E. Environmental control equipment. Any device such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.
F. Eyeglasses, contact lenses, dental prostheses or appliances, or hearing aids. Benefits for eyeglasses and contact lenses may be available through a rider 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 Supplies in this Description of Covered Services. Non-covered supplies include incontinence pads or ace bandages.

Tinnitus maskers; purchase, examination, or fitting of hearing aids.

Prescription Drug Rider Exclusions

Benefits will not be provided under this rider for:

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